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UNDERSTANDING MENTAL DISTRESS, COPING, HELP-SEEKING BEHAVIOURS AND SUBSTANCE ABUSE OF PSYCHOLOGY STUDENTS

BY

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DECLARATION

I, Deantha Pather declare that:

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2. This dissertation has not been submitted for any degree or examination at any other university.

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ABSTRACT

Mental distress and substance use among university students is a global concern, with many using ineffective coping strategies and showing reluctance to help-seeking. There is however a paucity of research on mental distress and substance use among adolescents and young adults, within the context of South Africa. The aim of this study was to understand the mental distress, coping, help-seeking behaviours, and substance use of psychology students. This study consisted of 200 psychology students within the University of Kwa-Zulu Natal, using a convenience sampling method to recruit all participants.

Various statistical analyses such as frequency analyses, reliability analyses, descriptive statistics, a One-Way ANOVA analysis, a T-test analysis, Chi-square analyses, correlation analyses, and backward multiple regression analyses were performed. The results from the analyses indicated that there was a high prevalence of mental distress and alcohol use among these students. Peer and parental alcohol use were found to be related to student's alcohol use. Students were also found to use negative coping behaviours in dealing with their distress. Students who used substances were also more likely to employ negative coping behaviours, with current cigarette use, current alcohol use, and current drug use being associated with negative coping. Male students reported more self-stigma of seeking help for their distress. Most of the results were consistent with the results obtained from past research.

The findings from this study are useful in creating awareness on the prevalence of mental distress and substance use among South African university students being a great concern. It also creates awareness on the types of coping and help-seeking behaviours (governed by self-stigma of seeking help) employed by these students. These findings not only aid our understanding of mental distress, coping, help-seeking and substance use among university students in South Africa, but also aims to alter the trajectory of mental distress, substance use, coping and help-seeking among South African university students. The findings of this study are also useful in assisting in future preventative measures and interventions that could be useful in curbing this growing burden of mental distress and substance use and promoting effective coping and help-seeking behaviours among South African university students.

CHAPTER ONE: INTRODUCTION

1.1. Background and Rationale of the study

Mental health and substance abuse are a global burden, with adolescents and young to middle-aged adults being associated with the highest burden of mental health and substance abuse issues (Whiteford et al., 2013). There however seems to be more studies focussing on the global issue of mental distress and substance abuse among older individuals as opposed to adolescents and young adults (Saban et al., 2014). Seeing that college students fall under these age groups and dealing with mental distress by engaging in substance abuse is a huge problem among college students, this particular age group should be widely looked at to try and curb this global issue.

According to Rosenblum et al. (2014), the National Epidemiological Survey of Alcohol and Related Conditions (NESARC), the National Survey of Drug Use and Health (NSDUH), and the Replication of the National Comorbidity Survey (NCS-R), have found using the DSM criteria, that there is a high comorbidity in the prevalence of substance use and mental disorders. This indicates that there is indeed an association between mental distress and substance abuse or a dual-diagnosis of mental distress and substance abuse.

Seeing that there is an association between substance abuse and mental distress, there is a paucity of research in developing countries; therefore there is a need for more research particularly within the context of South Africa (Saban et al., 2014). Research also shows that an estimated 20.0% of adolescents experience mental distress while 5.6% of adolescents and adults have substance abuse disorders in South Africa (Karim, 2016). These statistics are extremely high and show the extent of mental distress and substance abuse from this particular age group. Given the impact of the problem, very little research is done on the relationship between mental distress and substance abuse among South African college students.

The stigma associated with mental distress and substance use disorders is a huge barrier to individuals seeking professional help and making use of available resources (Whiteford et al., 2013). According to Lally, ó Conghaile, Quigley, Bainbridge, and McDonald (2013), research has shown that in the past year less than 25% of college-aged individuals have

received treatment for their mental disorders. Findings also show that an approximate estimate of 75% of lifetime mental disorders begin before the age of 24 which is often associated with poor educational and social outcomes, and occupational functioning being impaired. These college-aged individual's reluctance to seeking help for their mental distress is due to the stigma associated with mental distress, and the detrimental outcomes associated with not seeking help could lead to risk behaviours such as substance abuse as a coping strategy (Lally et al., 2013). The purpose of this study is to therefore find out why college students deal with their mental distress by engaging in substance abuse instead of seeking professional help for their mental distress.

The study aims to help us realise the impact of substance abuse and mental distress among South African college students, placing emphasis on the problem at hand and discovering peoples perceived stigma on seeking help that govern their behaviour and choices. This study is not only important in helping us come up with solutions to the problem at hand, but also to create awareness on the issues or lack of knowledge and support experienced by college students. This study is also especially useful, seeing that there is a lack of research done in the South African context, more specifically among university students, given that it is a growing concern.

