

## ACKNOWLEDGEMENTS

This study was carried out in the Public Service of Namibia. The topic and design of the study were the result of joint brainstorming around issues pertaining to an effective and efficient public service with my husband Estimate, also a public servant, and myself.

I was blessed to have such excellent, professional, learned and versatile supervisors. Firstly, I wish to express my sincere gratitude to Professor Joy Buitendisch, my first supervisor for her helpful and constructive comments during the first phase of this study and for still leaving me enough space to work independently.

## SCREENING FOR PSYCHOLOGICAL DISTRESS AND HELP-SEEKING

## BEHAVIOURS OF NAMIBIAN PUBLIC SERVANTS

I am deeply grateful to Professor Ian Rothmann for his encouragement and his patient contribution to the supervision of this study and his expertise based on his own studies on this topic and for teaching me critical scientific thinking. I am also obliged for his invaluable help and guidance in the

## A THESIS SUBMITTED IN PARTIAL FULFILLMENT

## OF THE REQUIREMENTS FOR THE DEGREE OF

I wish to express my heartfelt thanks to the Hon. Minister of Cabinet, Mr. Kapofi, for the support and encouragement given to allowing an opportunity for all various Offices / Ministries / Agencies during the data collection phase.

## MASTER OF CLINICAL PSYCHOLOGY

OF

## THE UNIVERSITY OF NAMIBIA

I am deeply grateful to my employer, the Government of Namibia through the Office of the Prime Minister, for the support towards my study. Without your favourable and flexible attitude, here, my study would not have materialised. Especially, I owe my gratitude to the Permanent

BY

Yrika Vanessa Maritz

February 2013

Secretary, Mrs Nangula Mbako, for your kind understanding when I presented repeated applications for leave of absence from work. Extended thanks are due to my colleagues at the Directorates of Management Services and Human Resources Management in the Office of The Prime Minister. The directors of these two Directorates in the Department Public Service Management gave me valuable advice and help in many practical questions during this study.

Supervisor: Professor Ian Rothmann

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I want to express my special thanks to the staff of the Ministry of Finance, particularly the Department of Public Service Employees' Medical Aid Scheme. I wish to thank Mr. Etienne Coetzee for the information on medical aid utilisation.

I sincerely thank the participants of the study, the over 200 persons in the Offices / Ministries / Agencies, who made this study possible. A special word of thanks is directed to Mr Thomas Mbeeli from the Ministry of Health and Social Services, whose insight into the workings of the health system was valuable.

I am also grateful to the General Practitioners who scheduled valuable consultation time to take part in the interviews – it was quite an opportunity to assess the situation from a different perspective.

Finally, I owe my heartfelt gratitude to my loving family. I want to sincerely thank my Mom, Monina and Dad, Amadeo for helping me through the many challenges encountered. My warmest and loving thanks go to my husband Etienne for his love and support throughout my studies, during which he had to bear my absence, physically, emotionally and mentally, when I got engrossed in the analyses or writing or was just absent-mindedly wandering in my thoughts. Special thanks go to our daughters Kathryn and Czarina for reminding me of the essence of life as well, as to their sisters Claudia and Michelle who have tolerated my long hours spent on this work as opposed to spending time with them in doing the fun things young people are used to!

I dedicate this thesis to my parents, whom I admire and owe so much. Dad for his boundless enthusiasm for life, his ability to think beyond the conventional or established, and to dream of endless possibility. Mom for her optimism, and her inclination to see humour and feel joy along the 'roller-coaster of life'. Together they have inspired a love of learning and taught me more about life than any academic pursuit could ever aspire to accomplish.

DECLARATIONS

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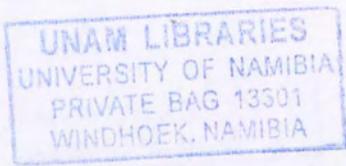
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## ABSTRACT

### ABBREVIATIONS

DALY - Disability Adjusted Life Years

GHQ – General Health Questionnaire

GP - General Practitioner

IFMS - Integrated Financial Management System

OMAs – Offices Ministries and Agencies

PSEMAS – Public Service Employees Medical Aid Scheme

SD – Standard deviation

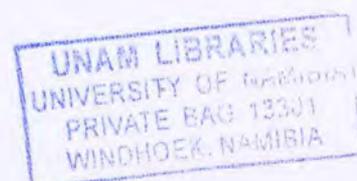
SPSS - Statistics Package for the Social Sciences

WHO – World Health Organisation

## ABSTRACT

This thesis explores the help-seeking behaviours of a sample of Namibian public servants and their utilisation of the government's Public Service Employees' Medical Aid Scheme (PSEMAS) for their problems related to psychological distress. At present, the PSEMAS covers unlimited treatment interventions to psychologists and other mental health practitioners for those experiencing psychological distress. The PSEMAS fund is presently available as a service benefit to all full-time employees of the public service. Despite the availability of paid psychological treatment, the current expenditure indicates that government employees very rarely seek help from psychologists. Failure to recognise and treat psychological distress leads to various additional problems resulting in extra visits to the general practitioner's (GP's) office. Of the 209 155 PSEMAS members, only 13 900 visited psychologists in 2007/2008 amounting to less than 6% of the current medical aid expenditure for government employees. This exploratory study adopted a mixed-methods approach and was designed in two phases. The first phase of the study which utilised a convenience sample of participants  $n = 284$  was quantitative in nature and aimed at establishing the level of psychological distress as it relates to various socio-demographic characteristics of the sample. The GHQ-28 and a socio-demographic questionnaire were employed as tools for data collection. The second phase of the study relied on the use of qualitative data which was obtained from interviewing a sample of general practitioners  $n = 5$  utilising the constructivist paradigm. The findings of the study point to the fact that a number of socio-demographic characteristics such as language, gender, marital status, age, residential area, education and income levels of public servants are related to psychological distress, help-seeking and utilization of their PSEMAS service benefits. Furthermore, the study concluded that the level of psychological distress is significantly related to seek professional psychological help for people working in the public service.

**Key words:** help-seeking, psychological distress, general health questionnaire (GHQ-28), Namibia.



## 1. INTRODUCTION

### 1.1. Statement of the problem

According to Mathers and Loncar (2006), conditions related to mental illness are associated with more lost work days than any other chronic condition, impacting on the Namibian economy with over 6.9% of the global burden of disease. This recent finding is associated with the growing concern of absenteeism, low productivity and lowered customer satisfaction levels. Since work plays a central role in formulating one's personal identity in the workplace such as for those working in the public service, it would also be expected that this finding would also interact negatively with service delivery. Despite this, the emphasis of most research on this area in Namibia over the past few decades has been limited (Government of the Republic of Namibia, 2008 ). The studies which were found in this area have focused on gender neutral associations between various psychosocial work environments (LeBeau, 2005) and physical health outcomes, often within a particular context (Shino, 2011). There are no known studies conducted on the relationship between the levels of psychological distress and help-seeking across the public service in Namibia.

This thesis therefore explores the help-seeking behaviours of a sample of Namibian public servants and their utilisation of the government's Public Service Employees' Medical Aid Scheme (PSEMAS) for their problems related to psychological distress. At present, the PSEMAS covers unlimited treatment interventions to psychologists and other mental health practitioners for those experiencing psychological distress. The PSEMAS fund is presently available as a service benefit to all full-time employees of the public service. Despite the availability of paid psychological treatment, the current expenditure indicates that government employees very rarely seek help from psychologists (Coetzee, 2008). Failure to recognise and treat psychological distress leads to various additional problems resulting in extra visits to the general practitioner's (GP's) office (Shino, 2011).

#### 1.1.1. Background

Worldwide, there are more than 450 million people who suffer from mental health problems and 80% of people with mental health problems in developing countries do not receive treatment. (WHO, 2008). According to Namibia's mental health policy which was launched in 2005, 10%

(about 108 000 adults) experience some form of mental health problem (Government of the Republic of Namibia, 2005).

In a report published by the Ministry of Health and Social Services (Government of the Republic of Namibia, 2008), an estimated 42,124 people with a mental health diagnosis (2.34% of the population) were treated at outpatient clinics, while 40,940 of these people who re-visited outpatient clinics were admitted owing to a mental health problem between April 2007 and March 2008. In the same report, the incidence figures cited in 2005 are similar, estimating that 2-3% of adults in Namibia have serious mental health disorders. Although these statistics suggest that the incidence of mental health problems in Namibia is lower than the global estimates, data from a similar study undertaken by the World Health Organization (2005) in South Africa also suggests that the information for Namibia underestimates the true incidence of mental health problems. As Namibia and South Africa have many social and historical similarities, the data can be used to suggest that there is also a high level of unmet need for mental health services in Namibia and it is likely that this is due to a lack of recognition of mental health problems rather than a lack of morbidity (WHO, 2005). In 2011, the Health Professions Council of Namibia confirmed that there are 90 registered psychologists which is the equivalent of four psychologists per 100 000 and one social worker for over 50 000 of the population (Government of the Republic of Namibia, 2008).

According to the Head of the Public Service Medical Aid Scheme (PSEMAS), less than 6% of the current medical aid expenditure for government employees is utilised on psychological services (E.J. Coetzee, personal communication, April 14, 2008). At a meeting hosted by the Psychological Association of Namibia (PAN), it was stated that only 13 900 of the 209 155 PSEMAS members visited psychologists in 2007/2008 (Coetzee, 2008). At the same meeting, it was emphasised that ailments related to stress, anxiety and other psychological symptoms are perceived to be disregarded by those seeking help. Instead of seeking help from a mental health practitioner, a GP is consulted and the person is subsequently booked off for primary medical health reasons (Coetzee, Presentation, 4 April 2008). Since these underlying psychological problems are not addressed, the physical or somatic ailments prevail and the patient returns to the GP with the same symptoms. This vicious cycle unfortunately has greater implications not just

for the employees concerned but has a negative impact in terms of the high absenteeism rate within government. Although the Namibian Public Service prides itself to have "...one of the best medical aid benefits in Africa" (Coetzee, personal communication, April 14, 2008), research on the utilisation of mental health services is of increasing value because of the high and still rising expenditure in health care (Namibia's Health in Crisis, 2007).

## **1.2. Research objectives**

Given the scarcity of research conducted on help-seeking for psychological distress of Namibian public servants, the primary objective of this study was to investigate the presence (or absence) of psychological distress, anxiety and depression among those employed by the public service. More specifically, the study aimed at exploring the reasons behind the lack of utilisation of psychological services with regard to these aspects. Furthermore, the study aimed at exploring the use of the General Health Questionnaire as a screening instrument for psychological distress within this context.

This study utilised the mixed methods approach to find an answer to the overarching question: How are the sociodemographic characteristics of public servants related to psychological distress, help-seeking and utilization of their PSEMAS service benefits and provision of psychological services in the Namibian public service?

More specifically, the objectives of this study are:

- To describe the levels of psychological distress of Namibian public servants;
- To describe the relationship between psychological distress and the socio-demographic characteristics of Namibian public servants;
- To describe Namibian public servants' utilisation of their PSEMAS benefits; and,
- To describe the perceptions of General Practitioners regarding the help-seeking behaviours of public servants.

## **1.3. Definition and operationalisation of concepts**

For the purpose of this study and for ease of reading, the terms "General Practitioner", "GP", "Medical Doctor", "Doctor" and "physician" are synonymous. Similarly, "Psychiatrist", "Social worker" and "Psychological counselor" refer to mental health practitioners in this study.

The study uses the terms "public servants", "government officials", "public service employees", "participants" and "respondents". These are used interchangeably and refer to the sample of people under study as those employed by a central government office, ministry or agency (O/M/A) in the Namibian public service.

### **1.3.1. Help-seeking**

Help-seeking generally refers to the use of "formal" supports, which are defined as health facilities, formal social institutions or professional care providers, either in the public or private sector. In many cases, "help-seeking" is synonymous with "health-seeking," which generally refers more narrowly to seeking services or remedies for a specific ailment or illness (LeBeau, 2000; Morgan, Ness & Robinson, 2003). In many of the documents consulted, "help-seeking" refers to the use of health and other services in the case of severe or serious mental health issues, including substance use, depression and suicide. In only a few cases in the literature is the term "help-seeking" used in a more comprehensive way to refer to the use of both formal supports and informal supports, which includes family, kinship networks, friends, traditional healers and/or religious leaders (Pillay & Rao, 2002; Chang, 2007; Biddle et al., 2007). The definition of help-seeking used in this study therefore refers to any action or activity carried out by an individual who perceives herself/himself as requiring personal, psychological or affective assistance with the purpose of meeting this need in a positive manner. This includes seeking help from formal services – for example, clinic services, counselors, psychologists, medical staff, traditional healers, religious leaders or youth programmes – as well as informal sources, which includes peer groups and friends, family members or kinship groups and other adults in the community.

Help-seeking, in this study is measured by the number of times an individual has indicated the need to visit either an informal or formal source of help.

### **1.3.2. Psychological Distress**

The term 'distress' is frequently used in medical literature to describe patient discomfort related to signs and symptoms of acute or chronic illness, pre- or post-treatment anxiety or compromised status of an individual or the respiratory system (Ridner, 2004 ).

'Psychological distress' may more accurately describe the patient condition to which medical practitioners respond than does the term 'distress'. Lahey (2009) found that psychological distress in the form of anxiety, sadness, irritability, self-consciousness and emotional vulnerability is strongly correlated with physical morbidity, reduced quality and duration of life, and increased use of health services. Psychological distress is thus defined in this study as a distinct concept which is embedded in the context of strain, stress and depression.

For the purpose of this study, the term psychological distress has been operationalized by the use of the 28 – item version of the General Health Questionnaire (GHQ-28).

### **1.3.3. Guiding principles**

The study rests on the premise that understanding help-seeking, psychological distress and the intersection of the two is imperative from a mental health promotion, treatment and service delivery perspective. The work primarily arose not from one theoretical framework, but, rather, from the researcher's direct experience working in the Namibian public service. This prior understanding was used to explore the various socio-demographic aspects of distress in the context of help-seeking, treatment and availability of support. Starting out with a particular framework in mind might have, it was thought, confined the exploration.

### **1.4. Significance of the study**

Although studies on help-seeking have become increasingly common internationally and across Africa, there have only been a small number of Namibian research studies on psychological help-seeking (Feinstein, Haidula, Plattner, & Shino, 2003; LeBeau, 2000; LeBeau, 2005), and the relationship with psychological distress (Bandeira & Kober, 2004). Government Offices and Ministries have expressed the need for more research in this area as little is known about the mental health of people working in the Namibian public service despite the fact that they represent 22% (90 000) of Namibia's population of two million (Government of the Republic of Namibia, 2010), and constitute an integral part of a social system geared towards providing public services to the broader Namibian population. Their psychological and physical wellbeing therefore contributes to the wellbeing of the Namibian society as a whole. Thus, this study will

have relevance for, and will contribute to the field of organisational, community and health psychology's current and ongoing involvement with the wellbeing of employees, their families and communities. More broadly, this study could contribute to the enhancement in terms of maintaining the utilisation of the current service benefit of paid psychological help in the current policy (Government of the Republic of Namibia, 2005).

Thus, this study sought to respond to this need by investigating the psychological help-seeking behaviours related to their problems related to psychological distress as well as explore aspects related to their sociodemographic profile. The results of this study may help in providing a better understanding of the mental health needs of public servants which in turn may enable the Public Service to develop health and safety policies and instigate strategies to further provide support to strengthen the service benefits for this group of individuals. Supportive employee benefits can result in healthier individuals, higher productivity and safety, lower absenteeism, lower staff turnover and greater organizational commitment and ultimately enhance service delivery (Fairbrother & Warn, 2003).

While the primary objective of this study was to investigate the presence (or absence) of psychological distress, depression and anxiety among Namibian public servants, it was considered important to validate this through the experiences of persons who have experienced one or all of the following symptoms: somatic symptoms, anxiety/insomnia, social dysfunction and severe depression as measured in the GHQ-28, and relate the findings to help-seeking.

### **1.5. Delimitations of the study**

According to Barbour (2001), the delimitations of a study are those characteristics that limit the scope and define the boundaries of the inquiry as determined by the conscious exclusionary and inclusionary decisions that were made throughout the development of the study.

This study generated a broad profile of a sample of public servants who were screened for psychological distress vis á vis how they seek help for psychological problems from the various providers of help. There were a number of interesting research questions that could have been asked but were not pursued, such as, "how are the mental health service providers affected by

the low utilisation levels of people from within the public service?", or "whether the culture or ethnic background of a mental health provider influences the decision of an individual not to seek help?" These questions were not pursued in this particular study because (a) the focus of the inquiry was on exploring the key reasons for individuals not utilizing their service benefits to seek paid psychological help and not on the mental health providers (b) the inclusion of these questions, while interesting, would have been beyond the reach of the research, given limited time and money for conducting the study.

### **1.6. Organization of the thesis**

Chapter 1 focuses on the study rationale, the framework and the objectives of the study.

Chapter 2 provides the reader with a detailed review of literature, which highlights findings from studies that explore help-seeking and psychological distress. A concerted attempt has been made to capture studies that highlight the relationship between socio-demographic variables which pertain not only to the African but specifically to the Namibian context.

Chapter 3 addresses the Research Design and Methodology utilized in the study. It elaborates on the choice of the General Health Questionnaire-28 (GHQ-28) as a tool for both data collection. The chapter also details the use of a semi-structured interview schedule developed for use with a sample of General Practitioners (GPs) to add depth to the study.

Chapter 4 outlines the results and lays the foundation for Chapter 5, the discussion section which elaborates on the findings gleaned from the themes and patterns presented in Chapter 4. Chapter 6 outlines the recommendations and concludes regarding the theoretical and specific objectives.

### **1.7. Summary**

This introductory chapter outlines the problem statement, background and rationale of the study. It elaborates on the research objectives of this study, and defines key concepts utilised as well provides an overview of the guiding principles. It concludes with an explanation on the significance as well as the delimitations of the study.

## 2. LITERATURE REVIEW

The review of literature covers what was known in the field at the time this study was undertaken. Gaps were identified which subsequently helped to shape the questions addressed in this thesis and to formulate both the socio-demographic questionnaire and the interview guide used in the study.

This section starts by introducing the concepts of health, illness and various socio-demographic concepts as they relate to help-seeking. Subsequently, it explores various literature sources and models on help-seeking in an effort to understand its importance in the context of mental health. It then examines the literature on how sociodemographic factors are related to help-seeking for psychological distress, the role of family, friends and service utilisation. Finally, it looks at findings from other studies on the role of the GP and the mental health provider respectively.

### 2.1. Concepts of health and illness

According to a recent study of a nationally representative sample of United States, English speaking adults over 18 years old (Demyttenaere et al., 2006), slightly over one-fourth of the persons sampled ( $n = 9282$ ) had been diagnosed with a mental disorder (anxiety, mood, impulse control, and/or substance abuse). Of those, just under one-half of them were diagnosed with two or more disorders. Furthermore, of the persons who were diagnosed with at least one mental disorder, approximately 60% were classified as serious (22.3%) or moderate (37.3%). Serious cases included: a serious lethal suicide attempt in the past 12 months, limits on work due to a mental or substance disorder, non-affective symptoms of psychosis, Bipolar I or II disorder, substance dependence that seriously interfered with routine daily functioning, serious repeated violence due to an impulse control disorder, or any mental disorder which resulted in 30 or more days out of normal life roles (i.e., job, education, family). Among those debilitated by a mental disorder, depression was the leading cause of disability in United States and Canada for those aged 15 – 44 years (WHO, 2008). Furthermore, mental illness and suicide have been found to account for over 15 percent of the burden of disease (years of life lost due to premature mortality and years of life lost due to time lived in states of less than full health) in the United States. This is more than the disease burden caused by all cancers (WHO, 2008).

The study of health, mental wellness, mental ill-health and accordingly, help-seeking behaviours occupies a position of utmost importance in the management of mental health problems. (Arthur & Cook, 2003; Fairbrother & Warn, 2003). The importance of understanding individuals' ideas of health and illness is well acknowledged by research for its theoretical and practical implications for health psychology. In so far as researchers agree that individuals' ideas of health and illness have an impact on their health attitudes and behaviour, people's thoughts of health and illness -related issues are increasingly being investigated (WHO, 2008).

The earliest notion of health as a disease-free state represents the traditional medical definition. This view of health was largely accepted during the first half of the 20th century, mainly by physicians and medical personnel. As described by Rosenstock (1966), such a traditional medical concept of health was based on the assumption that health and disease were objective and observable phenomena. According to the World Health Organisation, health is seen to be the sum total of an individual's complete physical, mental and social well-being and not merely the absence of disease (WHO, 2008). Rather than restricting health to an absence of illness, health is conceptualized more in terms of the presence of absolute and positive qualities. This holistic view of health encompasses and extends the traditional medical view by conceiving health as a positive state of well-being in which physical health is only one of the aspects involved.

Social, psychological, physical, economic and political aspects are incorporated in the definition of health and regarded as components of paramount importance for health and well-being. By adding the psychological and social criteria, the authors of the World Health Organization's concept of health acknowledge that health and illness are essentially multicausal. The authors also contend that there is also a shift in focus from a strictly medical perspective in which absence of illness was the criteria used to evaluate a person's status (WHO, 2008). The European Network on Mental Health Policy has defined health as a state of equilibrium between the individual and the environment. Mental health is an essential element of general health, as there is no health without mental health (Lechnyr, 1992). The concept of mental health is thus defined as a subjective experience of an ailment or feeling of not being normal and healthy. Illness may, in fact, be due to a disease. However, it may also be due to a feeling of psychological or spiritual

imbalance. This has led to the conclusion by some researchers that perceptions of illness are highly culture related while disease usually is not (Matsumoto, 2001).

Other researchers had stated that an adequate and universally valid concept of health is unattainable mostly because health is a value-laden term whose meaning is highly tied to different objectives which govern its use. In line with that, such researchers certainly agree that rather than representing an absence of illness, health refers to a number of states and is therefore, a multidimensional concept (Eberst, 1984; Laffrey, 1986).

Mental disorders, common in primary care, are often associated with physical complaints or the presence of principal mental disorders such as depression, anxiety and somatoform disorders (Herzig et al. 2012). This was recognised nearly 40 years ago when Shepherd, Cooper, Brown and Kalton (1966) completed their work on *Psychiatric Illness in General Practice*. For the first time, seeking help for health problems related to psychological distress became quantifiable, and these researchers were able to show that mental health problems were among the more common reasons for consultation in general practice (Fox, 2002; Heredia-Montesinos, Rapp, Temur-Erman & Heinz, 2012).

However, the findings remain largely similar: much of the psychological distress is concealed beneath the somatic complaints and a significant proportion of patients suffering from mental health problems have a less-than-optimal outcome (Goldsmith, 2002). Lechner (1992) found that only 5% of those suffering from a mental disorder see a mental health professional; the other 95% receive treatment from a family physician. Other research conducted on patients who have consulted a general practitioner (GP) for psychological problems have found a similar prevalence of common mental disorders of between 25% and 50% with depression accounting for 10% to 15% of consecutive consultations (Blacker & Clare, 1987; Verhaak & Wennink, 2008). Goldberg and Huxley (1980) found that there is a large variation between GPs in their ability to recognise mental health problems. During the same timeframe, Schulberg and McClelland (1987) attributed this reduced recognition to poor knowledge about mental health problems and this was later validated by Gulliver, Griffiths and Christensen (2010) who found that GPs were

largely preoccupied with organic illness together with a tendency to underrate the severity and treatability of mental health problems.

The report published by the WHO (2008) suggests that individual and social costs resulted from significant deterioration of mental health of the whole population are comparable (or in some mental disorders even higher) with costs of somatic diseases. Therefore, the significance of early detection of mental health disorders must be emphasized in view of increasing opportunity to benefit from professional intervention, which can diminish the risk of the development of serious disorders leading to long-term work disability (Fairbrother & Warn, 2003). Early detection of mental health disorders is understood as mental health monitoring in a given population at the primary medical care level.

Mental disorders in primary care patients are frequently associated with physical complaints that can mask the disorder. There is insufficient knowledge concerning the role of anxiety, depression, and somatoform disorders in patients presenting with physical symptoms (Menchetti et al., 2009). The routine monitoring of mental health in the Namibian public service is very important since mental health disorders are thought to be one of the ten most common diseases and complaints related to work (Goldsmith, 2002).

Standardized screening questionnaires allow for the detection of mental health disorders. David Goldberg's General Health Questionnaire has a high validity and has been confirmed by the results of many studies (Chung et al., 2006; Goldberg & Williams, 1988; Jackson, 2007; Segopolo et al., 2009;). The GHQ-28 which was validated in Namibia and translated into one of the local languages, Oshiwambo was found to be a valid screening instrument for psychological distress (Haidula et al., 2003). An examination of the literature addressing help-seeking behaviours revealed that although there have been some studies which have explored help-seeking (LeBeau, 2000) and psychological distress (Haidula, et al., 2003; Shino, 2011), only one Namibian exploratory study was found. This study by LeBeau (2005), focused solely on ex-combatants in the post war period and not so much on the broader relationship between distress and help - seeking behaviour among people employed within the public service itself.

## **2.2. Psychological distress**

According to Ryff (1989), psychological distress is the deviation from some objectively state of well-being. It implies maladaptive patterns of coping, with symptoms ranging from negative feelings of restlessness, stress, depression, anger, anxiety, loneliness, isolation and problematic interpersonal relationships. Goldberg and Huxley (1992) supported this finding when they found that psychological distress is a non-specific syndrome that covers additional constructs such as cognitive problems, irritability, anger and obsession-compulsion. A more recent study by Robinson, McBeth and McFarlane (2004) found that there was an association between the symptoms of depression and anxiety which are commonly referred to as psychological distress, somatic components and an elevated risk of premature mortality.

Individuals dealing with traumatic life events such as death of a close friend, experiencing a natural disaster, witnessing a brutal crime may experience psychological distress and difficulty dealing with day-to-day tasks (Brotman, Golden & Wittstein, 2007). Because these mental health problems tend to be of a temporary nature, they do not qualify to be defined as mental illness. Prompt and proper treatment of these issues in the form of counselling or other psychological intervention is critical, as they have the potential to progress into a long-term mental disorder or illness (Ryff, 1989). A recent survey found that psychological distress was a risk factor for death from all causes, cardiovascular disease, and external causes (Russ et al., 2012). The study reported that the greater the distress, the higher the risk. What was more alarming in the findings was that even people with low distress scores were at an increased risk of death and were unlikely to seek help from mental health providers due to these symptoms and were not receiving treatment. On the whole the findings underscore the link between physical and mental health and the need to alleviate even minor symptoms of anxiety and depression since this may improve longevity. Work by Salgado de Snyder (1988) found in studying rural Mexicans that conceptualizations of distress and the social context are related to help-seeking. The research further pointed out the importance of mental distress and related cultural models to understand how individuals and families cope with the identified problem, including the decision to seek help.

People should not ignore their mental health or to either get booked off or solve the problem by receiving medication, which GPs typically choose. According to Ridner (2004), measures of psychological distress have been used as a strategy to evaluate psychological well-being, although the best state they may distinguish is the absence of distress. The systematic screening and recognition of psychological distress is essential as it offers many benefits (Heredia-Montesinos et al., 2012).

### **2.3. The impact of psychological distress in the workplace**

In Namibia, the focus on psychological ill-health and distress at work has been dominated by attention to stress. The concept of stress is as elusive as it is pervasive. Definitions of stress in general and occupational stress in particular are so powerful that they are interrelated with one's daily life (Ridner, 2004). According to Goldsmith (2002), stress may be defined as, an individual, psycho physiological and subjective state, characterized by the combination of high arousal and displeasure. There is now strong evidence that, in a process of chronic exposure to risk factors such as insufficient recovery, behavioural, psychological and physiological reactions may lead to serious illness. Furthermore, it is difficult to find studies which do not find associations between physical disease and common mental disorders. The association is observed in a recent study (Russ et al., 2012) where, for example, there is a near fourfold increase in significant depressive symptoms in the 2 years following cancer diagnosis and smaller but significant increases following heart disease, arthritis and chronic lung disease. Similarly, medical illnesses as a whole are associated with an increased risk of suicidal ideation and attempts (Rickwood, Dean, & Wilson, 2007).

As discussed in the previous section, psychological distress can be used to describe both an individual's frame of mind as well as suffering from a clinical disorder or psychological ill-health. Data released by the Ministry of Health and Social Services (Government of the Republic of Namibia, 2009) reports that in 2011/12, over 250 000 people in Namibia (approximately half of the working Namibian population) believed that they were experiencing 'work-related stress' at a level that was making them ill. Reports on psychological ill-health at work tend to also consider the extent of ill-health related absence, partly as a measure of the severity of the symptoms experienced. Analysis of the information in the reports suggests that, at any point in

time, there will be a significant number of people at work who are experiencing psychological ill-health and related symptoms, though the figures vary significantly depending on how these problems are measured. Again, the most commonly experienced problems will be anxiety and depression. Worryingly, some estimates indicate that up to 30% of people are reporting symptoms of psychological distress at work and that on average 20% of the working population finds their work very or extremely stressful, which could make them more likely to suffer from related psychological and physical ill-health (Government of the Republic of Namibia, 2009).

Stress appears to play a prominent role in the complex manifestations of various types of physiological and psychological disorders. In the workplace, Maslach, Schaufeli, and Leiter (2001) suggest that occupational stress occurs when some factor or combination of factors at work interact with the worker to disrupt his or her psychological or physiological homeostasis. This work supports the initial studies in this area, particularly those of Newton's (1995) findings which highlight the fact that psychological distress in the workplace can contribute to individual and organisational skill effectiveness but it is also an aspect which, in most cases, leads to undesirable effects. In general, Maslach et al. (2001) suggest that organisational stress is an unpleasant state of being that affects employee creativity and work pleasure, while its results on physical and psychological well-being are evident. Arthur and Cook (2003) point out that the undesirable effects of job-related stress occur when this acts as a barrier to employees' adjustment to the work setting. In addition to the impact of occupational stress on the individual's well-being, the consequences for organisations are particularly important: poor individual functioning, compensation claims, accidents, absenteeism, medical expenses and the reduction of workplace satisfaction and productivity. Fairbrother and Warn (2003) validate this finding in their work, concluding that occupational stress is negatively related to job satisfaction. These factors relate to workplace stress and affect the workers' psychosomatic status as well as their organizations in terms of productivity and effectiveness.

According to an article in the Namibia Economist, the problems associated with sickness absence are of concern not only to employers, but also to doctors, other employees, trade unions, administrators of medical aid schemes and ultimately the taxpayer since they impact on the overall employment costs involved and the disruption of work (Namibia's health in crisis, 2007).

As in other occupational health areas, individual characteristics and behavioural styles of people do play a role in the complex and dynamic interplay between the combinations of work characteristics, work behaviour and health outcomes. The pathway between the exposure to psychosocial work characteristics and health goes via the individual appraisal of these characteristics. It is also true that people differ in their knowledge, skills and abilities as well as their attitudes and preferences, ultimately affecting how they choose to seek help (Sayal, 2006).

Cox, Griffiths, and Gonzalez (2000, p. 10), concluded that “there is a wealth of scientific data on work stress, its causes and effects, and some of the mechanisms underpinning the relationships among these”. According to their findings, occupational stress is a major problem in organizations for both the individual as well as for management; there are significant relationships between work factors, personal characteristics and short- and long-term consequences for the individual and the organisation; there are major risk factors for stress and its consequences for ill-health.

#### **2.4. Help-seeking**

The term help-seeking has a variety of definitions and contexts in the literature. In lay-terms, help-seeking behaviour arises from the decision of an individual to do something about a symptom or distress (Chew -Graham, Rogers & Yassin, 2003; Tijhuis & Foet, 1990).

Help-seeking behaviour, however, is complex and intricate. According to Nadler, Fisher and DePaulo (1983), other disciplines such as medicine, sociology and psychology have researched its many dimensions. In defining medical help-seeking behaviour, a patient consults a Doctor or GP. Taylor (2003) defines the term “patient” as a person who is suffering from or enduring pain, a concept related to the word patience. According to this definition, the modern understanding of the concept “patient” refers to a person who is seeking or is receiving medical care or treatment usually as a result of the presence of illness which propels people to seek medical help; however, not all who are ill become patients and not all patients necessarily become ill. In medical help-seeking, a patient contacts a doctor. A system according to the initial help-seeking behaviour is then centred around the patient, where the mere telephone call to the doctor’s office is made, the

appointment is confirmed, the patient sees the doctor and an action is taken around the help-seeking action (Taylor, 2003).

Non-medical help-seeking refers to the process a person follows to seek help from a variety of non-professional people such as a pastor, traditional healer, or even asking a relative or friend for advice (Morgan et al., 2003). Seeking help therefore, within this context may be defined in the following two ways: Firstly, voluntary contact with different types of professionals, including formal providers in the medical field (such as, general practitioners, other physicians, psychiatrists, psychologists, nurses or social workers) is defined as formal help-seeking (Fox, 2002). Secondly, any voluntary contact with informal providers (such as ministers, priests, spiritualists, and herbalists) is defined as informal help-seeking. Non-medical help-seeking behaviours often lead to medical contacts through advice and referral, and many patients engage in medical and non-medical help-seeking behaviours simultaneously. LeBeau (2005) found in her study that Namibian ex-fighters most often went to family, friends and relatives for help, but also went to religious leaders, other ex-fighters as well as to friends and family members.

Help-seeking has also been referred to as a term associated with students seeking help within an academic context. Within the field of education, Nelson-Le Gall (1981) distinguished five steps in a students' help-seeking process, namely, becoming aware of the need for help, deciding to seek help, identifying potential helpers, employing strategies to elicit help, and reacting to help-seeking attempts. In the same study, Nelson-Le Gall (1981) quoted psychologists who have labelled help-seeking behaviour as "an index of dependence and a degrading activity to be avoided" (1981, p. 228). Whereas one way to view help-seeking could be that needing help is a sign of weakness or dependence, a more productive view is that help-seeking is one strategic response to the problem at hand (Karabenick, 1998; Newman, 1990; Newman, 1998; Ryan & Pintrich, 1998) and an intelligent form of self-regulatory behaviour (Nelson-Le Gall & Resnick, 1998). Yet many people do not seek appropriate help because they may have performance (rather than mastery) goals, unsupportive interpersonal relationships and feelings of low personal competence. Some theorists pointed out that help-seeking can be predicted by embarrassment and loss of self-esteem. Other researchers attributed help-seeking to the demonstration of one's low-ability (Newman, 1990; Ryan & Pintrich, 1998). There are studies which have found that

Asian American, African American, and Latino students consistently seek help from counseling centers with greater distress than their Caucasian American counterparts (Lahey, 2009; Rickwood et al., 2005).

Based on future trends in global health and projections of mortality and burden of disease, it is expected that the impact of psychological symptoms will worsen in the future. Between 2002 and 2030, unipolar depressive disorders are projected to increase from the fourth to the second leading cause of Disability Adjusted Life Years (DALY); or “the equivalent years of full health lost due to diseases and injury in World Health Organization member states;” (Mathers & Loncar, 2006, p. 2015). More specifically, unipolar depressive disorders are expected to account for the highest proportion of DALYs in high-income countries, second highest in middle-income countries, and third highest in low-income countries (Mathers & Loncar, 2006). Furthermore, the WHO projections of the leading causes of death in the next 30 years reveal that self-inflicted injuries will increase in rank from being the 14th leading cause of death in the world to 12th (Mathers & Loncar, 2006).

According to Rickwood et al., (2005), there is an absence of a generic help-seeking model and currently no widely accepted measures of help-seeking. As a result of this, progress in the research area has been hampered by the inconsistencies in the definitions and measurement of help-seeking in the literature. In order to address this issue, various theoretical models have been cited in this study to operationalize the complex and multi-dimensional issue of health care utilisation. The multi-dimensional models offer some theoretical frameworks used in the research on the use of health care services to explain utilisation in the Namibian context.

### **2.5. Lay or informal sources of help**

There has been very little published research in terms of help-seeking attitudes and behaviour from lay sources of help. A study of 16 to 24- year-olds in Britain reported that lay sources were preferred for mental health problems (Marks et al., 2005). In Germany the lay support system is the preferred source of help for depression (Cox et al., 2000). However, in an Israeli study friends and family were only the third major source of help after health professionals and GPs (Rabinowitz et al., 1999).

A study of the informal response of social networks to mental illness found that the friendship network was a particularly striking source of help for people with mental health problems (Horwitz, McLaughlin & White, 1998). In general, studies find that people may initially seek help from family members, friends, pastors, supervisors, employers, before seeking help from a variety of professionals including general practitioners, psychiatrists, therapists or psychological counsellors (Murstein & Fontaine, 1993; Trude & Stoddard, 2003).

## **2.6. Formal sources of help**

The literature indicates that once the decision to seek help has been made, people seem most likely to select mental health professionals according to a doctor's recommendation (28% of respondents), to select providers according to their medical aid provisions (26%), and to base their decision on geographic proximity (Trude & Stoddard, 2003). Murstein and Fontaine (1993) found that 70 out of 90 respondents selected the GP as the most used source to address their help-seeking.

Research by Pill et al. (2001), based on the works of Shepherd et al. (1966), highlighted the important role that GPs play within the health care system. Pill et al. (2001) found that GPs fail to recognise mental health problems by treating the symptoms rather than exploring the causes.

## **2.7. Psychological help-seeking**

Psychological help-seeking has been defined by Morgan et al. (2003) as behaviour in which someone actively searches for psychological assistance from a mental health provider. Wills and DePaulo (1991) argue that psychological help-seeking is a complex process involving characteristics of the person seeking help, the kind of help, the context, and the potential helper. The following models, which have evolved over time, often incorporate key elements from the other approaches emphasises a particular aspect of help-seeking. One important commonality among all the models is the inclusion of predisposing factors, such as personality traits, previous experiences, and dispositions, which influence help-seeking behaviour. Socio-demographic characteristics such as age, gender, race and socioeconomic status are featured in each model, and each assumes that an awareness of symptoms or distress hastens the process of help-seeking.

A number of studies have shown that as psychological distress increases, the intent to seek psychological help also increases (Bland, Newman & Orn, 1997; Kushner & Sher, 1991; Morgan et al., 2003). For instance, when compared to individuals who do not seek help from a mental health provider, those who do seek help have more severe psychological distress (Pillay & Rao, 2002).

## **2.8. Models of help-seeking**

This section deals with several models of help-seeking behaviour, originating from various disciplines to explain help-seeking.

### **2.8.1. Help-seeking as a process**

A popular model of help-seeking is Fischer, Winer, and Abramowitz's (1983) five-stage process, which synthesized help-seeking models from the current literature at the time of its development. In the first stage of Fischer et al.'s (1983) model, the individual identifies a problem that is currently causing, or will in the future cause personal harm. The individual also acknowledges that the problem is initially psychological in nature. In the second stage, the individual weighs up the various options of addressing the issue. These options include the consideration of several alternatives, such as doing nothing, attempting self-remedial actions, seeking the opinions of others such as advice from a family member, friend, or clergy member, consulting a professional, or a combination of some of the options. During this stage, several possibilities may be tested and found to be unsatisfactory before psychological help-seeking is finally considered. Alternatively, the individual may perceive help-seeking to be the most effective option and choose it initially, or may be persuaded by others to consider help-seeking when other alternatives fail to produce change (Fischer et al., 1983). In the third stage, the individual forms an intention to seek help, which is informed by a cost-benefit analysis of the various aspects of the help-seeking process, including therapist or agency factors (monetary expense and perceived effectiveness of therapy), social factors (persuasion and stigma), and personal factors (tolerability of the problem and beliefs about accepting help). Fischer et al. (1983) suggests that some precipitating event, such as a marked worsening of the problem or increased resources to engage in therapy, must take place in order to mobilize the individual to take help-seeking

action. Occurring in the fourth stage, it is hypothesized that such an event will not propel the individual to seek help in the absence of an already-formed intention to do so (developed in stage three). The final stage, overt help-seeking, may result in a meeting with a therapist, or may be thwarted by a number of barriers.

### **2.8.2. The bio-psychosocial model**

The bio-psychosocial model which originated as a result of the failure of the biomedical model was originally introduced by Engel (1980). The model agrees with the view that an individual is vulnerable to sociocultural and psychological influences and acknowledges the role played by life experience and current social situations in the presentation of illness. According to the model, treatment interventions target the person and not the disease. The bio-psychosocial approach therefore stresses the importance of a holistic and integrated approach to the management of illness and is based on general systems theory (White, 2005).

Systems theory implies that all levels of an organization or system, beginning from molecules and cells and ending with society or biosphere, are linked to each other in a hierarchical relationship, so that a change in one effects changes in the others. In the context of help-seeking, an individual's perceptions of health and threat of illness, as well as the barriers in the social or cultural environment, will influence the likelihood that the person will seek help. White (2005) argues that knowledge on the bio-psychosocial approach may be beneficial in terms of the research on help-seeking, which aims to explain more thoroughly the relationships between various explanatory factors for example, somatic diseases, psychological factors and social environment, such as the family of health care utilisation.

Weinman and Petrie (1997) found the model to be limited in terms of its cross-cultural effectiveness because it does not challenge the construct validity of illness. Stanhope (2002) supported this and argued that, while the bio-psychosocial model of illness acknowledges social and psychological influences shaping the subjective experience and treatment options, it fails to mention that the standards of abnormality will differ across contexts. For an example, what is conceived to be illness in Namibia might be considered normal in another context. Rivera (2007) further found that although the model acknowledges the relationship between body and

mind, it fails to account for the specific cognitive processes that will impact on physical illness. Koenig (2000) offers one of the most comprehensive reviews of the relationship of spirituality, religion and health with regard to the bio-psychosocial model. According to Koenig (2000), with the expansion of the model to include all three dimensions, there are significant and potentially harmful effects. These may include the following examples such as refusing medical treatment on religious grounds (refusing blood transfusions, vaccinations, or antibiotics); replacing the need to seek psychological help or medical treatment with religious practices; or precipitating a greater sense of guilt, shame, or stress if the failure to regain one's health is seen as the sick person's fault or because of a lack of faith (Koenig 2000). At the same time, religious beliefs and practices have been associated with lower suicide rates; less anxiety, substance abuse, and depression; a greater sense of well-being; and more social support in addition to other benefits (Koenig 2000). D'Souza (2007) argued that the incorporation of spirituality and religion into clinical practice be the salvation of biomedicine as it would enhance the relationships between the patient and doctor.

### **2.8.3. Help-seeking as a social phenomenon**

In the model developed 3 decades ago by Purola in 1972 (2003), it is suggested that the use of health care is a social phenomenon. Purola argues that the basic setting for the use of health care services is the illness in a medical sense. The perceived illness is identified as a catalyst of behaviour; while predisposing and enabling factors act as modulators of a person's behavioural reactions (Matsumoto, 2001). Chew-Graham et al. (2003), found in their study of medical students that those avoiding any form of help-seeking have perceived norms regarding the experience of mental distress and that "... experiencing a mental health problem may be viewed as a form of weakness and has implications for subsequent successful career progression" (Chew-Graham et al., 2003, p. 873).

Antonovsky's (1979) model of utilisation reflects the manner in which an individual views the world and is expressed in a specific underlying attitude to illness and to the larger socio-cultural environment. This model takes into account the fact that medical care constitutes a small social system, which may be used to deal with diffuse social and psychological needs when the system is available, when its use is socially encouraged, and when it is receptive to peoples' needs and

orientation (Antonovsky, 1979). This is supported by research conducted by Trude and Stoddard (2003) who found that African-Americans were likely to seek help from the clergy or church as a resource in contrast to their relatively low use of the formal health system. They found that in comparison with Caucasian women, African American women were significantly more likely to report using prayer as a coping strategy and significantly less likely to seek help from mental health practitioners.

#### **2.8.4. The socio-behavioural model**

Anderson and Laake (1987) developed a conceptual model called the socio-behavioural model of utilisation, for determining the use of health services. Although it was initially developed in the sixties and tested extensively in the eighties, the model is still a powerful explanatory model to explain health services use. The socio-behavioural proposes that individuals first identify some perceived need for help. Predisposing social, personal, and cultural characteristics such as gender, age, socio-economic status, and other demographic and individual differences variables are also included in the model. Among the predisposing characteristics, demographic factors such as age, gender, education and ethnicity are counted; people's attitudes, beliefs and values regarding mental health care are predisposing characteristics as well.

Enabling factors have to do with the availability of appropriate help as well as financial resources. These are combined with the need and predisposing characteristics to influence an individuals' use of health services. Classical enabling factors are the geographical (distance) and financial (insurance, income) access to institutions. The socio-behavioural model of utilisation also proposes that the need for care should be the main determinant for the use of health care facilities. Need for care is divided in terms of the need for care as assessed by the clinician, and need for care from the patient's perception (i.e. the perceived need for care). The clinical need for care has a number of indicators: the diagnosis, severity, presence of co-morbidity, and recurrence (Anderson & Laake, 1987).