1.2. Research aim

The overall aim of the study is to understand mental distress, coping, help-seeking behaviours and substance abuse of psychology students.

1.3. Objectives

- To explore the nature and prevalence of mental distress among psychology students.
- To explore the nature and prevalence of substance abuse among psychology students.
- To explore the coping behaviours of psychology students experiencing mental distress.
- To explore the relationship between substance abuse and mental distress of psychology students.
- To explore the self-stigma of seeking help for psychology students experiencing mental distress.

1.4. Research questions

- What is the nature and prevalence of mental distress among psychology students?
- What is the nature and prevalence of substance abuse among psychology students?
- What are the coping behaviours of psychology students experiencing mental distress?
- What is the relationship between substance abuse and mental distress of psychology students?
- What is the self-stigma of seeking help for psychology students experiencing mental distress?

1.5. Ethical considerations

Ethical clearance was obtained from the University of KwaZulu-Natal Human and Social Science Ethics Committee (protocol reference number: HSS/1564/018M). Gatekeeper's permission was also sought from the registrar and the ethics committee, to conduct the study on the University of KwaZulu-Natal, Howard College students. Informed consents were also provided to students in order to maintain the confidentiality and voluntary nature of the study. Further information regarding the ethical procedures used in this study, will be discussed in detail in the Methodology chapter.

1.6. Overview of the chapters

Chapter 1: Introduction

This chapter presents a background and rationale for the research study, through the formulation of a problem statement for this study. This is then followed by the research aims, objectives and research questions, as well as a brief overview of the ethical considerations that will be detailed in the methodology section.

Chapter 2: Literature Review

Chapter two presents a review of literature and conceptual definitions of mental health, risky behaviours, substance use, help-seeking, and coping. Furthermore, the chapter presents the theoretical frameworks of the study, namely Urie Bronnfenbrenner's ecological model, and Icek Ajzen's theory of planned behaviour.

Chapter 3: Methodology

This chapter presents the research design, sampling methods, research instruments, as well as data collection and ethical procedures employed. It also presents the statistical methods of data analysis used in this study.

Chapter 4: Results

Chapter four presents the various statistical analyses employed in the study in relation to the research objectives. Statistical analyses such as frequency analyses, reliability analyses, descriptive analysis; mean tests i.e. One Way ANOVA and a T-Test analysis; chi-square analyses, correlation analyses and backward multiple regression analyses are presented in this chapter.

Chapter 5: Discussion

Chapter five discusses the results obtained from this study. The results will be discussed in relation to the literature and theoretical frameworks.

Chapter 6: Limitations, Recommendations and Conclusion

This chapter presents the strengths and limitations of the study as well as recommendations for the future. It also includes a conclusion based on the study findings.

1.7. Chapter Summary

This chapter introduces the research topic by providing some background information and a rationale. The aims and objectives of the study are also presented in this chapter. The next chapter (chapter two) will provide a literature review on mental health, risky behaviours, substance use, help-seeking, and coping, as well as the two theoretical frameworks used in this research study.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter consists of two sections; the first section consists of a review of past literature on mental distress among the youth, followed by a discussion of literature that shows a link between risky behaviour and mental distress. Thereafter, literature is used to explain the relationship between substance use and mental distress, the relationship between help seeking and mental distress, as well as the relationship between coping and mental distress. The second section of this chapter discusses the two theoretical frameworks used in this study and how they can be applied to the sample.

2.2. Mental health problems among young adults

Mental health problems among young individuals is a global concern. Poor mental health, especially among low to middle income countries is one of the major causes of morbidity, with depression being one of the main causes of this disease burden (Deasy, Coughlan, Pironom, Jourdan, & Mannix-McNamara, 2014; Asante, Meyer-Weitz, & Petersen, 2015). Approximately 5-17% of youth worldwide reportedly have mental health issues (Venning, Wilson, Kettler, & Eliott, 2013).

According to Venning et al. (2013), the absence of positive symptoms and the presence of negative symptoms is an indication of mental illness, which can be associated with mental distress or an individual's day-to-day functioning being impaired. According to Olfson, Druss, and Marcus (2015), the diagnosis of most disorders in the DSM-5 requires disorders to cause "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (p.2030). Psychological distress is often referred to as an emotional state characterised by anxiety and depressive symptoms (Deasy et al., 2014).

Some factors that contribute to mental health problems among young individuals are changes in the family environment such as family conflict, increased rates of single parenting, or having a parent or parents with mental health problems. This generations increasing screen time, internet, and social media exposure can also be detrimental to their mental health (Bor, Dean, Najman, & Hayatbakhsh, 2014). It has also been reported that the western culture could possibly negatively impact adolescent's development or lead to the emerging

narcissism seem among college students (Bor et al., 2014). The most common predictors that influence the referral of young people to mental healthcare are depression, anxiety, suicidal behaviour, and substance use (Kaess et al., 2014).