Despite inequitable or equitable access or the number of indicators, there are still variances in the number of visits to general practitioners. According to Goldsmith (2002), the socio-behavioural

model also focuses on patients' beliefs, experiences and other conditions that influence the propensity to seek services in the presence of perceived need.

#### **2.8.5. The health belief model**

Few studies have been carried out to identify the health beliefs held by people on mental distress. The findings are typically consistent with biomedical model, indicating that up to 20% believe depression to have biologic origins (genetic or chemical change) and 80% believe it to be primarily social (stress, bereavement, or childhood experience). The public service, like most other work environments is confronted with people experiencing major life challenges in the course of their career; this includes health-related challenges. People employed in the public service use a variety of information sources in managing illness. However, the complex nature of illness calls for an exploration of the main concepts used in this study. Moreover, definitions adopted by researchers are often not uniform. The health belief model originally developed by Rosenstock (1966) is often used to explain the health behaviour of a population. The model suggests that those seeking help do so in the belief that they can improve their lives and improve their levels of functioning (Leong, 1999). According to Rosenstock (1966), the model includes constructs similar to those identified in the socio-behavioural, but the health belief model places emphasis on the predisposing characteristics of the individual which may promote help-seeking behaviour.

In particular, the health belief model examines individuals' general and specific health beliefs such as concern about health, the willingness to seek help, perceived susceptibility to illness, prior health care experiences, and socio-demographic factors. In the context of this study, the health belief model may be applied indirectly to public servants through their human resource practitioners, supervisors or colleagues in the public service. The health belief model states that decisions to remain healthy and seek psychological help would have to be made on a daily basis. This was found to be the major flaw of the health belief model as daily decision-making towards healthy behavior would not work for decisions of such magnitude and duration (Thomas, 1995).

### **2.8.6. The help-seeking decision making model**

The help-seeking decision-making model according to Goldsmith (2002), consists of five stages. Firstly, somatic symptoms occur, followed by recognition of the need for help. Next, services and particular types of providers are accessed, and then decisions are made about continuing, changing, or ceasing care which includes one's personal health, background, characteristics of the current distressing event, and socio-demographic and predisposing characteristics. Drawing on the work of Guadagnoli and Ward (1998) application of the model found that an individual draws on the social support network, including socially influenced help-seeking attitudes and beliefs. This system interacts with the individual's illness, career, or past key experiences with the mental health care system, as well as characteristics of the treatment system itself, to predict present help-seeking tendencies.

One of the main factors in the encoding and interpretation process in terms of this model is therefore the personal significance an individual places on a symptom and what it means. Most psychologically relevant stimuli are subjective, and different attributions can be made regarding their importance. Kessler et al. (1994) found that those who attributed commonsense explanations for their symptoms were less likely to seek professional services. Examples might include mistaking the symptoms of depression for a bad night's sleep, chronic marital difficulties as situational stress, or the symptoms of anxiety as excitement. Furthermore, in a qualitative study, Pill et al. (2001), found that participants who did not believe that symptoms of emotional distress warranted the need to seek help and tended to report their own symptoms of emotional distress as unimportant and not worthy of attention.

Based on these findings, people may have difficulty making appropriate decisions about whether to seek professional help because they are not able to accurately recognize or understand what their symptoms mean (Pill et al., 2001). For example, a person may mistake a panic attack for a heart attack, which would lead the individual to worry about their health and to ultimately seek medical as opposed to mental health services. This may suggest that that people often do not know a lot about mental health services or mental illness and their perceptions are often based on inaccurate information gathered from various sources (Vogel et al., 2005). Secondly, in the

presence of psychological distress, maladaptive, rather than adaptive, interpretations are often made quickly in response to a specific stimulus (Pill et al., 2001).

### **2.8.7. Cultural determinants of help-seeking model**

Saint Arnault's (2009) research centered on gender and culturally specific influences on mental health where she developed and tested her Cultural determinants of help-seeking model. This model includes symptoms, meanings such as stigma and meaning of life, social support, social negativity, and help-seeking. Her clinical ethnographic interview intervenes to promote help-seeking and examines cultural factors that influence meaning, expectation, and expression of mental illness. The model examines the importance of physical as well as emotional symptom experience for people from a variety of cultures. In the Namibian and wider African context, indigenous perceptions of illness cannot be divorced from the understanding of the self making illness a medical, social and cultural construct (Karasz, 2005). Although there are few documented studies about the rationale and ideology behind African perceptions on illness, African conceptions of illness, like any other tradition or belief, do not exist in a vacuum but change with acculturation, modernity and increased access to information and services (Lund & Flisher, 2003; Petersen & Lund, 2011). Irrespective of these developments and changes, African indigenous conceptions of illness remain in use and need to be researched, explored and documented (Nsereko et al., 2011). Documenting marginalized conceptions of illness can help explain people's subjective experiences and interpretations of illness. This can yield important information that can be used by health professionals to improve therapeutic alliance and clinical outcome, especially for illnesses where medical intervention has had limited success.

### **2.9. Socio-demographic influences on help-seeking behaviour**

Research on help-seeking behaviours has taken many forms, including large epidemiological studies (Moller-Leimkuhler, 2002; Rabinowitz, Gross, & Feldman, 1999; Robinson et al., 2004; SERU, 1999). There is conflicting evidence regarding the role of gender and recognition although rates of diagnosing depression in men are lower than those in women (Mechanic, 2002). This is supported by Jackson et al. (2007), who found that psychological and attitudinal factors, including stigma, stoicism, and self-efficacy were less important. Corrigan (2004), on the other hand noted that attitudes toward seeking help for a personal emotional problem is a salient

predictor of help-seeking intention among Americans. Men have been shown to seek psychological help at lower rates than women (Kessler, 2004). Research conducted by Brownhill et al. (2003) has demonstrated that much mental illness, particularly depression among men may go unidentified and untreated. Moller-Leimkuhler (2002) found that women tend to have more positive attitudes than men do regarding seeking professional help and for less severe diagnoses such as depression and that women tend to seek help more often than men do. Leaf and Bruce (1987) support this in their research which found that men are more likely to be treated for severe psychiatric diagnoses (Leaf & Bruce, 1987). Furthermore, men who seek help, as compared with women who seek help, are more likely to rate their level of distress as extreme or severe (Chang, 2007).

### **2.9.1. Gender**

Gender roles seem to play a part in help-seeking decisions (Fischer & Turner, 1970; Good, Dell, & Mintz, 1989; Moller-Leimkuhler, 2002; Morgan, Ness, & Robinson, 2003; Tijhuis, Peters & Voet, 1990). Addis and Mahalik (2003) suggest that traditional gender roles influence professional help-seeking by affecting the level of concern a woman or a man has about seeking help. The male gender role, with its emphasis on being independent and in control for example, may increase the perceived risks associated with seeking help for emotional issues or increase concerns about the loss of self-esteem, because it may mean that the man must admit that he is unable to handle problems on his own. In fact, it has been suggested that some men may experience illness as a direct threat to their masculine identity (Williams, 2000).

### **2.9.2. Marital status**

Pillay and Rao (2002) found that married people were nearly three times as likely as single people to seek help for mental health concerns. These researchers also found that divorced/separated/widowed individuals were twice as likely as were single people to seek help for a mental health concern. In additional research, Pill and colleagues (2001) showed that significant psychological distress, being female, and being married or divorced/separated were significantly related. A study conducted by Mechanic (2002) found that individuals who were divorced or separated were more likely to seek help than were married individuals.

### **2.9.3. Culture**

Cultural values, beliefs, and norms can affect the perceived barriers to using professional services (Matsumoto, 2001). Seeking professional help may be viewed as inconsistent with certain cultural values (Karasz, 2005). For example, cultural norms regarding the degree of privacy and the importance of seeking help for personal or emotional problems (Saint Arnault, 2009) can affect a client's comfort with talking about a problem to a mental health professional. (Jackson et al, 2007). Some cultures also hold a value that suggests that the best way to deal with problems is to avoid thinking about them or dwelling on them which may conflict with the counselor's values of verbal self-disclosure and emotional catharsis (LeBeau, 2000). It has been reported that in African culture, for example, men are encouraged to show a brave disposition during difficult situations (Nsereko et al., 2011). Some Asian cultures have been reported to value self-control and the restraining of feelings (Matsumoto, 2001). Furthermore, talking about specific types of problems may be seen as taboo in some cultures. In the Zuni culture, for example, because suicide is forbidden, a person might feel intense pressure not to admit to another person that she or he has had thoughts about suicide (Thomas, 2006).

The influence of cultural values on help-seeking behavior can be particularly important in cultures that have close networks (Razali & Najib, 2000; Tata & Leong, 1994). Finally, individuals in some cultures may be reluctant to seek help outside the home because such behaviour is regarded as shameful. Similarly, concerns about how seeking services would affect one's family can inhibit a person's decision to seek help from a professional (Russ et al., 2012). As a result, the effects of labeling and stigma on different racial groups need to be better understood (Thomas, 2006). In sum, the potential role that culture and ethnicity have in influencing help-seeking is significant. However, researchers have generally not focused on whether, in fact, certain avoidance factors are more pronounced for minority individuals. As a result, a better understanding is needed of the impact of culture and ethnicity on psychological help-seeking.

### **2.9.4. Income**

According to Zwaanswijk (2003), the influence of income on help-seeking seems to depend largely on a country's health care system. Countries such as France, Finland and the Netherlands,

in which health care is readily available and where there are no major financial constraints to receiving professional help, have not found any association between income and help-seeking. Fisher and Turner (1970) found that children and adolescents from families with fewer financial resources were more likely to have unmet needs: youths identified as being in need of psychological services were less likely to obtain services if their families received public assistance or if the youths were not covered by health insurance. Similarly, Lechnyr (1992) found that among adults of Mexican descent who had a mental disorder, those with private rather than public insurance were more likely to visit a mental health provider. Financing of the mental health system is another aspect of the delivery system that needs significant attention. Society and its elements are not only relevant as predictors of service use and quality of care but also can be conceptualized as consequences or outcomes of mental health care or a lack thereof. In particular, it is important to examine the economic and social costs of mental illness to society, systems of care, families, and individuals.

#### **2.9.5. Educational background**

Tijhuis et al., (1990) found that people who are more prone to seek help from a GP have a lower educational level. This is contrary to findings in the literature on educational background and help-seeking where the findings have also shown that individuals who are in their 20s and who have a college education have more positive attitudes toward seeking professional help and are more likely to seek help than older persons or those without a college education (Blumenthal & Endicott, 1996). In one study, Veroff, Kulka, and Douvan (1981) found that 22% of individuals with a college education versus 10% of those without a college education sought help. A more recent study by Jackson and colleagues (2007) has shown that education has been shown to be associated with increased help-seeking and may also affect access to information about rights and services.

#### **2.9.6. Age**

Most of the authors examining the role of age in the help-seeking process have examined the help-seeking behavior of adolescents. In general, these studies have shown that adolescents underutilize services (Rickwood et al., 2005; Wilson & Deane, 2002). Similar to adolescents, individuals who are over 65 years old have also been found to underutilize services (Andrews et

al., 2001; Veroff, 1981), which may be the result of the increase in the salience of certain avoidance factors. Individuals in this age group, for example, are more likely to think that their distress is linked to physical problems. Consistent with the belief that problems have a more physical basis is the finding that individuals who are over 65 were more likely to seek help from a general medical doctor (Leaf, Bruce, Tischler & Holzer, 1987) and were less likely to identify their symptoms as a mental health problem.

### **2.10. The role of family and friends**

Research conducted by Rivera (2007) noted the importance of family support in protecting mental health. Interdependence, an externalized locus of control, and family involvement are significant cultural factors that has been held responsible for a better prognosis for people with psychological distress in developing countries when compared to Europe and America (Stanhope, 2002).

Studies in North America on different ethnocultural immigrant groups have yielded contradictory findings. In a quantitative study using multivariate analysis that examined association among acculturation, family support and depressive symptoms in a sample of 850 South Florida Latinos, a significant relationship was found between acculturation and depression that was mediated by social support (Rivera, 2007; Surgenor, 1985). There is evidence to suggest that individual social networks may decrease individual susceptibility to anxiety and depression (Kawachi & Berkman, 2001; Kendler, Myers, & Prescott, 2005). One study of women in Lusaka, Zambia and Durban, South Africa suggested that membership in community groups was associated with better self-rated mental health (Thomas, 2006).

Another qualitative study conducted in Uganda, which used interviews with service providers in a psychiatric facility and a review of medical records as tools of data collection (Nsereko et al., 2011), presented a more ambiguous picture. Family involvement was seen as both a strength and a barrier to help-seeking and service utilization. Family participation was crucial to history-taking because of the nature of illness in the patients; however family conceptualization of illness and its causes and perceived stigma led to delayed help-seeking, non-adherence to treatment

regimens, and drop-out from treatment. This suggests that the role of family can differ in different ethnic groups and can be influenced by factors such as perceived stigma.

Because of the negative impact of mental illness, understanding the process by which persons seek or don't seek psychological help is important.

### **2.11. Service utilisation and provision**

A study by Kirmayer (2006) found that there are challenges to identifying distress, understanding cultural expressions of distress, and making appropriate diagnoses as expressions of distress differ in different cultures leading to misdiagnosis. For example, in the traditional western model of depression, the focus is on the individual's symptoms or 'depression as a disease' model (Karasz, 2005), whereas studies with African populations suggest that it is the social factors that are seen as important in depression, thereby leading to a suggestion that social dimensions of depression should be the focus while working with non-western populations (Nsereko et al., 2011)

Studies reveal considerable challenges in service provider – service user interactions. In a study in the United Kingdom, Green et al. (2002) found that Chinese immigrants underutilise services in comparison to other ethnic minority groups. The study further found that communication with health care professionals was hindered by language and lack of shared concepts pertaining to health and illness which deterred access (Green et al., 2002). A study of Somali immigrants in Minnesota found that Somalis identified family needs as important while service organizations did not (Robillos, 2001). These differences could arise because of differing world views: individualistic vs. collectivistic/ego-centric vs. socio-centric. Such disparity can translate into differences in determining goals and needs during the help-seeking process (Robillos, 2001). The findings also revealed differing expectations in terms of treatment outcomes between the immigrants and the physicians due to cultural differences. Communication difficulties were also recorded. Thus, this simultaneous exploration of service providers and service users yielded important insights. However, there are studies that indicate that belonging to a similar culture does not automatically translate into better service provision. Bhui, Stansfeld & Hull (2003) noted that family physicians may not be adept at diagnosing mental health

problems within their own cultures. Karasz (2005) supported this by finding that cultural stereotypes and cultural filters of service providers may lead to the overlooking of symptoms of depression in their own communities.

### **2.12. Help-seeking for psychological distress**

According to Maree (2007), the major virtue which a researcher should possess to conduct research is the ability to question and probe beyond that which is obvious. Research on the social correlates of psychological distress demonstrates this virtue to the limit, perhaps occasionally beyond it. The only reasonable measure that can be applied in conducting social research is whether it leads to an improved understanding of the questions which can be asked. By this measure, studies relating social factors to the incidence of psychological distress will support a person's likelihood to seek help. Much social science research in this domain must inevitably rely on the use of cases identified as sick by general practitioners. Similarly, the GP's knowledge of mental illnesses and psychological distress stems from an observation of patients who seek help. It is arguable whether this selected category of the population presents a complete picture. The GP on one hand seeks to help individuals, no matter how unrepresentative they may be of the total population of sufferers. The researcher, on the other hand, seeking to establish social regularities related to help-seeking within the context of mental illness is in a very different position. Asking for professional help is a socially significant act, whether performed by the patient or by others around them. To ignore this bias-creating factor is to take a considerable risk. Nevertheless, some of the most provoking studies of psychological distress undertaken by social scientists have been based on those very premises.

As a case in point, in any one year, 14% of patients registered with a GP in the United Kingdom will consult for a mental health problem (Shepherd et al., 1966). Goldberg and Huxley (1992) found that patients often present physical symptoms at the onset of a psychiatric illness. Goldsmith (2002) found that 50% of patients with five or more functional somatic symptoms met criteria for a current psychiatric diagnosis with the strongest associations for depression and anxiety. Of patients suffering from depression or anxiety, 76% presented with physical and somatic symptoms. Research conducted by Veroff, Kulka, and Douvan (1981) on help-seeking behaviours pointed towards a number of factors which were found consistently to be predictive

of both mental health utilisation and attitudes toward formal help-seeking. These include socio-demographic factors such as gender, age, and marital status; illness-related factors such as having a mental disorder and psychological distress. Brous and Olendzki (1985) found that being middle-aged, unemployed, bereaved, separated or white make it more likely that a person will seek help for mental health problems.

Based on young British adults (aged 16 to 24 years), Biddle et al. (2007), developed a conceptual model to explain how psychological distress is related to help-seeking, named the Cycle of Avoidance Model. According to this model, the intention to seek psychological help is low when people rely on their own coping mechanisms to overcome psychological distress. As available coping mechanisms become exhausted over time, the distress becomes increasingly more severe until a threshold is reached. At this time, persons' intentions to seek outside help increases in order to relieve distress (Biddle et al., 2007). A study on help-seeking, psychological distress and social support found that when compared to individuals who do not seek help from a mental health provider, those who do seek help have more severe psychological distress (Pillay & Rao, 2002).

Although the degree of psychological distress has been found to predict help-seeking intentions independently, there is some discrepancy in the literature whether attitudes toward seeking psychological help and psychological distress are related to one another (Chambless & Ollendick, 2001; Lahey, 2009). For instance, Cramer (1999), Morgan et al., (2003) and Vogel et al., (2005) did not find a relationship between seeking psychological help and distress., Chang (2007), however, discovered that psychological distress predicted help-seeking attitudes.

According to the Ministry of Health and Social Services (Government of the republic of Namibia, 2001), the roles of the GP and the mental health practitioner with regard to treating a psychologically - distressed individual are not clearly defined. The referral system is not well established although there are referral guidelines which are to be followed in order for PSEMAS to cover the costs. A referral letter is required from a general practitioner for other services, including that of psychologists, as general practitioners are considered the gate-keepers by PSEMAS. A major portion of psychological services in primary and secondary care settings is

provided by nurses, social workers and psychologists at the government hospitals. Private practitioners also provide mental health services but these services are limited to those who can afford them and who have access to medical aid facilities. According to the Deputy Director at the Ministry of Health and Social Services, the number of individuals experiencing psychological distress seeking the services in this sector is unknown (Mbeeli, personal communication, 1 April, 2008). The process of obtaining a referral from a general practitioner, the complexities of medical aid coverage, and the variations between referral sources in the Namibian context can also be considered as additional barriers.

Murstein and Fontaine (1993) found that among health professionals most likely to be consulted, "most people prefer to consult GPs rather than mental health professionals for emotional problems" (Murstein & Fontaine, 1993, p. 841). They support their findings with a previous study regarding mental health services conducted at the Rand Cooperation where 60% of clients received their mental health services solely from a GP.

Lund and Flisher (2003) found that people experiencing psychiatric symptoms and disorders most commonly consult their general practitioners to treat the physical symptoms. Razali and Najib (2000), found that the possible reasons for the reluctance to seek a referral from a general practitioner to a mental health practitioner include the stigma associated with mental health problems, concerns that general practitioners are not well trained to recognise psychological problems, concerns that a record in their notes will compromise future job prospects and concerns that the general practitioner will prescribe pills. Robbins (1981), argued that since only a minority of people seek professional help, the need for general practitioners to be trained in determining the extent to which people are experiencing psychological distress is of prime importance.

The process by which people decide to seek help for mental distress and particularly depressive symptoms involves multiple steps, both in choosing a health provider and in following through with treatment. According to Mechanic (2002), beliefs about the helpfulness of the general health provider and treatment effectiveness affect both the decision to seek help and the type of provider sought. Factors found to correlate with the decision to pursue care for depression

include higher levels of education and high levels of distress from the episode (longer duration, greater impact on role functioning). Seeking care from a GP as opposed to a mental health practitioner is associated with lower educational level and ease of access, but not with severity of symptoms, medical co-morbidity or level of social support (Blumenthal & Endicott, 1996).

According to Kessler et al. (1994), the type of symptoms experienced influences the decision to seek professional help or not. Van den Bos and De Leon (1988) found that people are more likely to seek help for somatic complaints, whereas most persons with mental disorders do not get professional help. Moreover, somatic symptoms such as fatigue, musculoskeletal pain and sleep problems are common in both anxiety and depression (Ohayon, 2004). Demyttenaere et al. (2006) found that people with both affective disorders and painful physical symptoms have a significantly lower rate of help-seeking for emotional reasons. Although over 80% had consulted their doctor in the previous six months, most presented with somatic (rather than psychological) symptoms. Jackson et al. (2007) established that possibly as many as 50% of cases on mental illness go undetected in the general practitioner's surgery. In their research, Goldberg and Huxley (1992) found that only a minority of people with mental disorders were being treated by their general practitioner. They concluded that low recognition of mental disorders seemed to be the greatest barrier to care for people with depression and anxiety.

### **2.13. Summary**

A review of the current literature identifies 2 major gaps described that this study hopes to fill: Firstly, there are only a few studies that address the direct relationship between help-seeking and psychological distress. Secondly, there are just as few Namibian studies on the public service population despite the fact that it is the largest employer in Namibia.

While help-seeking has been the focus of many studies, little has been explored in terms of ongoing help-seeking and continued engagement in care and the interface between psychological distress against the multiple dimensions of help-seeking. The literature studied has found that there are many models of help-seeking each focusing on a specific area and all leading to the understanding of the complexity of the subject. While underutilization is reported widely amongst ethnoracial populations, gender research shows greater rates of utilization, and more

favourable attitudes towards mental health services by women in comparison to men. However, many studies are restricted to women and studies that look at men and women simultaneously usually use quantitative methodology.

The literature on service utilisation and provision speaks to the challenges faced by both service providers and service users in the Namibian context. These studies demonstrate that a simultaneous analysis is crucial to understand the interrelationships of social and demographic influences in the public service, and to check whether this reality is reflected in service providers' perspectives and practices. Such a view will provide a real time analysis of the situation, and strengthen clinical and policy recommendations as it will factor in the experience of two stakeholder groups crucial to health care. There are no previous studies that have examined this in the Namibian public service population.

### 3. METHODOLOGY

This chapter discusses the research design as well as the rationale for the design method used in the study. It explains the choice of the study population, sample and research instruments. The settings and procedures are described as well as the research methods. This chapter further elaborates on the research design and methods employed to address the overarching research question. Separate dimensions embedded in this larger exploration are stated as research aims in the next paragraph.

#### 3.1. Research aims

The aims of the study are as follows:

- To study the relationship between help-seeking and sociodemographic variables across the public service.
- To establish the presence of psychological distress and how it relates to seeking psychological help-seeking.
- To investigate the role of the GP in supporting patients experiencing psychological distress to seek further help from mental health practitioners.

This exploratory study adopted a mixed-methods approach. According to Maree (2007), this approach is one in which the researcher bases knowledge claims on pragmatic grounds. Methods of enquiry involve collecting data either simultaneously or sequentially to best understand research problems. The data collection also involves gathering both numeric information as well as text information so that the final database represents both quantitative and qualitative data. The mixed methods approach enables the researcher to collect, analyse and mix both quantitative and qualitative data within a single study in order to understand a research problem more completely (Maree, 2007).

The study was designed in 2 phases. The first phase of the study was quantitative in nature and aimed at establishing the levels of psychological distress as it relates to various socio-demographic characteristics in the sample. The second phase of the study relied on the use of qualitative data which was obtained utilising the constructivist paradigm (Mertens, 2005). This

is based on the belief that reality is socially constructed and, true to constructivism (Barbour, 2001), the exploration began without a firm theoretical framework in mind.

The GHQ was employed as the choice tool for data collection based on the fact that this research method does not position the exploration on a clean slate (Barbour, 2001) with respect to the researcher. Rather, it encourages the researcher to embody previous learning and experience, as well as the results from previous studies into the context of the current study to enhance the conceptualisation of the study and encourage expansion into areas that are yet to be explored, while also providing a substantive backdrop and support for such an expansion. The researcher's previous knowledge and experience are incorporated into the study, not as a bias, but as an enrichment to the process (Maree, 2007).

### **3.2. Rationale for the research design and method**

Prior to this study, the researcher had the opportunity to work on a human resource project at the Office of the Prime Minister. This project included consulting public servants on their service benefits (of which the current medical aid PSEMAS is a major benefit) entitled to people employed by the public service. Furthermore, the project was a quantitative study which drew on the data contained in the PSMEAS database which records and captures the medical aid utilisation of government employees. The PSEMAS Database Application System was developed as part of the Integrated Financial Management System (IFMS) system for the Government of Namibia and is used for the computerization of the Medical Aid functions. The IFMS was launched on 1 April 2006 across all O/M/As as one of the strategies to contain the cost of health care on PSEMAS. In turn, the overarching health care benefit design strategy deals with measures taken to discourage members from claiming unnecessarily. The ultimate purpose of these project efforts on the part of government is to curb over-utilisation.

The claiming patterns of each PSEMAS member are available on the data base while the managed health care system makes provision for contractual agreements between the Ministry of Finance, as the custodian of PSEMAS, and the providers of health care. The quality of service is continually monitored and methods have been introduced to influence the behaviour of consumers of services and service providers. The Auditor-General in accordance with the State

Finance Act, (Government of the Republic of Namibia, Act 31 of 1991) carries out an audit of the financial statements and Performance Audits of Central Government, which examine the way in which public sector resources are utilised. This includes audit reports for the Ministry of Finance in terms of the IFMS records, of which the PSEMAS database is key. The results of the audits are then tabled at the National Assembly and considered by the Assembly's Select Committee on Public Accounts. The Committee reports their findings to the National Assembly and makes constructive recommendations aimed at improving financial management, controls and use of resources. (E.J. Coetzee, personal communication, April 14, 2008). Further analysis of the PSEMAS data in the database showed a number of socio-demographic differences with regard to help-seeking, but did not answer the question "why" or "how"? This warranted a qualitative exploration.

As a student, the researcher also had the opportunity to attend various meetings organized by the Psychological Association of Namibia (PAN) where the issue of the non-utilisation of psychological services was raised. While the discussions yielded rich insights, they were all viewed from the service provider perspective. An inquiry into the beneficiaries of PSEMAS and service providers was therefore deemed to be appropriate.

### **3.3. Choice of the Namibian public service population**

The focus on a specific population group was deemed central to the study as many investigations on help-seeking have tended to focus on specific western populations by major geographic region (Nsereko et al., 2011; Rickwood et al., 2005; Segopolo et al., 2009; Shaw, 1999; Surgenor, 1985; Thomas, 2006). In Africa, many studies have focused on gender, culture, Only a few relevant studies on help-seeking for mental health in South Africa were found (Flisher, 2003; Lund & Lambert, 2005; Ngubane, 1977; Petersen & Lund, 2011). The emphasis of the findings relate to the status of mental healthcare services but also highlight the fact of insufficient resources and resulting in the classic revolving-door phenomenon with common mental disorders remaining largely undetected and untreated in primary healthcare. All these studies highlight the need for promoting mental health services as well as mental health literacy to assist in improving help-seeking behaviour and stigma reduction.

Studies in Namibia tended to focus largely on specific groups categorized either in terms of race and culture (LeBeau, 2000), illness condition and gender (Shino, 2011). Only one study focussing on a sample of Namibian ex-fighters by LeBeau (2005), concluded that members in the armed Forces are in need of intervention because of the stressful nature of their work, and which could possibly exacerbate residual psychological distress caused by military service. This blanket approach to categorizing groups might not allow for a fine-grained analysis of the factors pertinent to specific sub-populations such as the public service. The population under study includes all employees of the Namibian public service across all OMAs at central government, on all levels. The public service carries a staff contingent of approximately 80 000 people. For the purpose of the research, the population was limited to a sample of employees in central government, based in Windhoek.

### **3.4. Sample**

For the first phase of the study, the convenience sampling approach in selecting participants ( $n = 284$ ) was used. Inclusion criteria for participation in the study was that the person had to be an employee of the public service, aged  $\geq 18$  years, ability to speak, read and understand English, ability to give written and / or verbal consent and knowledge of their general health state. Participants who were not willing to give consent or take part in the study were excluded.

The second phase of the study involved the recruitment of GPs was through a process of convenience sampling. They were recruited from a master list of 50 listed full-time medical practitioners supplied by PSEMAS. Of the 50 names, 10 were non-randomly selected. A non-random sampling approach was used because it is believed that any GP could provide reliable and consistent information on the issues in question. Appointments with all ten selected general practitioners were scheduled, but only five would talk to the researcher giving an overall response rate of 50%. Two of the five GPs who were not interviewed cancelled the appointment at the last minute, while the other three cited time constraints as reasons for not speaking to the researcher.

Further inclusion of the GPs in the research was based upon the geographical selection, which in this case was limited to Windhoek, Namibia. Furthermore, the researcher attempted to interview

GPs who were in the vicinity of government offices. Registration with PSEMAS as a service provider was considered important as this will influence the likelihood of retaining clientele group from the public service. For instance, if a GP is registered at PSEMAS, then the patient is only required to pay a minimal consultation fee of 5% of the total cost and, Representation of different sexes (herein referred to as gender) to determine if this influenced help-seeking. Three male and two female GPs were interviewed. It was emphasized to the participants that participation in the research was voluntary and declining to participate would not have any negative consequences for them. With the general practitioners, before an interview was conducted, consent was sought from each participant, clarifying all the necessary information pertaining to the research.

In all cases, participants were made aware of the purpose of the study, the format in which the data will be published, the possible harm involved in the study and how that would be handled and it was stressed that there were under no obligation to participate. Confidentiality of the identifying details was stressed to all the participants. To ensure confidentiality, it was noted to the general practitioners that the audiotapes and questionnaire were to be kept secured. It was also mentioned that only the supervisor and the researcher would have access to the audiotapes and questionnaires. It was further mentioned that because the research was about personal experiences, those participants who were to be emotionally or otherwise made uncomfortable by the research process were to be referred to professional counsellors. Arrangements to this effect had been made with the counselling colleagues of the researcher.

Information pertaining to the Public Service Employee Medical Aid Scheme (PSEMAS) data was granted to the researcher by its custodian, the Ministry of Finance.

### **3.5. Research instruments**

#### **3.5.1. The General Health Questionnaire (GHQ)**

The GHQ (Goldberg & Williams 1988) is used as a tool to screen for emotional distress or those likely to be at risk of developing psychological disorders and serves as measure of the common mental health problems or domains of depression, anxiety, somatic symptoms and social withdrawal. The questionnaire concentrates on two fundamental groups of problems: the

inability to carry out one's normal "healthy" functions and the appearance of new phenomena of a distressing nature. It focuses on break in normal functioning and not on permanent traits. It is available in a variety of versions using 12, 28, 30 or 60 items, with the 28-item version being used most widely. This is not only due to considerations given to the time it takes to administer it but also because the GHQ-28 has been used most widely in other working populations, allowing for more valid comparisons. While the GHQ-12 / 30 /60 versions all yield only an overall total score, the GHQ-28 is a scaled version which examines a profile of scores rather than a single score yielding four sub-scores, each based on seven items and a total score (Goldberg & Huxley, 1992).

The subscales in the GHQ-28 are: somatic symptoms (items 1-7); anxiety and insomnia (items 8-14); social dysfunction (items 15-21); and, severe depression (items 22-28). It allows for mental health assessment on four dimensions. The structure of all questions is always the same. The respondent is asked to assess changes in his or her mood, feelings and behaviours over a recent period. Examples of items include, 'lost much sleep over worry', 'felt constantly under strain', 'been feeling unhappy and depressed', 'been able to face up to your problems', and, 'been thinking of yourself as a worthless person'. The respondent evaluates their occurrence on a 4-point response scale. The scale points are described as follows: "less than usual", "no more than usual", "rather more than usual", "much more than usual". The standard scoring method recommended by Goldberg for the need of case identification is called the "GHQ method" (Segopolo et al., 2009).

The GHQ-28 takes about five to ten minutes to complete, is self-administered and complete instructions are provided for the respondent. Respondents should complete the questionnaire individually or in a group session in which privacy is insured. Respondents must feel comfortable about expressing their true feelings and they should be able to complete it anonymously (Goldberg & Huxley, 1992).

According to Goldberg and Williams (1988), there are four methods of scoring the questionnaire. The first is known as the GHQ scoring method which assigns scores according to (0-0-1-1). The second method, known as the likert scoring assigns scores as a scale from zero to three (0-1-2-3).

The modified likert scoring method is similar to the likert scoring method but assigns a zero to the first and second scales, one to the third scale and two to the fourth scale (0-0-1-2). The fourth method, known as the C-GHQ scoring method (0-0-1-1) for positive items, where agreement indicates health, and 0-1-1-1 for negative items, where agreement indicates illness). For both GHQ and likert scoring, the wording of the items mean that they can all be scored in the same direction so there would be no need to reverse score. This means that the higher the score, the more severe the condition. The likert scoring method produces a wider and smoother score distribution if a researcher wishes to assess severity and the C-GHQ method is more normally distributed than the GHQ scoring method. Goldberg and Williams (1988) maintain that the modified likert is inferior to simple likert and is the least used method. C-GHQ scoring is a relatively specialised method and is useful only when it is important not to miss cases with long-standing disorders.

Higher scores indicate a greater probability of psychological distress. Total scores that exceed 4 out of 28 according to the GHQ scoring method and a score of more than 23 out of the maximum score of 84 according to the likert scoring method suggests probable distress. (Chung et al. 2006). In this study, the likert scoring method (0-1-2-3) was used. Similarly, the optimal cut-off points that can serve as a tool for screening for distress was established at the 4/5 level and obtaining 23 out of the maximum score of 84 for the GHQ-28.

Likert scale data for each of the 28 items was entered into a principal components analysis. A four-factor solution was selected on the pragmatic basis that it would facilitate comparison with existing studies. Although an oblique rotation has been recommended when the emerging factors are expected to be significantly correlated (Wright, 1996), a varimax rotation was applied, which according to the same authors provide results which are easier to interpret and is the technique used in previous studies (Wright, 1996). A loading score of .50 was used as the cut-off score for assigning items to a factor, and items were assigned to the factor to which they revealed the highest loading.

### **3.5.1.1. Reliability and validity of the GHQ-28**

The reliability coefficients of the GHQ-28 have ranged from 0.78 to 0.95 in various studies (Chung et al., 2006; Jackson, 2007; Werneke et al., 2000). Summarised results from these research studies indicate that the median specificity is 0.82, whilst the median sensitivity is 0.86 for the GHQ-28. The intercorrelations between the subscales are rather high, with the mean correlation being about 0.52 (range 0.40-0.62). This outcome implies that the subscales are not independent of each other. The correlation coefficients between the subscales and the GHQ-28 total scale range from 0.75 (severe depression) to 0.89 (anxiety/insomnia) which indicate the unidimensionality of the scale (Haidula et al., 2003). The correlation coefficient between the subscale anxiety/insomnia and the GHQ-28 total scale supports the assumption that anxiety is a core phenomenon of psychological distress (Goldberg & Huxley, 1992).

### **3.5.1.2. Motivation for using the GHQ-28**

The GHQ-28 results can be useful in understanding various sources of distress for employees, as well as any predisposing factors. It is recommended that results of such assessments not be used in isolation, but rather in combination with other information which is indicative of psychological distress or illness such as sickness absence, poor productivity or increased turnover. The Namibian version of the GHQ-28 was pilot tested with the Oshiwambo-speaking people in northern Namibia. Subsequent data analysis indicated that the Namibian GHQ-28 was a valid method of screening for psychological distress in rural northern Namibia. Although Haidula et al. (2003) suggest a Namibian GHQ-28 cut off point of 10/11 for their population of clinic attendees, international scales show a cut off point of 4/5 for respondents going to GPs. Similarly, the Setswana version of GHQ-28 was found by Segopolo et al. (2009) to be a valid instrument of screening for psychological distress in a primary healthcare setting in Botswana. A recent validity study on the GHQ-28 in Zambia reported validity indices that suggest that the tool is widely acceptable for detecting psychological distress (Chipimo & Fylkesnes, 2010).

### **3.5.2. The Socio-demographic questionnaire**

It is important to appreciate an individual's socio-economic and cultural background as the Namibian public service is diverse in terms of its educational, economic and social demographics. Thus, knowledge of language group, gender, marital status, age, residential area,

education and income levels is relevant. With the onset of illness, particularly if it is chronic, these variables and how they play a role in seeking help becomes significant. Drawing on the work of Veroff, Kulka, and Douvan (1981) on help-seeking behaviours, a number of factors were found consistently to be predictive of both mental health utilisation and attitudes toward formal help-seeking. These include socio-demographic factors such as gender, age, and marital status; illness-related factors such as having a mental disorder and psychological distress. Within the context of this research, the help-seeking behaviour of single male, unqualified public servants as opposed to their married, more qualified female, counterparts becomes significantly different.

In addition to the questions on socio-demographic data (language group, gender, marital status, age, residential area, education, income levels and occupation) the questionnaire took account of questions based on a previous study about barriers to mental health care (Jackson et al., 2007). For the questions on help-seeking, the study was not limited to asking about specific mental health problems and therefore mental health problems were defined as the respondents' perceived need for mental health care. The choice of the questions explores the decision-making processes with regard to treatment options. The questions relate to whether the person visited a medical health provider about emotional or personal problems over the past six months; the kind of medical health provider such as a GP or nurse visited; and, whether they were referred by the medical health provider to a mental health provider. The mental health provider options were, Psychiatrist, Psychologist, Psychological counsellor or Social Worker. Furthermore, in terms of utilising the Fischer et al.'s (1983) model on help-seeking as a process as well as the help-seeking decision making model (Pill et al., 2001) the questions aimed at demonstrating how conceptions and perceived causes of illness influence decisions regarding the appropriate steps to take in dealing with distress. Respondents were also asked to list the number of times they visited the mental health provider(s), the suburb where the mental health provider was located. Respondents were also asked to respond to each of nine possible barriers to the use of services and whether they had visited any other mental health provider such as a minister, priest or pastor over the past six months. A question with a list of five possible options on how the problem was solved eventually was listed.

In terms of the nine possible barriers to the use of services, each statement was scored according to a likert scale of one to five with zero (no barrier) under an option of strongly disagree or five (barrier) under an option of strongly agree. The questions on the visits to alternative mental health providers and the possible options on how the problem was solved was also subjected to the likert scoring method. McIver and Carmines (1981) describe the likert scale as a set of items, composed of approximately an equal number of favourable and unfavourable statements concerning the attitude object as given to a group of subjects. Each respondent was asked to respond to each statement in terms of their own degree of agreement or disagreement. In each case, they were instructed to select one of five responses: strongly agree, agree, undecided, disagree, or strongly disagree. The specific responses to the items were combined so that individuals with the most favourable attitudes would have the highest scores while individuals with the least favourable (or unfavourable) attitudes would have the lowest scores.

#### **3.5.2.1. Reliability and validity of the socio-demographic questionnaire**

Cronbach's coefficient alpha was computed to assess the internal consistency reliability of the measuring instruments that have different scoring and response scales. Cronbach's alpha reliability coefficient normally ranges between 0 and 1. However, there is actually no lower limit to the coefficient. The closer Cronbach's alpha coefficient is to 1.0 the greater the internal consistency of the items in the scale. This index suggested that all the items in the questionnaire measured the same characteristics (Howell, 1992). High internal consistency implies a high generalisation of items in the test as well as items in parallel tests. Inter-item correlation coefficients were used to determine if the internal consistencies of the constructs were not too high that they affected the validity.

#### **3.5.2.2. Motivation for the use of the socio-demographic questionnaire**

The use of a sociodemographic questionnaire answered the need to gather responses in a standardised manner, ensuring objectivity. Due to time and cost constraints, it was deemed more suitable to use a questionnaire in targeting a large sample size of more than 250 participants in one sitting. In addition, the administration of the questionnaire had limited affect to its validity and reliability. The results of the questionnaire can be analysed more scientifically and objectively than other forms of research. A major consideration of using the socio-demographic

questionnaire was its use in comparing and contrasting the many socio-demographic dimensions as related to help-seeking and psychological distress.

### **3.5.3. The Semi-structured interview schedule**

Mertens (2005) states that the purpose of qualitative interviews is to gather description about peoples' life-worlds, with the intention of formulating an interpretation. The interviews did not follow a defined structure since the questions followed a semi-structured format and were derived from individual experiences although there were five key questions that all the GPs were required to answer. The questions were developed on the basis of current literature on the components of help-seeking behaviour. These elements included the Health Belief Model (Rosenstock, 1966); barriers to health care use (Trude & Stoddard, 2003), support, including recognition of needs and socioeconomic status (Engel, 1980). The questions ranged from asking about the demographics of their patients, their social support systems, perceived medical problems, whether they referred them and finally asking them about their patients' perceived barriers to seeking psychological help.

#### **3.5.3.1. Reliability and validity of the semi-structured interview**

Qualitative research has often been criticized for being subjective and therefore very hard to replicate. Thus, findings are sometimes considered to be lacking reliability. However, the on-going review of the data and codes increased the validity of the data because the emergent codes were better grounded in the experiences of the participants and limited imposition and projections especially when the researcher is familiar with the subject (Miles & Huberman, 1994).

Another critique often launched against qualitative research is that it is subjective, thus running the risk of projection and collusion that may have a negative impact on both reliability and validity of the study. Craftsmanship is an important tool in qualitative research as it ensures validity and safeguards against imposition by the researcher (Miles & Huberman, 1994). Craftsmanship is described as the researcher's qualification, his or her competent observation and the ability to accurately record and transcribe the data. However, according to Mertens (2005), qualitative research is justified when collection of very detailed data about just a few

samples of phenomenon permits analysis of multiple aspects of a topic. The use of a semi-structured interview schedule thus yielded a vast repository of data of a multitude of interacting elements and aspects of the topic studied. Barbour (2001) states that when conducting qualitative research, researchers must be selective in their analysis and also exercise freedom from the restrictive constraints of meeting statistical assumptions. The author also states that interviews permit consideration of fine distinctions, exceptions and complex patterns of relationships used to capture people's subjective experience. Barbour (2001) further mentions that qualitative methods afford an opportunity to explore issues further, enabling the researcher to cross check understanding with the participants to enhance validity. A number of studies in the field of illness have successfully used interviews to elicit people's subjective experience. Mertens (2005) advocates that interviews are better tools for yielding rich quality data because they are open-ended and not restrictive. They therefore do not limit or impose on the participant. Furthermore, such questions limit the influence of the researcher on the participants' responses.

Barbour (2001), mentions that interviews are one of the qualitative methods that can be used to capture people's subjective experience. Mertens (2005) supports this by stating that qualitative methods afford an opportunity to explore issues further, enabling the researcher to cross check understanding with the participants to enhance validity. A number of studies in the field of illness have successfully used interviews to elicit people's subjective experiences. (Friedman, 2003; Robinson, McBeth & MacFarlane, 2004). Thomas (2006), successfully used an interview schedule with open-ended questions to elicit women's knowledge and beliefs about their mental health. Lambert (2005) used the same type of data collection methods in his studies on African Art and Rituals of Divination with South African traditional healers. Again, Ngubane (1977) used qualitative research interviews to gain an in-depth understanding of the lived experiences of distress among the people of KwaNyuswa in KwaZulu-Natal.

In this study, checking and capturing the GP's narratives helped strengthen the validity of the study. Qualitative validity is therefore interpersonal rather than methodological. Mischler (1990) argues that qualitative research cannot be conducted alone; there is a need for another person who can review the data and challenge the conclusions drawn from the data. To fulfil that criterion, a colleague with both a research and Psychology background played that role of a

member checker. The colleague was given the transcript and was asked to identify codes and those were compared to the initial codes generated by the researcher. In cases of discrepancies, a compromise was reached and the most suitable code was used.

### **3.5.3.2. Motivation for the use of the semi-structured interview**

This part of the study aims to provide insight into the general practitioners' perspective on why people do not consult mental health practitioners for help, and to gain additional insight into patterns of seeking mental health care. In particular, the method of obtaining data through a semi-structured approach explores the role of social factors, health beliefs, perceived barriers, and referral to a mental health practitioner as possible determinants of people's mental health and their help-seeking behaviour. The roles of the general practitioner and the mental health practitioner with regard to treating a psychologically distressed individual are not clearly defined in the Namibian context. The referral system is not well established although there are referral guidelines which are to be followed in order for PSEMAS to cover the costs. A referral letter is required from general practitioners for other services, including that of psychologists, as general practitioners are considered the gate-keepers by PSEMAS.

## **3.6. Settings and research procedures**

### **3.6.1. Negotiations with management**

Before starting the research the researcher scheduled a meeting with the head of the Public Service, Mr Frans Kapofi, the Secretary to Cabinet to discuss the aims and objectives of the study. The research proposal was also discussed with key management colleagues at the Office of the Prime Minister and commitment was obtained from them for the study. It was also decided that feedback would be given to management in the form of a general, anonymous report, as well as to individuals.

### **3.6.2. Administration of the GHQ-28 and the socio-demographic questionnaire**

For the first phase of the study, participants were a convenience sample of public servants who were invited to attend a workshop on government service delivery at the Nampower Convention Centre in Windhoek Namibia. Participants were approached by the researcher during a 30 minute comfort break. The aim of the study was verbally explained and consent obtained. Permission for

data collection was granted in writing by the head of the public service, the Secretary to Cabinet, Mr. Frans Kapofi which inter alia serves the purpose of ethical approval (Appendix 1). Permission for data gathering was granted by the workshop host, the Permanent Secretary of the Office of the Prime Minister, Ms. Nangula Mbako (Appendix 2).

The questionnaire which was titled "General Health and Socio-demographic Questionnaire" (Appendix 3) took approximately 15 minutes to complete, but there were no time restrictions during the distribution of the questionnaires. The questionnaire was constructed in such a way that each variable could be given a code and could be processed in numerical form in excel. Maree (2007) states that data analysis involves the data collection process, which will be supplemented by computer software after it has been processed with a view to quantification, which is an important procedure in the data analysis. The researcher made use of a statistics expert to assist with the data processing and analysis. The quantitative data in terms of language group, gender, marital status, age, residential area, education, income levels and occupation was presented in frequencies and percentages by means of tables and graphs according to the various sections and sub-sections in the questionnaire.

### **3.6.3. Semi-structured interviews with GPs**

The second phase of the study involved making an appointment to see each of the GPs with the purpose of the study being explained by the researcher. Each appointment was made between 13:00 and 14:00. The main focus of the interviews was to gain insight from the general practitioners on why Public Servants do not seek psychological help from mental health practitioners. Semi-structured interviews were conducted to record the answers of the GPs interviewed in this study on their thoughts on why public servants do not seek psychological help. The interviews lasted for a half an hour on average. They were all conducted in the offices of the GPs and were all conducted in English. Written consent was sought prior to the commencement of the interview. (Appendix 4). The interviews covered the various factors that have been identified in other studies (Moller-Leimkuhler, 2002; Morgan et al., 2003; Murstein & Fontaine, 1993; Nsereko et al., 2011) as possible barriers of a public servant's recognition of their mental health care needs, as well as their use of the medical aid benefits. The interview schedule (Appendix 5) included questions on their patient's social factors, perceived barriers of

the patient to seeking psychological help, and on whether they would refer the patient to seek further help from a mental health practitioner.

The interviews were very animated and open as they were relating to the researcher both as a student and as a public servant. The researcher tried to maintain a “distance” and sought clarification when understanding was assumed on the part of the respondent. For example if a GP said “You know how it is”, the researcher would respond by saying “Please could you elaborate?” There was no honorarium offered. All the GPs were thanked for their time and participation.

In this study, the interviews were digitally recorded. The recordings were played and recorded word for word. The transcripts were read over a couple of times to get a feel of the data. Small summary notes were then written on the margins of the prescribed interviews. The research questions were then used as categories. Mischler (1990) refers to this process as the trustworthiness of the procedure whereby the raw data are transcribed into manageable data and results. The interactive nature of the approach chosen captures meaning.

### **3.7. Data analysis**

#### **3.7.1. Quantitative data**

Data was stored and filtered for high GHQ scores over 23 in the main sample initially using Microsoft Windows Excel 2010. The Statistics Package for the Social Sciences (SPSS, 2011) was used to obtain descriptive statistics on the results of the questionnaires which include language, sex, marital status, age, residential suburb, educational level as well as occupation. Descriptive analyses included the frequencies, means, standard deviations, and observed minimum or maximum values, as appropriate, were calculated for each demographic and corresponding variables. In this study, the mean is used as measure of central tendency. The standard deviation quantifies the variability or scatter of the individual scores from the mean. The higher the standard deviation, the greater the distances are, on average, from the mean (Wright, 1996).

The practical significance with regard to the comparison between groups is computed as follows:

$$d = (MA - MB) / SDMAX$$

where:

MA = the mean of group A,

MB = the mean of group B, and

SDMAX = the maximum standard deviation between the two groups.

The practical significance is set at  $d = 0.50$  (medium effect).

Multivariate analysis of variance (MANOVA) was used to analyse the significance of differences between the general health of gender groups. MANOVA tests whether mean differences among groups on a combination of dependent variables are likely to have occurred by chance (Tabachnick, & Fidell, 2001). In MANOVA a new dependent variable, which maximizes group differences, was created from the set of dependent variables. One-way analysis was then performed on the newly created dependent variable. Wilk's Lambda was used to test the significance of the effects.

### **3.7.2. Qualitative data**

For the semi-structured interviews with the GPs, the text analysis strategy (Crabtree & Miller, 1992) was employed to process the data derived from the interviews. This gave rise to a thematic analysis where the interviews were transcribed and analysed in English. After transcribing the data summary, notes were written on each printed transcript, along the margins. The notes were not mere descriptions; they aimed at identifying the underlying meaning of the narratives, as stipulated by (Crabtree & Miller, 1992). The summaries were structured around three main themes that were again used as categories. The three themes were: Support from partners and peers, help-seeking and barriers to seeking psychological help.

## 4. RESULTS

This chapter begins with reporting the results of the socio-demographic questionnaire. Descriptive statistics (e.g. means and standard deviations), alpha coefficients, t-tests and multivariate analysis of variance (MANOVA) were used to analyse the data. The level of statistical significance was set at  $p < 0.05$ . A cut-off point of 0.50 (medium effect, Cohen, 1988; Steyn, 1999) was set for the practical significance of the correlation coefficients. This is followed by a discussion on the analysis of the semi-structured interviews with the GPs.

Next, the results of the descriptive statistics and reliability of the measuring instruments are reported followed by the analysis of the semi-structured interviews with the general practitioners will be discussed.

### 4.1. Quantitative and descriptive results

The demographic profile of the entire research population is discussed in terms of the number of respondents, their age, language group, marital status, educational and income level.

Two hundred and eighty-four participants completed the socio-demographic and general health questionnaire. Approximately 10,2 % of the screened sample were positive cases which were identified by the Likert method (cut off score 23/24).

The mean, standard deviation (SD), skewness and kurtosis of sub-scales on the GHQ-28 and the biographical questionnaire were computed. Coefficient alpha ( $\alpha$ ) were computed to determine the internal consistency of the GHQ-28.

#### 4.1.1. Differences between groups

T-tests for independent samples were conducted to determine whether there were differences between the two groups on the same variable, based on the mean value of that variable for each group.

#### 4.1.2. Factor and reliability analyses

A simple principle components analysis was conducted on the 28 items of the GHQ of the total sample of public service employees. An analysis of eigenvalues (larger than one) and scree plot

indicated that one factor could be extracted, explaining 76% of the variance. This result supports the finding of (Goldberg & Huxley, 1992) that a one-factor model fits the data best. Given the fact that a four-factor structure has often been reported for the GHQ (Goldberg & Williams, 1988), the alpha coefficients of the four factors were also computed. The descriptive statistics of the GHQ are reported in Table 1

	Minimum	Maximum	Mean	SD	$\alpha$
Somatisation	1.00	4.00	1.32	0.54	0.92
Anxiety	1.00	4.00	1.29	0.60	0.95
Social dysfunction	1.00	4.00	1.25	0.61	0.97
Severe depression	1.00	4.00	1.16	0.46	0.97

Table 1: Descriptive statistics and alpha coefficients of the GHQ sub-scales

Table 1 shows that acceptable alpha coefficients were obtained for Somatic symptoms, Anxiety/insomnia, Social dysfunction, and Severe depression. The scores on the four sub-scales were relatively low. The highest scores were obtained for somatisation and anxiety.

Biographical data were obtained with regard to the language spoken at home, gender, marital status, age, residential area, education level and income level. In addition to the biographical questions, questions relating to the subsequent recent visit a person made to a medical practitioner; whether a referral was given; recent visit to a mental health provider; reasons for not seeking psychological help and how the problem was finally resolved were collected. A total of 284 questionnaires were analysed.

### 4.1.3. Language

The distribution of respondents in terms of language is reported in Table 2.

	Frequency	Percentage
Afrikaans	54	19.0
Damara>Nama	39	13.7
English	6	2.1
German	5	1.8
Oshiwambo	129	45.4
Otjiherero	39	13.7
RuKavango	1	.4
Silozi	11	3.9
Total	284	100.0

Table 2: Distribution of respondents according to language

The language diversity of the sample reflects the Namibian population. The questionnaire was completed by eight language groups with the Oshiwambo speaking group (45%) being the largest in the sample followed by Afrikaans speaking (19%) and the Damara>Nama (14%) and Otjiherero (14%) speaking group respectively. Participants who spoke Silozi (3,9%), English (2,1%), German (1.8%) and Kukavango (0,4%) were in the minority.

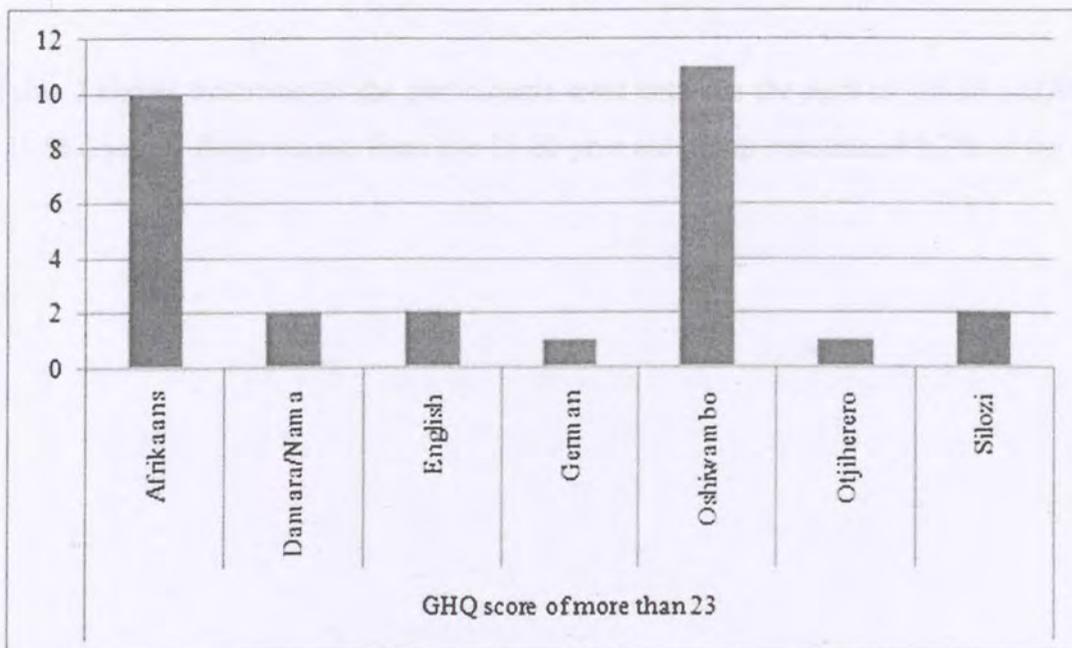


Figure 1: Language distribution of respondents who scored more than 23

Figure 1 illustrates a graphical representation of language groups which shows that respondents who had scored more than 23 were Oshiwambo speaking (3,8%) followed by Afrikaans speaking (3,5%) respondents. Participants from the Damara>Nama, English, German, Otjiherero and Silozi groups were less represented in terms of obtaining a GHQ score of more than 23 in terms of the Likert scoring method.

#### 4.1.4. Age

	Frequency	Percentage
18-24	19	6.7
25-29	35	12.3
30-34	61	21.5
35-39	79	27.8
40-44	44	15.5
45-49	28	9.9
50-54	16	5.6
55-60	2	0.7
Total	284	100.0

Table 3: Distribution of respondents according to age

Table 3 shows that most of the participants were between the ages of 35-39 (27,8%) and 30-34 (21,5%) years. Respondents from the 55-60 year old group constituted 0,7% of the sample.

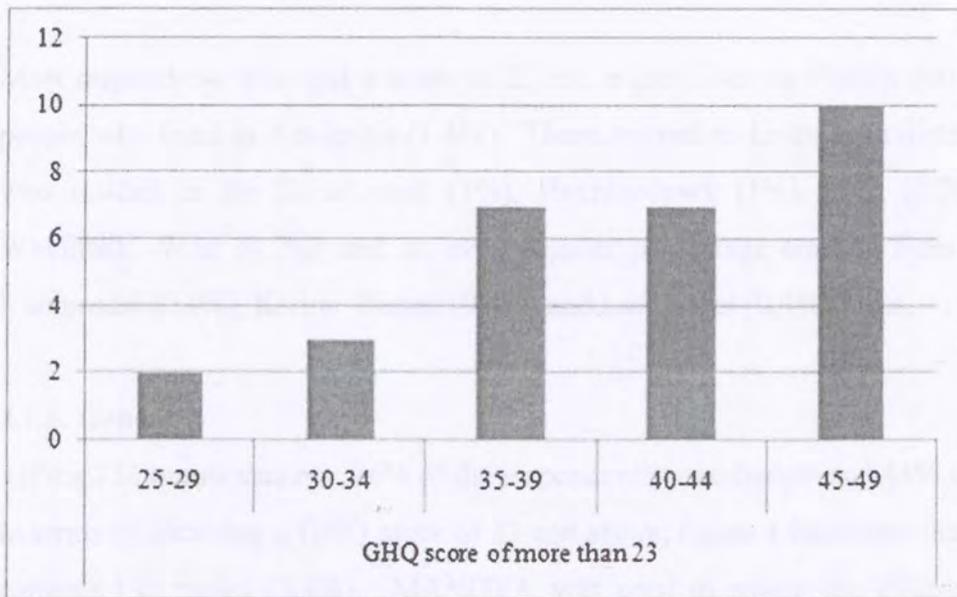


Figure 2: Age distribution of respondents who scored more than 23

In terms of the number of participants who had scored more than 23 and their corresponding ages, Figure 2 illustrates that the respondents came from the 45-49 year old (3,5%) group . Respondents from the 35-39 and the 40-44 year old (2,5%) groups respectively followed. Respondents who scored more than 23 on the GHQ-28 in the 30-34 year old (1,1%) and 25-29 year old (0,7%) category were fewer.

#### 4.1.5. Suburb

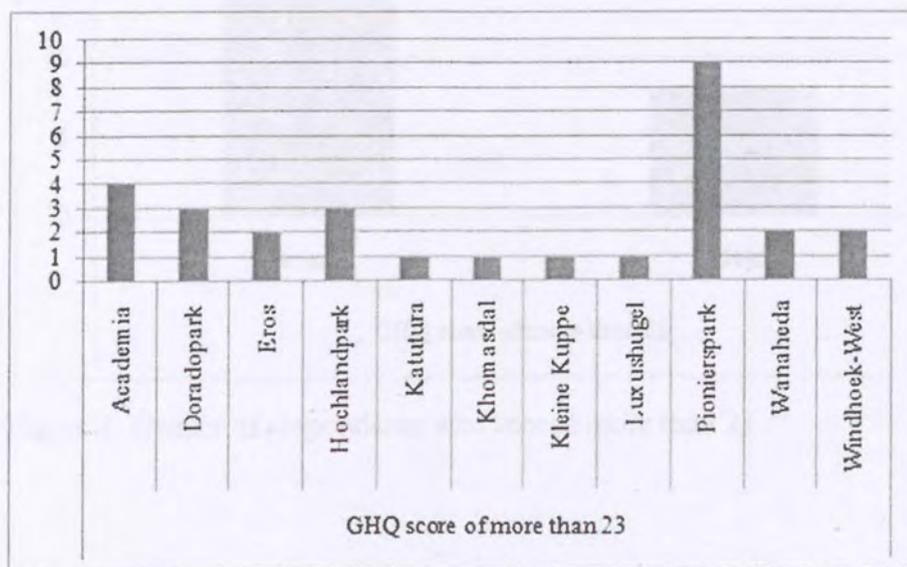


Figure 3: Distribution of respondents and their suburbs

Most respondents who had a score of 23 and higher lived in Pioneerspark (3,1%), followed by people who lived in Academia (1,4%). There seemed to be an even distribution of respondents who resided in the Doradopark (1%), Hochlandpark (1%), Eros (0,7%), Wanheda (0,7%), Windhoek -West (0,7%) and an even smaller percentage coming from the Katutura (0,4%), Khomasdal (0,4%), Kleine Kuppe (0,4%) and Lukshugel (0,4%) areas.

#### 4.1.6. Gender

Of the 284 questionnaires, 56% of the respondents were female and 44% were male. In terms of obtaining a GHQ score of 23 and above, figure 4 illustrates that more females (7,4%) compared to males (2,9%). MANOVA was used to assess the differences between general health dimensions of males and females. The results showed that gender had a statistically significant effect on the experience of general health symptoms (Wilk's Lambda = 0.94;  $F(4, 276) = 4.19$ ,  $p < 0.01$ ,  $h^2 = 0.06$ ). Further analyses regarding the nature of the differences are reported in Table 4.

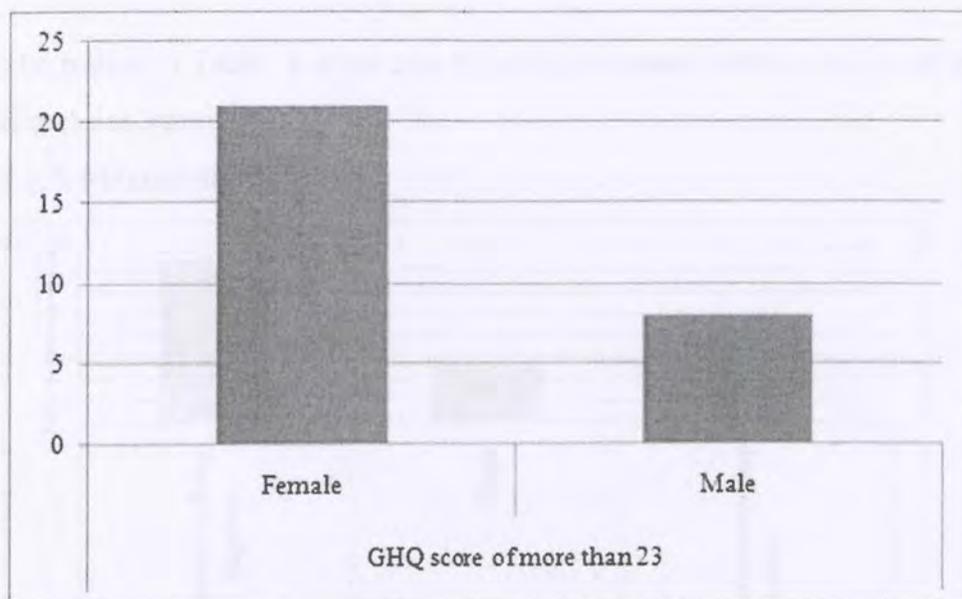


Figure 4: Gender of respondents who scored more than 23

	Sex	Mean	SD	p
<b>Somatisation</b>	Male (n = 122)	1.28	0.43	0.43
	Female (n = 159)	1.36	0.61	
	Total	1.32	0.54	
<b>Anxiety</b>	Male (n = 122)	1.25	0.42	0.34
	Female (n = 159)	1.32	0.71	
	Total	1.29	0.60	
<b>Social dysfunction</b>	Male (n = 122)	1.19	0.43	0.74
	Female (n = 159)	1.30	0.72	
	Total	1.25	0.61	
<b>Severe depression</b>	Male (n = 122)	1.08	0.24	0.01*
	Female (n = 159)	1.22	0.56	
	Total	1.16	0.46	

\*  $p < 0.01 + d > 0.80$  (practically significant, large effect)

Table 4: Gender and general health

The results in Table 4 show that females (compared with males) were more inclined to report depression symptoms.

#### 4.1.7. Marital Status

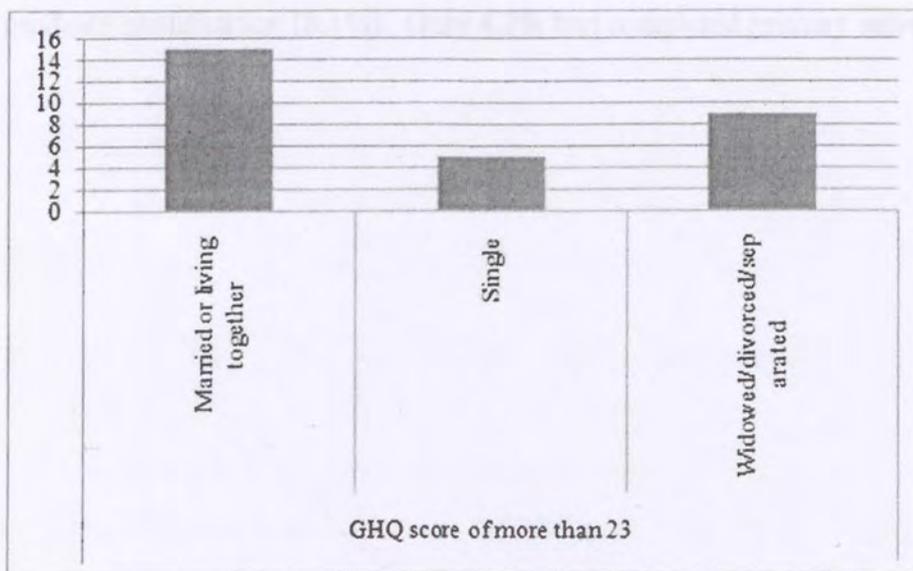


Figure 5: Marital status of respondents who scored more than 23

Figure 5 illustrates the general health dimensions of participants with different marital status and who had obtained a GHQ score of more than 23. Those who were either married or living together (5,2%) were in the majority, followed by those who were widowed, divorced or separated (3,2%). The single category (1,8%) were the least in terms of obtaining a GHQ score of more than 23.

A MANOVA analysis showed that marital status had no statistically significant effect on the experience of general health symptoms (Wilk's Lambda = 0.98;  $F(8, 550) = 0.55, p > 0.05$ ).

#### 4.1.8. Educational level

Education level	n	Percentage
Completed post-graduate	21	8.1
Completed 3-year Qualification	97	34.5
Completed high school	151	53.2
Completed Primary school	12	4.2

Table 5: Distribution of respondents according to education level

The overall sample in table 5 shows that 34.5% had completed a 3-year qualification while 53.2% had completed high school. A small percentage of the sample had completed a post-graduate qualification (8,1%). Only 4,2% had completed primary school.

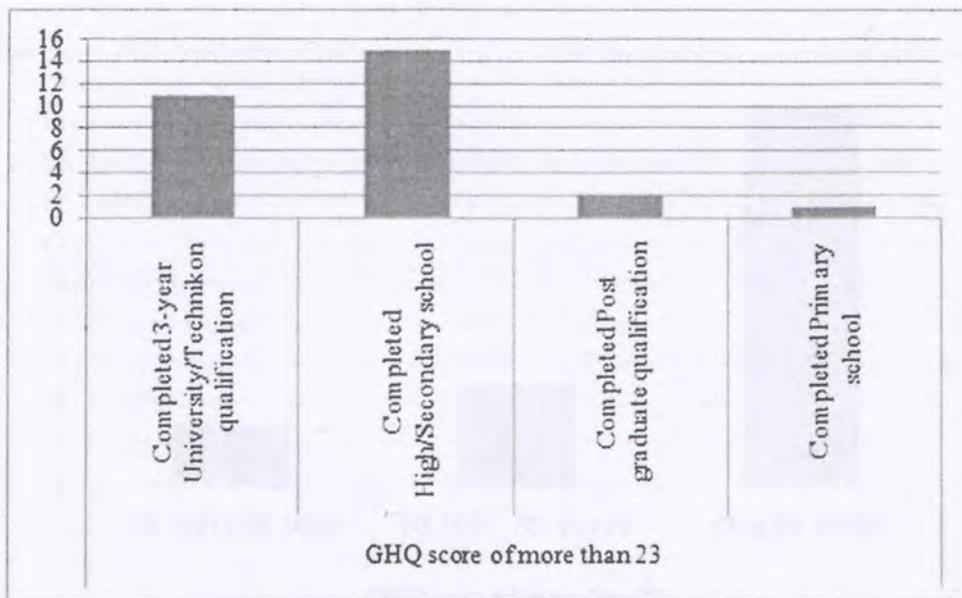


Figure 6: Education levels of respondents who scored more than 23

Figure 6 illustrates the number of respondents who had scored more than 23. The graph depicts that 5,2% had completed high / secondary school followed by those who had completed a 3-year university or technikon qualification (3,9%). Furthermore, educational level had no statistically significant effect on general health symptoms (Wilk's Lambda = 0.22;  $F(12, 725) = 1.28, p > 0.05$ ).

#### 4.1.9. Income

	Frequency	Percentage
Over NS 10 000	148	52.1
NS 5001 - NS 10 000	96	33.8
NS 2501 - NS 5000	19	6.7
NS 701 - NS 2500	9	3.2
Under NS 700	12	4.2
<b>Total</b>	<b>284</b>	<b>100.0</b>

Table 6: Distribution of respondents according to monthly income

Table 6 illustrates that the majority of respondents (52%) earn over N\$10 000 followed by 34% of respondents who earn between N\$5001 and N\$10 000 a month. A smaller percentage of respondents earn between N\$2501 and N\$5000 (6,7%); under N\$700 (4,2%) and between N\$701 and N\$2500 a month (3,2%).

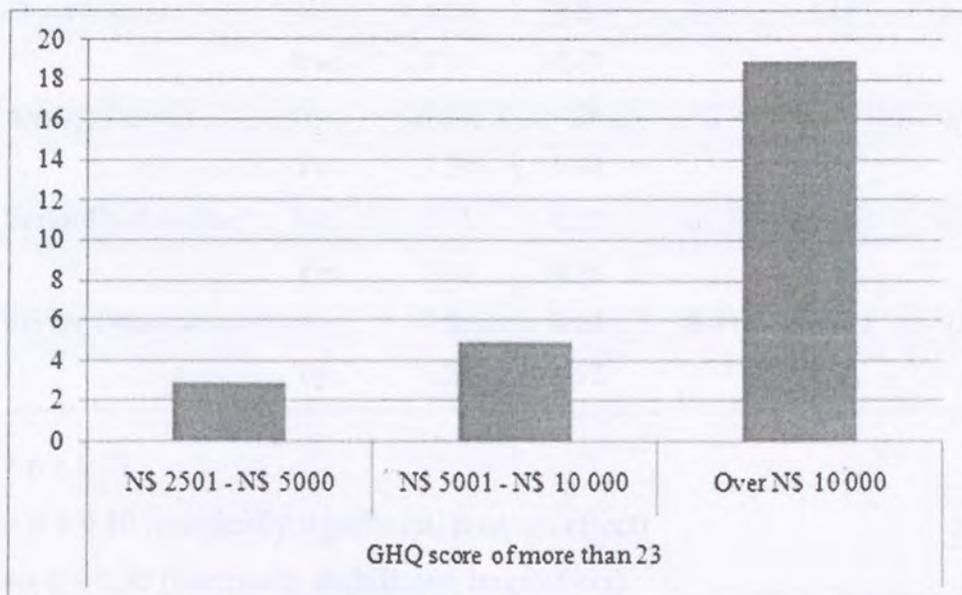


Figure 7: Monthly income of respondents who scored more than 23

On those who were identified to obtain a score of more than 23 and the corresponding income levels, figure 7 illustrates that respondents who earned over N\$10 000 (6,7%) followed by those in the N\$5001-N\$10 000 (1,8%) and N\$2501-N\$5000 (1%) income range.

90% of the total sample answered that they had not visited a medical health provider such as a general practitioner (medical doctor) about emotional or personal problems over the past six months.

	Frequency	Percentage
No	255	89.8
Yes	29	10.2
Total	284	100.0

Table 7: Distribution of respondents who had visited a medical health provider about emotional problems over the past 6 months

Table 7 shows that only 10.2% of the participants in the overall sample had visited medical health providers about emotional problems over the past 6 months.

		Mean	SD	t	p	d
<b>Somatisation</b>	No	1.21	0.23	-3.51	0.001	0.30+
	Yes	1.41	0.67			
<b>Anxiety</b>	No	1.18	0.28	-3.19	0.001	0.55++
	Yes	1.39	0.74			
<b>Social Dysfunction</b>	No	1.11	0.29	-3.78	0.001	0.33+
	Yes	1.36	0.76			
<b>Severe Depression</b>	No	1.05	0.20	-3.87	0.001	0.33+
	Yes	1.24	0.57			

\*  $p < 0.01$

+  $d > 0.50$  (practically significant, medium effect)

++  $d > 0.80$  (practically significant, large effect)

Table 8: Visit to a medical health provider and general health symptoms

The results in Table 8 show that respondents who visited a mental health provider over the past six months obtained statistically and practically significantly higher scores in all four general health dimensions (all large effects) than those who did not visit such providers over the past six months. Therefore, individuals who visited mental health care providers had experienced higher levels of social dysfunction, anxiety and somatic symptoms.

	Frequency	Percentage
<b>Doctor</b>	28	9.9
<b>Nurse</b>	1	.4
<b>Total</b>	284	100.0

Table 9: Kind of medical health practitioner visited by respondents over the past 6 months

Table 9 shows that only 10% of the total sample visited a GP while 1 person (0,4%) visited a nurse for emotional or personal problems over the past six months. From the 284 respondents, 29 scored more than 23 (10,2%) on their GHQ score and were identified to be at risk of experiencing some form of psychological distress.

	Frequency	Percentage
Not referred	280	98.6
Referred	4	1.4
Total	284	100.0

Table 10: Respondents referred by a general health provider to see a mental health practitioner such as a psychologist, social worker or psychological counsellor.

Table 10 illustrates that only 1% of the total population who had visited a GP was actually referred to seek additional help from a mental health provider such as a psychiatrist, psychologist, social worker or psychological counsellor.

The scores on the GHQ subscales for participants who visited a mental health provider for emotional or personal problems over the past six months are reported in Table 11. The table illustrates that 10,2% of the sample visited a mental health provider.

General Health Dimension	No Visit to Mental Health Provider (n = 255)		Visit to Mental Health Provider (n = 29)		t	p	d
	Mean	SD	Mean	SD			
Somatisation	1.16	0.17	2.78	0.41	-21.07	0.001*	3.95+
Anxiety	1.11	0.13	2.94	0.55	-17.88	0.001*	3.33+
Social dysfunction	1.06	0.09	2.96	0.55	-18.52	0.001*	3.46+
Severe depression	1.02	0.06	2.36	0.62	-11.63	0.001*	2.16+

\*  $p < 0.01 + d > 0.80$  (practically significant, large effect)

Table 11: General health of respondents: visits to mental health providers

Table 11 shows that participants who visited a mental health provider over the past six months obtained statistically and practically significantly higher scores in all four general health dimensions (all large effects) than those who did not visit such providers over the past six

months. Therefore, individuals who visited mental health care providers had experienced higher levels of social dysfunction, anxiety and somatic symptoms.

In terms of illustrating the accessibility of mental health providers, Table 12 illustrates the respondents who have scored more than 23 and their residential area as well as the vicinity of the nearest mental health provider.

Suburb	Number of respondents who scored more than 23	Mental Health provider location
Academia	4	
Doradopark	3	
Eros	2	Eros
Hochlandpark	3	
Katutura	1	
Khomasdal	1	
Kleine Kuppe	1	
Luxushugel	1	
Pionierspark	9	Pionierspark
Wanaheda	2	
Windhoek-West	2	Windhoek-West
Klein Windhoek	0	Klein Windhoek

Table 12: Location of mental health providers and respondents who scored more than 23.

Table 12 illustrates that most of the mental health providers are located in Eros, Pionierspark, Windhoek-West and Klein Windhoek. These are the largely more affluent (middle to upper-income) residential areas in Windhoek. The majority of participants who scored more than 23 live in Pionierspark (3,1%), and accordingly visit the mental health provider in the same area. There are no mental health providers cited by the sample of respondents residing in the lower-income areas such as Wanaheda, Khomasdal and Katutura which would cater for 1,4% of the sample. Similarly, The same applies to the middle-income area such as Academia, Doradopark, Hochlandpark, Luxushugel which would account for 3,9% of the total sample.

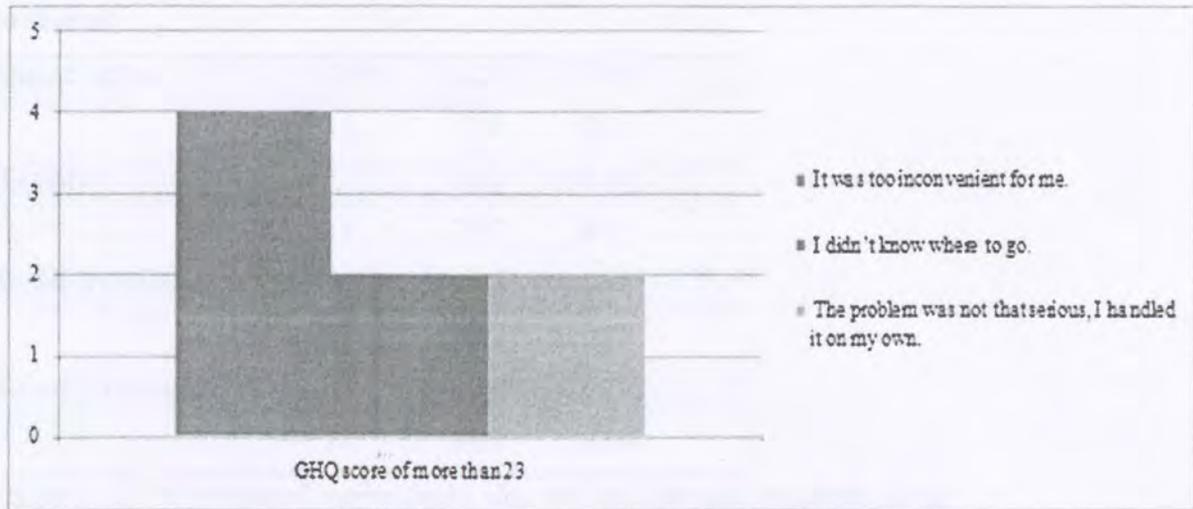


Figure 8: Participants who had not visited a mental health provider over the past 6 months

Figure 8 shows that the participants who had a score of more than 23 and who had not visited a mental health provider over the past 6 months cited that it was too inconvenient (1,4%) as well as the reason that the problem was not that serious and the person handled it on their own (0,7%). One other reason, of not knowing where to go was also cited as a reason for not visiting a mental health provider over the past 6 months.

In response to the question asking whether the participant spoke to any other person such as a Community Leader, Priest, Minister or Pastor about emotional or personal problems over the past six months, the data analysis shows that there is a low rate (0,7%) of seeking help from community leaders, priests, minister or pastor in terms of the sample of participants who scored more than 23. Figure 9 depicts how the problem was solved eventually, illustrating that 0,7% of those who were at risk of developing psychological distress were given medication by the GP. A similar percentage of the sample spoke to a Pastor / Community elder (0,7%), while 0,4% spoke to family and friends.

Worked through problems	n	Mean	SD
Somatisation	269	1.25	0.44
	15	2.66	0.32
Anxiety	267	1.20	0.44
	15	2.97	0.55
Social Dysfunction	269	1.156	0.46
	15	2.93	0.56
Severe Depression	268	1.09	0.32
	15	2.37	0.76

Table 13: Distribution of respondents who worked through problems alone

Table 13 shows that 5,2% of the overall sample preferred to work through their problems alone. Of the total sample, 15 had identified positively for somatisation, anxiety, social dysfunction and were also experiencing severe depression.

General Health Dimension	Did not speak to family and/or friends (n = 268)		Spoke to family and/or friends (n = 16)		t	p	d
	Mean	SD	Mean	SD			
Somatisation	1.23	0.37	2.87	0.47	-13.58	0.001*	3.48+
Anxiety	1.19	0.43	2.96	0.60	-11.51	0.001*	2.95+
Social dysfunction	1.15	0.43	2.96	0.65	-11.03	0.001*	2.78+
Severe depression	1.09	0.35	2.25	0.63	-7.32	0.001*	1.84+

\*  $p < 0.01 + d > 0.80$  (practically significant, large effect)

Table 14: General health of respondents: spoke to friends and family

Table 14 shows that participants who spoke to family and/or friends obtained statistically and practically significantly higher scores in all four general health dimensions (all large effects) than those who did not speak to family and/or friends about mental health problems. Therefore, individuals who spoke to family and/or friends experienced higher levels of social dysfunction, anxiety and somatic symptoms.

The responses to the question on how the problem was solved eventually was analysed together with the reasons for not visiting a mental health provider over the past six months.

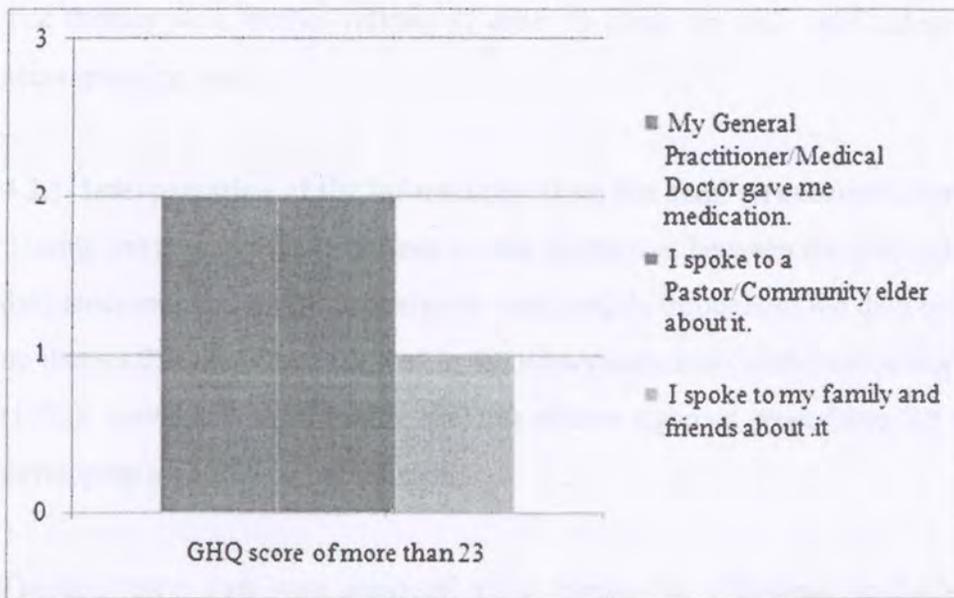


Figure 9: How the problem was solved eventually

#### 4.2. Qualitative results

Table 15 below provides information on the GPs interviewed in the study. Information from the interviews suggested that the GPs themselves may be part of the reason people do not seek help from mental health practitioners.

	Range	Minimum
Years of practice	18.00	5.00
Age	28.00	29.00

Table 15: General practitioners interviewed in the study (n= 5)

During the first phase known as immersion, the researcher read the transcripts and examined them for key words and emerging themes using the two-step approach adapted from Crabtree and Miller (1992). First, the researcher read the transcript several times. Then a segment of text from the transcript that was viewed as a response to the open-ended questions asked was chosen. The second step involved developing a set of thematic categories that included specific themes. This was done by sorting and resorting the text segments which were focused on and identified.

The themes were further refined in order to come up with final categories, themes and their accompanying text.

#### **4.2.1. Interpretation of the information from the semi-structured interviews**

During the process, there was not a clear distinction between the data collection process and the data analyses. The data was analysed continuously throughout the data collection process to pick up themes that could be followed in the subsequent interviews. According to Crabtree and Miller (1992), movement to and from the data allows rigorous procedures for checking, refining and developing a good sense of the data.

The qualitative data were analysed using immersion, a thematic analysis approach that got the researcher intensively involved with the data so that they became sensitized to the content, range, and various subtleties within it. The method involved taking one piece of data, for example one phrase, one theme or one interview, and constantly comparing it with others with the aim of conceptualizing possible relationships between the different data sets (Crabtree & Miller, 1992). Within-case and cross-case comparisons were conducted. Responses were compared across the five general practitioners. To begin the analysis process, the phrase as a unit of analysis was chosen. For example, "Women don't have a problem seeking help from others". This made it easier to condense the data into manageable chunks. Irrelevant information was left in the original transcript and was not summarized into the summary sheets.

The codes mainly emanated from the literature, research questions and the data. Miles and Huberman (1994) mention that this helps the researcher not to lose focus. For example, questions around referring patients to seeking psychological help emanated from the interview and literature on proposed PSEMAS limitations on seeking help from mental health practitioners. The codes were either expanded or had lost relevance to the study as new data was collected. Miles and Huberman (1994) stress that not all data should be coded but the researcher should be able to sift the relevant information that best answered the research question. During Crystallization, the second part of the process that reflected the gradual formation and emergence of themes offered by participants, the transcripts were examined for key words and emerging themes.

Three key themes were identified in this study as a result of interviewing the sample of GPs:

- (1) support: men appear to get most of their support for health concerns from their female partners and very little from their male friends;
- (2) help-seeking: perceived vulnerability, fear, and denial are important influences on whether people seek help; and
- (3) barriers: personal and systematic barriers (perceived and real) that prevent people from seeking psychological help.

A conceptual definition of each of the categories was drawn up. Each of the conceptual definitions clearly stipulated the inclusion criteria in each category. Moreover, in each category there were a number of themes that made up the category. It was difficult to avoid overlap between the categories because the categories were closely related. Furthermore, the participants incorporated a number of themes that would fit into different categories into a single phrase. To deal with the problem the phrases were used in the different categories that they fell into. To distinguish between the different codes, care was taken that each code was exclusive and exhaustive and this was done using the subheading from the questionnaire.

### **4.3. Summary**

This chapter reported the quantitative and descriptive results of the socio-demographic questionnaire. The second part of the chapter discussed the process of analysing the semi-structured interviews with the GPs. Three distinct themes were identified as a result of the qualitative analysis.

Chapter 5 will provide a discussion of the results outlined in this chapter.

## 5. DISCUSSION

In this chapter the results of the study are reported and discussed. First, the quantitative results of the GHQ-28 as they relate to the socio-demographic questionnaire and are linked to the findings in previous research findings. A discussion of the qualitative findings from the interviews with the GPs follows.

### 5.1. Discussion of the quantitative and descriptive results

In terms of the descriptive statistics and the GHQ-28, the acceptable alpha coefficients obtained for somatic symptoms, anxiety/insomnia, social dysfunction, and severe depression on the four sub-scales were relatively low. The highest scores were obtained for somatisation and anxiety. Relatively not too high sensitivity obtained for the GHQ in this study would be difficult to explain by the economic and / or cultural features of the general population. The GHQ-28 validity study, carried out in 2008 under the patronage of the World Health Organisation, covering almost 5500 patients of general practice settings in various countries, showed that General Health Questionnaires work well in developed and developing countries, with little differences in validity resulted from minor variations in the criteria used for defining a case. In this study, individuals who had completed the GHQ-28 and had scored a global total score of 23 were filtered and defined as a 'case'.

In studies employing General Health Questionnaires, carried out during preventive, periodical examinations of working people, the values of validity coefficients calculated in the study can be related rather to the specific character of the community examined than to the specific character of the population as a whole. This community, consisting of only working people, could be more homogenous than an entirety of adult patients of general practice settings, in other words the community in which other studies have been usually carried out. Considering the homogeneity of the working community of people in the public service, one may say about its mental and somatic state of health that the state of health is not so bad and the psychological distress is not so acute to influence fundamentally the work ability of people working in the Namibian public service.

### **5.1.1. Language**

Namibia is a largely multi-cultural society with a number of different ethnic and social groupings. There are over 10 language groups in Namibia with both traditional indigenous languages spoken as well as European derived languages such as English, Afrikaans and German. Despite the fact that English has been officially adopted as the official language in Namibia, the five most commonly spoken languages are Oshiwambo (48%), Khoekhoegowab (Nama/Damara) (11%), and the Kavango languages (10%), Afrikaans (11%) and Otjiherero (8%) (Government of the Republic of Namibia, 2003). The current study reflected the multi-lingual and diverse nature of the public service. The percentage of participants from the Oshiwambo speaking group was depicted to be the highest in terms of experiencing psychological distress (3,8%). Despite being a low figure, this is an area which may warrant further research. Thomas (2006) in his study concluded that culture and ethnicity (of which language is a major part) are significant in terms of the experience of distress and similarly establishing reasons for low service utilisation.

### **5.1.2. Age**

Confirming the finding of previous research, (Andrews et al., 2001; Rickwood et al., 2005; Wilson & Deane, 2002), respondents between the ages of 40 and 45-49 year old group were found to experience higher levels of psychological distress whereas those in the 25-29 year old category were fewer. This may be of concern despite the fact that the figure is small. Similarly, the report from the Ministry of Health and Social Services (Government of the Republic of Namibia, 2009) cites a figure of over 250 000 people in Namibia who are experiencing psychological ill-health and related symptoms. The report also mentions that most commonly experienced problems will be anxiety and depression.

### **5.1.3. Gender**

In terms of gender, 56% of the respondents were female and 44% were male. Of this larger sample, more females (7,4%) compared to males (2,9%) scored a GHQ score of above 23. This is congruent with the phenomenon that women are more likely to seek professional care than men. (Addis & Mahalik, 2003; Moller-Leimkuhler, 2002). There is an empirical inconsistency regarding sex and styles of help-seeking; one line of findings suggests that men use direct styles

of help-seeking more often (and indirect ones less often) than women (LeBeau, 2000), whereas another line of findings suggests that there is no such sex difference. Mustein and Fontaine (1993) also suggest that women are trained to use indirect styles, as they may be seen as 'unfeminine' otherwise and men, due to power differences, use direct styles of help-seeking more often than women, whereas women use indirect styles of help-seeking more often than men. In this study, the results indicate that females (compared with males) were more inclined to report depression symptoms. This finding is consistent with other studies conducted in Zambia (Chipimo & Fylkesnes, 2010) and Botswana (Segopolo et al., 2009).

#### **5.1.4. Marital status**

The results show that those who were either married or living together (5,2%) were in the majority, followed by those who were widowed, divorced or separated (3,2%). The single category (1,8%) were the least in terms of obtaining a GHQ score of more than 23. This finding is consistent with the findings of multiple studies conducted assessing the influence of predisposing factors on help-seeking behavior (Rabinowitz et al., 1999; Razali, & Najib, 2000; Rickwood et al., 2005). These studies have found that predisposing factors of marital status, gender, and psychological distress are significant predictors of help-seeking in individuals. In terms of marital status serving as a predisposing factor in professional help-seeking, past studies found that individuals who were separated or divorced were significantly more likely to seek mental health services than were married individuals (Leaf & Bruce, 1987). A more recent study has confirmed this finding that individuals who were divorced or separated were more likely to seek help than were married individuals (Mechanic, 2002). Marital status has been a consistently proven factor that contributes to differences in help-seeking behavior. One theoretical explanation for the influence of marriage on help-seeking is the availability of social support in the relationship (Pillay & Rao, 2002).

#### **5.1.5. Educational level**

Of the overall sample 34.5% had completed a 3-year qualification while 53.2% had completed high school. Related to the number of respondents who had scored more than 23, 5,2% had completed high / secondary school followed by those who had completed a 3-year university or technikon qualification (3,9%). This is in line with the findings of Jackson et al., (2007) who

found that individuals who are in their 20s and have completed a 3 year tertiary qualification and have more positive attitudes toward seeking professional help.

#### **5.1.6. Income**

respondents who had a score of 23 and higher earned over N\$10 000 followed by those in the N\$5001-N\$10 000 income range. A frequently studied barrier to help-seeking is the economic status of individuals and families (Fisher & Turner, 1970; Lechnyr, 1992). According to Coetzee (2008), considerable attention has been given to assessing the costs of various treatments yet much less attention has been given to assessing the costs associated with persons who need services but are not receiving them. Among the economic costs are lost wages of individuals and families as well as the costs of lost productivity to the public sector. There are also social costs, such as the burden to the family and the fact that the individual is not fulfilling various social roles and obligations.

#### **5.1.7. Visits to medical health providers**

Participants who visited a mental health provider over the past six months obtained statistically and practically significantly higher scores in all four general health dimensions (all large effects) than those who did not visit such providers over the past six months. Therefore, individuals who visited mental health care providers had experienced higher levels of social dysfunction, anxiety and somatic symptoms. This confirms the work of Kushner and Sher (1991) and also the research of Morgan et al., (2003) who found that as psychological distress increases, the need to seek psychological help also increases. However, in this study, of those consulted, the GP was the most visited medical health provider compared to a nurse or other health provider. Of concern is the fact that only 1% of the total population who had visited a GP was actually referred to seek additional help from a mental health provider. The results of this study in the data analysis indicated that those who attained a global score of more than 23 on the GHQ-28, spoke to both family and friends in addition to receiving medication. It is interesting to note that there were highly significant results on those scoring high on the GHQ particularly on somatic symptoms and severe depression yet preferred to work through the problems on their own. Similarly, those receiving medication and also scoring high on the GHQ are also significant in terms of the study.

### **5.1.8. Visits to mental health providers**

Psychologists are one of the least likely places for public servants to seek help when they have problems. Confirming the findings of LeBeau (2005), the most frequently cited help-seeking source were family members, friends or religious leaders which were seen to be the greatest help. Again, unfortunately for this study, psychologists seemed to have offered the least help. This can be attributed to the fact that seeking help from formal sources in an African setting is not common neither is it encouraged; it is rather preferred to fall back on the spiritual for total help and assistance. In line with Saint Arnault's (2009) Cultural determinants of help-seeking model, the African culture may be described as spiritual oriented and has spiritual explanations for everything an individual experiences (Nsereko et al., 2011).

### **5.1.9. Location of mental health providers and residential suburbs of participants**

The majority of respondents who had scored more than 23 on the GHQ lived in Pioneerspark and accordingly visited mental health providers in Pioneerspark. Windhoek West, Eros and Hochland park.

The questions dealing with accessibility included: an inconvenience to patient needs, physical constraints such as family and work responsibilities that interfered with seeking help, geographical location (not enough providers in an area), difficulty obtaining transportation to the psychologist's office, difficulty obtaining a timely appointment to see a psychologist, and inconvenient office hours. 14% stated that they found it inconvenient and 7% did not know where to go.

Only 2% of the entire sample reported that they consulted a Psychologist. The respondent's choices of most preferred helper differed significantly as a function of age ( $p < 0.0001$ ). Respondents who preferred not to seek professional psychological help were younger than those who preferred professional psychological help. Those who most preferred friends and relatives were female (34%) followed by those who preferred to handle their problems themselves.

Previous studies found that the main barrier to seeking help was the perception of family and friends about mental health problems (Blumental & Endicott, 1996; Kushner & Sher, 1991). In

this study this was not reported as a major reason. The most common barrier to service use was logistic. Respondents with high GHQ scores more than the other respondents reported one or more such barriers as a reason for not seeing a psychologist. The logistic barriers included factors such as getting help was either too inconvenient or they did not know where to go. It is highly possible that these people had already seen a general practitioner and they may have experienced these barriers.

#### **5.1.10. How public servants solved the problem eventually**

A GP was consulted and medication was prescribed and family and friends were cited as a help-seeking source. 15 respondents worked through the problems on their own. Individuals who spoke to family and/or friends experienced higher levels of social dysfunction, anxiety and somatic symptoms. Responses were examined in terms of these individual's likelihood of seeking help from five specific sources and by relative preference among these sources. Consistent with previous research (Rivera, 2007; Stanhope, 2002), respondents rated that they worked through the problem on their own as their most likely manner of solving the problem. Another 52% reported that they would be most likely to consult their family and / or friends. Overall, the sample preferred family and friends to psychological help, which is consistent with the findings from previous studies (Murstein & Fontaine, 1993; Trude & Stoddard, 2003; LeBeau, 2005).

Another interesting finding was the low rate (0,7%) of seeking help from community leaders, priests, minister or pastor in terms of the sample of participants who scored more than 23. This ties in Nsereko et al.'s (2011) research where their findings indicated that African men are expected to hide their emotions and put up a brave front. A larger use of seeking help from friends and family by the smaller sample who had scored more than 23 may be attributed to their perceptions that health professionals cannot provide for their needs. However, people who consulted a GP who referred them to a mental health practitioner also followed through with the psychological treatment. It shows that experience with professionals gives people greater confidence in using their services. Preference for friends over professionals for help-seeking raises questions about the quality and type of help received, because, although friends are a

source of support, they are not trained in providing help for any kind of mental health problem. Using friends as the only source of support may place people with psychological distress at risk.

## **5.2. Discussion of the qualitative results**

### **5.2.1. The semi-structured interviews**

Different models of help-seeking have been highlighted previously to explain help-seeking in an attempt to evaluate and contextualize them in this study. For example, Fischer et al.'s (1983) model explains help-seeking as a process and often a result of complex interpersonal interaction between the patient and the immediate environment. There are instances when individuals consult a GP not by choice but having been forced by others. In addition, precipitating events motivate further help-seeking action. Help-seeking, according to the model may be thwarted by additional barriers such as, lack of knowledge of resources, or unavailability of appointments. This may well be the case in the Namibian public service context where the process contributes to the low utilisation levels.

The socio-behavioural model (Purola, 2003) incorporates subjective and objective variables and biological, psychological and social factors, which are appropriate to an integrative model of help-seeking. This model therefore, provides a wide understanding of the ways individuals will decide whether to seek psychological help or not. An understanding of the patterns of help-seeking will assist in understanding an individual's decisions and promote shared decision making. It has been shown that individuals who are more involved in their treatment decision-making are more satisfied and more compliant with their treatment (Guadagnoli & Ward, 1998).

The health belief model (Rosenstock, 1966) provides a theoretical rationale for recommending the need for professional psychological help as feelings and behaviour are largely determined by the way one interprets the world. Also, people who are psychologically distressed have distorted and negative interpretations about events pertaining to an individual. The goal of therapy would then be to share this model collaboratively with the patient and to help reinterpret his or her experiences as the fault of thinking biases that may potentially be corrected so that less negatively biased thinking is restored and mood improved. A very important finding of the study is that Namibians in general see health and illness as social phenomena.

In contrast, the bio-psycho-social model (Engel, 1980) suggests that an individual's perceptions of health, threat of illness, barriers in the social or cultural environment, will influence the likelihood that a patient will seek help and will ultimately act as a guide for coping responses such as help-seeking behaviour and treatment adherence (Weinman & Petrie, 1997; Rivera, 2007).

The help-seeking decision-making model (Goldsmith et al., 1988) is based on the premise that individuals are active problem solvers whose health-related behaviours are attempts to close the perceived gap between their current health and a future goal state. The coping strategies they select (including whether to see a GP, mental health practitioner or take medication) are guided by their interpretation and evaluation of their illness. The outcome of these behaviours is then evaluated and fed back into their model of the illness, and used to shape future coping responses.

Finally, there are a number of similarities in these models that have sought to outline the variables that are important in health behaviour. In particular, these models emphasise the importance and collaborative roles of the GP, mental health practitioner, as well as the need for individuals to use a range of self-regulatory skills and strategies to ensure that strong intentions are translated into behaviour.

In this study, the general practitioner had been one of the most used source of help. It shows that they should be aware of the specific symptomatic and psychological needs of clients, the psychosocial context in which mental health problems are experienced and the implications for help-seekers. It also shows the necessity of keeping public servants up-to-date and aware of the psychological help benefits available to them. Another interesting finding was the low rate of seeking help from pastors, priests or spiritual healers, suggesting that the participants do not readily seek help from religious sources. Viewed from this perspective, the GP plays a greater role in helping people with mental health problems in this case.

Three major themes emerged out of the data analysis (Table 2):

(1) support: how public servants obtain support for their psychological problems;

- (2) help-seeking: help-seeking behaviour patterns; and finally,
- (3) barriers: real and perceived barriers that prevent public servants from seeking psychological help.

The second phase of analysis, crystallization, reflects the gradual formation and emergence of the above-mentioned themes:

### **5.2.2. How public servants obtain support for their psychological problems**

Two themes emerged involving support from partners and peers. Most of the GPs mentioned that people in general and particularly, males do not seek much support for their health concerns. However, when they do seek support, males usually expect to get support from a female partner. It was indicated that the female partners were the ones who listened to their health concerns and urged them to seek medical help. Additional research by Biddle et al. (2007) found that young men were particularly reluctant to seek help unless severely distressed, which may be important in understanding the high suicide rate for men.

"I don't think I can remember any of my patients telling me that they have spoken to a friend who have advised them to see a GP for their problems as opposed to hundreds of men who have spoken to their wives or female friends who have encouraged them to see a GP."

"Women don't have a problem seeking help from others. They might begin with their friends or family, who might tell them to see a GP. Others will go on to see both a psychologist and a psychiatrist."

"Men do not ask their male buddies for advice, except in cases where they see the health problem to be a safe topic, such as a sports-related injury. They will speak to their friends as long as it is a sports-related injury. If it is a sports-related injury they will discuss it with their golfing buddy, their trusted male colleague or their gym partner."

### **5.2.3. Help-seeking behaviour patterns of public servants**

General practitioners also described their perceptions of patterns of sharing concerns about illness and health. Most general practitioners felt that men were more likely to share their concerns in an indirect rather than a direct or straightforward manner compared to women. For example, one general practitioner described how the male patients would often come in for a consultation with no complaints or just general complaints about their health; however, these men hoped that the general practitioner would ask focussed questions to find out why they were really there. The exception to this was when a man had a specific problem that was not complicated, like flu or common cold.

“Women just talk and give you the entire history of their problem, possibly even offering answers and describing the nature of their illness.”

"I would say most male patients will come in for a general problem hoping that I would ask the right questions. The only problem is that the practice is so busy, I usually spend an average of five minutes per patient on a busy day, so I don't really spend that much time guessing."

### **5.2.4. Real and perceived barriers that prevent public servants from seeking psychological help**

General practitioners perceived their female clients to over-consult, even telling another doctor what the previous general practitioner had said. In contrast, male patients were described as having a high threshold of tolerance before seeing the doctor. These men needed to feel very vulnerable before they would seek help. Men would often need to be persuaded to see a doctor by their partners. Almost all the general practitioners viewed the influence of partners as critical to these men's decisions to seek help. Older men (older than 55 years) with a history of serious illness or numerous risk factors sought medical help on their own regardless of whether their partners encouraged them or not.

"There is a group of people I consider very much health-conscious and who are taking more interest in their health, especially people under 50, 55. The other group I would say talks a lot about health ... those having gone through major physical illness. They spent a lot of time talking

to each other about how they got better. A lot of my male patients, I think, get spoken to by their wives, and yet do not actively speak to their wives. The wife says, 'You know, you aren't doing enough exercise, and you are smoking and drinking too much, and you are taking on too much at work, you had better go and see a doctor.' The next thing she says is, 'I have already made an appointment for you to see the doctor.'"

The general practitioners believed that although their patients had arrived at their offices with general complaints about their health, they were usually there for a specific problem. Most of the general practitioners interviewed felt that female patients were far more likely to consult for general items, such as complete check-ups and preventive medicine than male patients. Female patients were even more likely to self-diagnose and even ask for a referral to see a psychologist. Meanwhile, men needed to have a concrete problem before they sought help (for example, getting a physical for insurance purposes or a focused injury).

Confirming the findings of Van den Bos and De Leon (1988), this suggests that patients from the public service may abstain from seeking the much needed medical care because they tend to self-diagnose their symptoms such as neck, muscle and joint pains, headache, sleeping problems, and so on. As a consequence of self-diagnosis, they self-treat their symptoms with over-the-counter medications and request to be booked off. This approach may lead to more serious health problems later.

"They come because they have a physical complaint: headache, backache, sore throat; 'I want you to fix it today, because I have to go back to work.' Sometimes they are very open: 'I've been sick for three days. I don't like being sick; make me well.'"

General practitioners were also asked why they thought their patients from the public service did not attend to their psychological health care needs. They identified two types of barriers; namely, personal and systemic.

### **5.2.5. Personal barriers**

Personal barriers have to do with traditional social roles. These include feeling a sense of immunity and immortality; difficulty relinquishing control; a belief that seeking help from a psychologist or other mental health practitioner is not acceptable behaviour for people. Most men in particular who are referred are against seeing any form of mental health practitioner. The female GP said that men are not interested in prevention. When asked to be specific, she mentioned the following:

"Feeling vulnerable."

"The fear of giving up control."

"The apprehension of talking about confidential, private, and psychological issues."

### **5.2.6. Systemic barriers**

General practitioners identified systemic barriers in the delivery of psychological services that they believed their patients from the public service perceived as deterrents to getting proper medical help. These included long waiting periods before the patient would finally manage to see the psychologist, limited hours of operation and the fear of having to disclose the reason for the visit to an assistant or receptionist. However, several GPs indicated that they did not believe that these barriers were specific only to men (although they had been gender-specific in the past).

"There are a few patients who I have referred who do end up going to a psychologist. They say they absolutely hate sitting in the waiting room... I don't know what they fear more – to be sitting there or the height of anxiety of having to sit there for hours."

"I wonder if one of the barriers also is that when you do make an appointment people might ask what it is for. It may be something they may not want to say over the phone to a receptionist."

Several GPs stated that they thought the lack of a male psychologist was a barrier for some of their male patients, especially those in the younger age bracket. They mentioned that older women, more than men, were likely to consult a psychologist for more help with their problems.

In addition, the location of practices and absence of peer counselling and counsellors in the workplace were identified as barriers.

"If you are ... working ... and can't get time off from your job to go to a doctor, let alone a psychologist- it is a big deal to get time off - it is a lot harder."

The questions dealing with knowledge, attitudes, and beliefs related to perceptions of mental health problems were grouped together with questions on attitudinal barriers which included respondents' thinking that the problem was not that serious. Personal barriers had to do with the minimization of illness and lack of family support. This did not appear to be the case in this study.

The questions dealing with the healthcare systems comprised themes of trust and confidence, and self-diagnosis/self-treatment. Here respondents could have indicated that trust and confidence in healthcare professionals impacted their decision not to seek healthcare consultation: individuals may have had previous negative experiences with a mental health practitioner. Respondents were given an option to indicate that they thought the treatment would not help. In this study 3% felt that the treatment would not help. In general it seems that the most common response to questions about seeking psychological help is seen as a good option if a person had the need but would not use it as there was no need. This position strongly supports Le Beau's (2005) findings which indicated that most people would not seek psychological help from professionals unless they had exhausted all other alternatives such as family members, friends and religious leaders – which are the people they currently use for counselling proposes.

### **5.3. Summary**

This chapter provided an explanation of the findings as reported in the previous chapter, 4. The first section discussed the role of language, age, gender, marital status, educational and income levels and confirmed the findings of previous studies indicating the relationship of each of these socio-demographic variables to psychological distress and the need to seek psychological help. The most salient findings of this research point out that in the sample, more Oshiwambo-speaking participants in the public service experience high levels of psychological distress.

Similarly, the discussions show that respondents within the middle (40-49) age group experience psychological distress and of these, the majority are women. In line with this, the finding that individuals only seek help from service providers when the level of distress has become unbearable is significant.

The second section in the chapter discusses the qualitative results as outlined by the interviews with the GPs. An interesting observation is that the GP may well be the reason for the low utilisation of mental health practitioners for many reasons. Firstly, the issue of referral points out the gate-keeping role they play in the health system. Secondly, the GP was found to be quick to remedy the problem with a solution by prescribing medication and booking the individual off as opposed to dealing with the root cause. Lastly, there is the observation that GPs need to be trained to establish and identify the underlying problem by adopting and administering a screening mechanism or tool such as the GHQ to detect psychological distress.

The following chapter deals with the limitations of this study as well as a set of recommendations, conclusion and proposes areas for further research.

## 6. RECOMMENDATIONS AND CONCLUSIONS

This concluding chapter begins with outlining the limitations of this study. A two-fold pair of recommendations for the public service as well as for future research are made. This is followed by two sets of conclusions pointing at, firstly, conclusions regarding the theoretical objectives and secondly the conclusions regarding the specific research objectives.

### 6.1. Limitations of the study

This was a small study that provided a unique opportunity to explore help-seeking behaviour for mental health problems in the Namibian public service. Unlike most studies in the field, this study touched on both the users and one of the main providers of help.

Information sourced from the Ministry of Finance provided a strong basis for the study. Despite a relatively favourable response rate ( $n=284$ ), the study relied primarily on self-reporting to measure key help-seeking behaviours. The honesty therefore of participants is presumed but not ascertained. In addition, the actual experiences of the participants were not observed by the researcher to determine their validity; additionally, self-reporting may be affected by cognitive and culturally influenced biases.

Moreover, there are usually limitations with data obtained from a convenience sample, therefore, the non-responses of the sample could not be accounted for. It is possible that the attitudes and behaviour towards seeking help among the non-respondents in the study were different from those of the respondents. People were asked if they had sought help in the past six months but there was no information about their subsequent and earlier patterns of help-seeking. Furthermore, the research does not provide information about the personal beliefs and motivations underlying the help-seeking intentions and behaviour of the participants.

One of the limitations in terms of the qualitative study of the use of the GPs in the sample is that the size was small ( $n=5$ ), with the participants consisting of urban physicians, most of whom had never been placed in a rural setting. This would limit the transferability of the findings to general practitioners in other settings. However, a good sampling of the target population's opinion was attained, because saturation after four interviews was achieved. A further limitation is that all of

the findings are based on the general practitioner's perspective. Future research should investigate general practitioners in primary health, community practice and in the rural setting. It would also have been interesting to look at the perspectives of mental health service providers in order to gain a deeper understanding of the different role-players in promoting overall health.

This study also shows that barriers to mental health utilisation are a problem for people in the Public Service. Perceived mental health status, accessibility, and lack of knowledge about the services provided by mental health practitioners in the system were barriers impacting on utilisation. The current study was limited in that at best, only 24% of the variance in professional help-seeking intentions was explained by the variables included in the study. Certainly, there are a number of barriers, such as culture, religion, background of service provider among others that may have been identified but not explored at great depth in this study, and those that have not been identified and reduce peoples' intentions to seek psychological help.

More research is also recommended to study the complex processes that lead people to mental health service utilisation and the specific reasons for lack of use of services in a larger sample in both rural and urban areas. The general limitation of this study is that the study was confined in terms of its geographic location of both the sample of public servants in central government as well as the GPs who were based in Windhoek.

## **6.2. Recommendations**

### **6.2.1. Recommendations for the public service**

Psychological distress affects people at different rates and causes a variety of more serious physical health problems. The unfortunate part is that these illnesses are often treatable and even preventable. The impact is felt in the person's private life, but problems related to psychological distress also have staggering effects on the Namibian work force in areas of productivity, morale, and absentee rates. This study provides an insight for mental health policy-makers and programme developers in the Public Service of Namibia and strongly suggests that promoting the mental health of people would be a sound investment to prevent mental health problems and to reduce the economic burden associated with them.

This study has outlined numerous international studies and accordingly, the political will of leaders in the Namibian government who acknowledge that there are several issues impacting on a person's willingness to seek help. This research generally points to the conclusion that low awareness levels about mental health issues, and the concerns over confidentiality and career impact have allowed a stigma to persist, and therefore continually prevent government staff members from seeking help from psychological facilities.

Since the GPs seem to be the most common resource for those seeking help, their perceptions of therapy, their likelihood and ability to make referrals might be very important for increasing services from mental health professionals. The training of physicians in the care and management of these common mental disorders therefore needs to continue to focus on the somatic presentation of mental disorder (somatisation) coupled with the development of therapeutic models that include social, psychological, and pharmacological treatments (Goldberg & Huxley, 1992). This supports Murstein and Fontaine's findings (1993), that people experiencing psychiatric symptoms and disorders most commonly consult their GPs to treat the physical symptoms. It is therefore argued that improving the recognition of mental health problems, for example by using a screening tool such as the GHQ as part of a patient-completed questionnaires, will directly benefit patient care.

Three key themes were identified in this study as a result of interviewing the sample of GPs:

- (1) support: men appear to get most of their support for health concerns from their female partners and very little from their male friends;
- (2) help-seeking: perceived vulnerability, fear, and denial are important influences on whether people seek help; and
- (3) barriers: personal and systematic barriers (perceived and real) that prevent people from seeking psychological help.

It is important to strengthen the identification, treatment and/or referral capabilities of the GPs, as they have a strong role in initiating help-seeking. Early intervention would be made possible by strengthening the capacity of these sectors. This recommendation has been made before (Demyttenaere et al., 2006; Fairbrother & Warn 2003; Fox, 2002). It is especially pertinent as

findings of the current study indicate that the GP may not always identify depression. An extension of training and capacity-building to other service providers such as other general health practitioners (nurses) and mental health practitioners is required, as people tend to first seek services outside of the traditional health system, preferring to seek help from either family or friends or resorting to solve the problems themselves.

### **6.2.2. Recommendations for future research**

Considering all of these, the following recommendations for future research and possible intervention are suggested:

This study points to the need to expand research in several directions. The role of the GP in utilising a screening tool such as the GHQ-28 in problem identification, referral and treatment has been clearly identified – the responsiveness of the GP and further referral to a mental health practitioner needs to be researched. The finding that women are the ones who acknowledge the first signs of psychological distress encourage help-seeking is important to build upon. The preference for speaking to family and friends in solving problems can help the public learn how to identify the symptoms of mental illness and educate them as to what the symptoms mean need to be developed. Such efforts would empower people to make informed judgments about their needs.

These initiatives could directly address (a) the types of symptoms associated with different disorders, (b) the cause of different disorders, (c) the frequency of different symptoms and disorders, (d) the consequences and the causes of mental illness. These would also in turn better inform not only public servants but also the public at large and allow them to make more appropriate interpretations regarding their mental health. In doing so, the public service may be able to increase the public's awareness of mental issues and thereby minimize misperceptions and reduce the problems associated with misidentifying, mislabeling, or misinterpreting mental health symptoms.

An awareness programme should be developed for the general public, focussing on somatic complaints as highlighted in section "A" of the GHQ-28 questionnaire. The topics in this

programme should focus on symptoms associated with developing at-risk psychological issues, such as fatigue, sleep, and pain, and encourage people experiencing these symptoms to seek help promptly. It would be recommended to all general and mental health providers that patients seeking help with these symptoms may need continued monitoring for potential distress, depression and other psychological problems.

A similar awareness programme targeting patients, GPs and mental health providers should be developed with the goal of improving interactions among these three groups in terms of psychological distress. This programme would emphasise the accurate diagnosis of underlying psychological symptoms by the GP thereby decreasing misdiagnosis and increasing psychological treatments in order to provide targeted therapy. Furthermore, it would encourage continued dialogue between patients, GPs and mental health providers in terms of management of psychological illness.

These efforts hope to enable them to recognize the criteria in order to identify psychological distress and at the same time address perceived stigma and trust for persons seeking help in the area of psychological illness. Concrete examples of these efforts would include reducing the GPs barriers to referring patients to mental health providers by increasing knowledge about mental health issues including depression, stress, anxiety and suicidal ideation. The aim would be to increase diagnostic self-efficacy and skills as well as facilitate understanding of the patient's needs. This approach would also focus on improving individual perceptions of seeking help among persons with mild psychological distress with the goal to decrease unconstructive attitudes and beliefs that may act as barriers.

These interventions should target each of the barriers measured in this study, particularly those related to the systemic issues. There should be an emphasis on providing information to people on their perceived mental health status, accessibility to psychologists; targeting both male and female patients, as well as providing information on the knowledge about services provided by mental health providers in the Namibian system.

It is equally important for people particularly in the public service to understand that professional help-seeking is often the best way to manage distressing personal-emotional problems and certainly, the best way to manage problems related to chronic psychological illness.

Public servants should also be given the opportunity to consult either a peer counsellor at work through the wellness programmes before they become psychologically distressed and less likely to seek help from any source, particularly from formal help-sources. The promotion of professional help-seeking is paramount but at the same time people should also be educated about the help that professional sources provide. Added to this, it is also important that people should have the basic understanding that professional help can be beneficial.

A focussed attempt towards providing information about the ways in which the different mental health practitioners, such as a psychological counsellor, psychiatrist, psychologist or social worker can assist with different problems should be spearheaded by the Ministry of Health and Social Services. Providing people with statistics from the PSEMAS database about the effectiveness of psychological treatments may be of benefit. Through prevention programmes and personal contact with mental health practitioners, it is important to let people know that no problem is insignificant if it causes distress and that professional help is a good way to start reducing that distress.

Finally the prompting and raising of awareness regarding the accessibility of mental health providers is important. Psychologists, social workers and psychological counsellors should be more accessible to people in the workplace. Firstly, by exploring the knowledge public servants have about mental health and mental health providers. Secondly, by involving the Ministry of Health and Social Services to promote mental health in order to generate help-seeking experiences with mental health service providers. These interventions should include aspects that provide opportunity for people to reassess their attitudes and beliefs about mental health practitioners and help-seeking.

The extent to which the application of these recommendations would be successful in reducing peoples' barriers to mental health providers and remains an important area of study for future research.

### **6.3. Conclusions**

#### **6.3.1. Conclusions regarding the theoretical objectives of the study**

The study verified the assumptions that were made on the basis of the initial literature review that socio-demographic factors probably play a significant role in impacting The level of psychological distress, help-seeking and engagement in treatment in the Namibian public service. The study has added to the literature by beginning to fill important gaps, for example, working qualitatively, focusing on the public service population and analyzing both service user and service provider (medical and mental health) perspectives. The implications for the utilisation of services and PSEMA's benefits in this study are strong.

Although the impact of psychological distress can be reduced or eliminated through early and on-going support, many studies (Demyttenaere, et al., 2006; Kawachi & Berkman, 2001; LeBeau, 2005; Rickwood, et al. 2007) have shown that people with emotional difficulties do not always seek treatment and those who do, discontinue treatment when referred to a psychologist or mental health practitioner. Stigma, or negative attitudes towards people suffering from psychological distress seriously reduces a person's ability to seek help. Once in treatment, stigma may decrease the likelihood that people will continue to use these supports or services. Thus, any attempt to increase help-seeking in the public service must also focus on reducing stigma.

This study has educational and clinical implications. The findings assume the need to raise the GP's knowledge and awareness about how to recognize and manage a person suffering from mental distress in a proper way.

#### **6.2.2. Conclusions regarding the specific objectives of the study**

The results obtained from this study showed that the socio-demographic data supports the general findings of the wider medical aid utilisation in the public service where only 13 900 of the 209 155 PSEMA's members visited psychologists in 2007/2008 (Coetzee, 2008). From the

larger sample of respondents only 10 percent were identified as experiencing psychological distress. Furthermore, the findings support the need to use the General Health Questionnaire as a screening instrument for psychological distress within this context.

A person's ability to carry out these help-seeking behaviours rests on a multitude of factors. Studies have shown that a person's knowledge, attitude, previous help-seeking experiences, and perceptions about the severity of the problem will influence these help-seeking behaviours. The help-seeking behaviours also depend on a host of environmental factors, including the nature and extent of mental health practitioners or services available. The recognition of mental illness and early intervention is critical to treatment and recovery. Nonetheless, due to cultural variation in clinical presentation, people experiencing psychological distress are not diagnosed properly and do not receive appropriate treatment. In this study, the emphasis was on the role of the GP as well as the mental health practitioner in the management of psychological distress without psychotic features. Treatment and coping strategies should focus on seeking social support from lay people including family, neighbours, and religious practice as well as doing pleasurable activities, as the first step, and then seeking medical support from mental health practitioners.

Further work should be undertaken across the public service and in a range of other settings including schools and the private sector to include more active components in the intervention to enhance engagement.

The study concludes that a number of socio-demographic characteristics such as the language group, gender, marital status, age, residential area, education and income levels of public servants are related to psychological distress, help-seeking and utilization of their PSEMAS service benefits. Furthermore, the study concludes that the level of psychological distress is significantly related to seek professional psychological help for people working in the public service.

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## REPUBLIC OF NAMIBIA

## OFFICE OF THE PRESIDENT

Telephone: (061) 2707787  
Fax: (061) 221770

Cabinet Secretariat

5 September 2012

Dear Ms Maritz

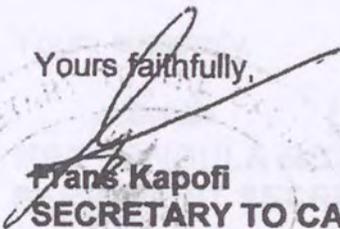
RE: RESEARCH ON HELP-SEEKING BEHAVIOURS AND SCREENING FOR  
PSYCHOLOGICAL DISTRESS AMONG A REPRESENTATIVE SAMPLE OF  
NAMIBIAN PUBLIC SERVANTS

Your letter dated 3 September 2012 requesting permission to conduct research on the above-mentioned topic is hereby acknowledged and approved.

Kindly ensure that the results of the study are furnished to this office as soon as it has been released and published.

Wishing you well in your studies

Yours faithfully,

  
**Frans Kapofi**  
**SECRETARY TO CABINET**

All correspondence should be addressed to the Secretary to Cabinet



## REPUBLIC OF NAMIBIA

## OFFICE OF THE PRIME MINISTER

Telephone: (061) 2872030  
Fax: (061) 230741

Private Bag 13338  
Windhoek

5 September 2012

Dear Ms Maritz

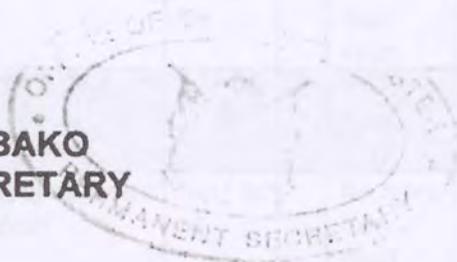
RE: RESEARCH ON HELP-SEEKING BEHAVIOURS AND SCREENING FOR  
PSYCHOLOGICAL DISTRESS AMONG A REPRESENTATIVE SAMPLE OF  
NAMIBIAN PUBLIC SERVANTS

Your request to conduct research for your thesis on the above-mentioned topic is hereby registered. The topic of the study is interesting and the results may prove to be beneficial in terms of the provision of psychological services to people in the public service.

Approval to conduct the research is hereby granted provided that this office receives a copy of the final report and findings.

Yours sincerely,

**MRS NANGULA MBAKO**  
**PERMANENT SECRETARY**



All correspondence should be addressed to the Permanent Secretary

The purpose of this questionnaire is to explore how healthy people are in the public service. The results of this research may be used in order to provide better medical and psychological help benefits in future. I would greatly appreciate if you would take the time to complete this questionnaire. Please try to answer ALL the questions. You may remain anonymous so your name or personal details will not be required. The information will also be treated confidentially. If you need any assistance with answering any of the questions, or would like additional information about this research, please contact Yrika Maritz on 061-2872188 or on my mobile on 0813168548. You can also reach me via e-mail on [yrika.maritz@gmail.com](mailto:yrika.maritz@gmail.com) The questionnaire will take approximately 15-20 minutes of your time.

Date: Questionnaire no: 

### GENERAL HEALTH AND SOCIO-DEMOGRAPHIC QUESTIONNAIRE

I would like to know if you have had any medical complaints and how your health has been in general, over the past few weeks. Please answer ALL the questions on the following pages. To answer the questions, please tick the appropriate box or give a written reply where applicable. Please note that I want to know about present and recent complaints, not those that you have had in the past.

A. Have you recently							
A1	<i>been feeling perfectly well and in good health?</i>	Better than usual		Same as usual		Worse than usual	Much worse than usual
A2	<i>been feeling in need of a good tonic?</i>	Not at all		No more than usual		Rather more than usual	Much more than usual
A3	<i>been feeling run down and out of sorts?</i>	Not at all		No more than usual		Rather more than usual	Much more than usual
A4	<i>felt that you are ill?</i>	Not at all		No more than usual		Rather more than usual	Much more than usual
A5	<i>been getting any pains in your head?</i>	Not at all		No more than usual		Rather more than usual	Much more than usual
A6	<i>been getting a feeling of tightness or pressure in your head?</i>	Not at all		No more than usual		Rather more than usual	Much more than usual
A7	<i>been having hot or cold spells?</i>	Not at all		No more than usual		Rather more than usual	Much more than usual

B. Have you recently						
B1	<i>lost much sleep over worry?</i>	Not at all		No more than usual	Rather more than usual	Much more than usual
B2	<i>had difficulty in staying asleep once you are off?</i>	Not at all		No more than usual	Rather more than usual	Much more than usual
B3	<i>felt constantly under strain?</i>	Not at all		No more than usual	Rather more than usual	Much more than usual
B4	<i>been getting edgy and bad-tempered?</i>	Not at all		No more than usual	Rather more than usual	Much more than usual
B5	<i>been getting scared or panicky for no good reason?</i>	Not at all		No more than usual	Rather more than usual	Much more than usual
B6	<i>found everything getting on top of you?</i>	Not at all		No more than usual	Rather more than usual	Much more than usual
B7	<i>been feeling nervous and strung-up all the time?</i>	Not at all		No more than usual	Rather more than usual	Much more than usual

C. Have you recently						
C1	<i>been managing to keep yourself occupied?</i>	More so than usual		Same as usual	Rather less than usual	Much less than usual
C2	<i>been taking longer over the things you do?</i>	Quicker than usual		Same as usual	Longer than usual	Much longer than usual
C3	<i>felt on the whole you were doing things well?</i>	Better than usual		About the same	Less than usual	Much less than usual
C4	<i>been satisfied with the way you've carried out your tasks?</i>	More satisfied		About the same	Less satisfied than usual	Much less satisfied
C5	<i>felt that you are playing a useful part in things?</i>	More so than usual		Same as usual	Rather less than usual	Much less than usual
C6	<i>felt capable in making decisions about things?</i>	More so than usual		Same as usual	Rather less than usual	Much less than usual
C7	<i>Been able to enjoy your normal day-to-day activities?</i>	More so than usual		Same as usual	Rather less than usual	Much less than usual

D. Have you recently						
D1	<i>been thinking of yourself as a worthless person?</i>	Not at all	No more than usual	Rather more than usual	Much more than usual	
D2	<i>felt that life is entirely hopeless?</i>	Not at all	No more than usual	Rather more than usual	Much more than usual	
D3	<i>felt that life isn't worth living?</i>	Not at all	No more than usual	Rather more than usual	Much more than usual	
D4	<i>thought of the possibility that you might do away with yourself?</i>	Definitely not	I don't think so	Has crossed my mind	Definitely has	
D5	<i>Found that you couldn't do anything because your nerves were too bad?</i>	Not at all	No more than usual	Rather more than usual	Much more than usual	
D6	<i>found yourself wishing you were dead and away from it all?</i>	Not at all	No more than usual	Rather more than usual	Much more than usual	
D7	<i>found that the idea of taking your own life kept coming into your mind?</i>	Definitely not	I don't think so	Has crossed my mind	Definitely has	

E. What is the language you speak at home?	
English	Afrikaans
Oshiwambo	Otjiherero
Damara / Nama	Rukavango
German	Setswana
Khoi-San	Silozi
If other, please state:	

F. Are you?	
Female	Male

G. Are you?	
Married or living together	Single
Widowed / Divorced / Separated	Unsure

H. How old are you?	
1. 18-24	
2. 25-29	
3. 30-34	
4. 35-39	
5. 40-44	
6. 45-49	
7. 50-54	
8. 55-59	
9. 60-64	

I. Which suburb do you stay?					
Academia		Hochland park		Windhoek-North	
Auasblick		Katutura		Olympia	
Avis		Khomasdal		Pioneerspark	
Cimbebasia		Klein Windhoek		Prosperita	
Doradopark		Kleine Kuppe		Rocky Crest	
Eros		Ludwigsdorf		Suiderhof	
Erospark		Luxushügel		Windhoek-West	
If other, please state:					

J. What is the highest level of education you have completed?	
Completed primary school	
Completed high / secondary school	
Completed 3-year University / Technikon qualification	
Completed post-graduate qualification	
If other, please state:	

K. What is your gross monthly income?	
Under N\$700	
N\$701-N\$2500	
N\$2501-N\$5000	
N\$5001-N\$10 000	
Over N\$10 000	

L. Have you visited a medical health provider about emotional or personal problems over the past six months?		
Yes	No	
If unsure, please state why:		

M. If your answer to question "M" was "Yes", what kind of medical health provider have you seen about emotional or personal problems over the past six months?		
General Practitioner (Medical Physician / Doctor)	Nurse	
If other, please state:		

N. Did the medical health provider refer you to see a mental health provider such as a psychiatrist, psychologist, social worker or psychological counselor?		
Yes	No	
If unsure, please explain:		

O. Have you visited a mental health provider for emotional or personal problems over the past 6 months?			
Yes	Unsure	No	

If your answer to question "O" is "No", please leave out questions "P" and "Q" and answer only question "R".

P. How many times did you visit a mental health practitioner ie. psychiatrist, psychologist, social worker or psychological counselor over the past six months? Please tick as many that apply in the appropriate box.					
	None	Once	2-3 times	4-5 times	6-7 times
Psychiatrist					

Psychologist				
Psychological Counsellor				
Social Worker				
If other, please state				

**Q. What part of Windhoek is s/he in?**

Academia		Hochland park		Windhoek-North	
Auasblick		Katutura		Olympia	
Avis		Khomasdai		Pioneerspark	
Cimbebasia		Klein Windhoek		Prosperita	
Doradopark		Kleine Kuppe		Rocky Crest	
Eros		Ludwigsdorf		Suiderhof	
Erospark		Luxushügel		Windhoek-West	
If other, please state:					

**R. If you have not visited a mental health practitioner over the past six months, which of the following reasons most closely relate to you? Please tick as many reasons that apply in the appropriate box.**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
It was too inconvenient for me					
The waiting period to get an appointment was too long for me					
I didn't know where to go					
The problem was not that serious – I handled it on my own					
I did not trust the person referring the mental health practitioner					
I had previous negative experiences with a mental health practitioner					
I was afraid that my family and friends would think I'm crazy					
I thought that the treatment would not help					
The people I trust most did not recommend seeing a mental health practitioner					
If other, please state:					

**S. Did you speak to any other person such as a Community Leader, Priest, Minister or Pastor about emotional or personal problems over the past six months?**

Yes		No	
If unsure, please explain:			

**T. How was the problem solved eventually? Please tick as many reasons that apply in the appropriate box.**

	Yes	No
My General Practitioner (Medical Doctor) gave me medication		
I worked through the problem on my own		
I spoke to a Community Leader, Priest, Minister or Pastor about it		
I went to see a Traditional Healer about it		
I spoke to my family and / or friends about it		

### Consent Form for General Practitioners

*You are being invited to participate in a research study. Please note that participation is completely voluntary and that declining to participate or withdrawing from the study early is possible with no adverse consequences.*

The Research Project for which consent is requested is titled, "**HELP-SEEKING BEHAVIOURS AND SCREENING FOR PSYCHOLOGICAL DISTRESS AMONG A REPRESENTATIVE SAMPLE OF NAMIBIAN PUBLIC SERVANTS.**"

The investigator of the study is Yrika Maritz, who is a Masters student of Clinical Psychology at the University of Namibia. For information on the research and for answering any questions or concerns, she can be contacted at +264813168548.

Professor Ian Rothmann is her supervisor. He can be contacted on **Tel: +27(16)9103433 or via Fax: +27(18)2856024**

Your participation in this study will be very helpful in understanding the needs of the Public servants. To participate in this study you must meet the two main conditions:

1. You are in close proximity of government offices.
2. You are registered with PSEMAS as a service provider

Please note that you waive no legal rights by participating in this study

The interview will last for approximately an hour. It will take place in a location that is convenient to you.

You will be asked the following questions:

1. Could you describe the type of people (from the public service) who see you for psychosomatic problems – men or women? -How old would you say the majority of them are? -What language groups?
2. Besides seeing you for these problems, what kind of social support systems do you think these people have?
3. How do they approach you with their presenting problems?
4. When you realise that the symptoms being presented could have an underlying psychological problem, do you refer them to a mental health practitioner?
5. What would you say are the perceived barriers in following through on your referral?

Your participation in the interview is completely voluntary. If at any time during the interview, you wish to withdraw from the interview, you are free to do so. You may also choose not to answer certain questions. There are no known risks in participating in this study. If you feel emotional during the study and want to refuse further participation, you are free to do so.

Though there are no direct benefits to you by participating in the study, the findings from this study may lead to better mental health service provision for public servants who form part of your clientele group in the future.

Your participation in the study will be kept confidential. Except for the investigator who is also the interviewer, and the supervisor, no one will know your personal identity. The interviews will be tape-recorded. After the recording, the interviewer will go over the tape and erase portions where your name is mentioned. If you do not want the interview audio taped, but would like to participate in the interview, that is possible too. The notes taken at the interview will not have your name in it. Instead it will have a code number.

After the audiotapes have been transferred to notes, they will be destroyed. When data is presented, it will be made sure that there is no information through which you can be identified.

When quoting what you have said, identifying information such as your name or names of others that you mention will be removed.

A summary of the thesis will be made available at the University of Namibia.

Thank you for your consent. You are being given a copy of this informed consent to keep for your own records.

## Interview schedule with General Practitioners

## Introduction

I'm interested in hearing from you about your knowledge and experiences with people in the public service seeking mental health services for psychological distress and stress-related concerns. If you want to start by just talking about your experience, that's fine, or I could begin by asking you some questions:

1. Could you describe the type of people (from the public service) who see you for psychosomatic problems – men or women? -How old would you say the majority of them are? -What language groups?
2. Besides seeing you for these problems, what kind of social support systems do you think these people have?
3. How do they approach you with their presenting problems?
4. When you realise that the symptoms being presented could have an underlying psychological problem, do you refer them to a mental health practitioner?
5. What would you say are the perceived barriers in following through on your referral?

Thank you for your time.