The high prevalence of mental health disorders worldwide is a growing concern as it leads to human, social, and economic costs seeing that it has been known to cause impairments and disability (Buttery, Mensink, & Busch, 2015). Findings suggest that University students fall at a greater risk for mental health issues. Research shows that this particular population is at a higher risk due to the fact that the age onset of engaging in tertiary education is concurrent with the age onset of many mental disorders such as anxiety, depression, schizophrenia, and substance related disorders (Wynaden, Wichmann, & Murray, 2013). The age onset of mental health problems among college students is very important to identify, as it is often linked to poor outcomes, different presentations from that of a later onset, and longer episode duration, and an increased risk for co-occurring psychological problems at a later stage in life (Pedrelli, Nyer, Yeung, Zulauf, & Wilens, 2015).

Stress can lead to psychological distress and a variety of health and well-being consequences that could impact university student's academic performance (Deasy, Coughlan, Pironom, Jourdan, & Mcnamara, 2015). University students may also be at risk for mental or psychological distress due to the stressors they face such as dealing with their emotional, social, and academic demands, their financial uncertainty, and poor employment prospects (Wynaden et al., 2013; Deasy et al., 2014).

There are two groups of college students, the traditional college students (younger students who enter college straight from high school), and the non-traditional college students (older college students). Many traditional college students are faced with stressors such as being forced to take on more adult-like responsibilities without the cognitive maturity and skills of adulthood, facing experiences for the first time such as part time work, being in significant relationships, and coping with the academic workload stress that may all contribute to their mental distress. Many non-traditional college students are faced with the stress of juggling full-time work, family demands, and academic demands that could result in mental distress (Pedrelli et al., 2015).

Findings suggest that there is an increasing burden of mental health problems, due to the large amount of social changes occurring in the 21st century that negatively influence this generation of young individual's mental health symptoms (Bor et al., 2014). Research shows

that adolescents seem to be at a greater risk for internalising their symptoms which in turn increases their burden of mental health problems, more so among adolescent girls when compared to adolescent boys (Bor et al., 2014). The most prevalent psychiatric problems among university students are anxiety disorders such as social phobia, generalised anxiety disorders, and post-traumatic stress disorder. Another common mental health problem among adolescents is depression, with suicide, attention-deficit/hyperactivity disorder, eating disorders, and substance abuse being a few other psychiatric problems prevalent among college students (Pedrelli et al., 2015).

University students experiencing high levels of mental distress are at a greater risk for long-term psychological disorders, however unfortunately these students are reluctant to seek help (Deasy et al., 2014). One of the main forms of mental distress and the most disabling disorders worldwide is depression (Torikka, 2017; Whiteford et al., 2013). Adolescents experiencing depression are at a greater risk of social and personal impairment, stress, suicidal ideation, and other psychiatric conditions (Torikka, 2017). Compared to the general population, cognitive symptoms such as self-blame, lack of concentration, and self-dislike, were more prominent among the students with depression (Wynaden et al., 2013). Research shows that University students experience greater mental distress than the general population. It is also found that there is a higher reporting of psychological distress symptoms from females than males (Deasy et al., 2014; Deasy et al., 2015).

Findings suggest that HIV infection can attribute to psychological distress such as depression, anxiety, and conduct disorders. Individuals dealing with HIV are faced with stigma as well as medical, social and psychological demands that come with the illness, which could lead to mental distress (Mutumba et al., 2017).

According to Austin et al. (2012), personal distress is often accompanied by psychological disorders; however, some may have a psychological disorder and not show any signs of distress. It is important to note that distress alone does not imply and is not sufficient to define abnormality. Research suggests that many major somatic symptoms, such as changes in appetite and sleep patterns, can be due to social and academic schedules and therefore makes it difficult to accurately predict negative emotional states among university students based on these symptoms (Wynaden et al., 201). Distress is a normal, healthy response to negative life events that every individual will experience at some point in their lives. It is therefore difficult to define which forms of distress are regarded as normal or abnormal, with

the constantly changing political and sociocultural forces that influence our views on mental disorders or mental distress (Austin et al., 2012).

2.3. Risky Behaviours of individuals experiencing mental distress

The poor coping behaviours and reluctant help-seeking behaviours of young adults lead to many engaging in risky behaviours as a form of coping for their mental distress. Research has found a correlation between risk behaviours and mental distress; therefore, the engagement in risk-behaviours could potentially aide in the early detection of psychiatric disorders (Kaess et al., 2014). University student's perceived inability to cope with stress often result in psychological distress. Psychological distress experienced by university students can lead to risk behaviours which in turn can result in more serious mental health disorders (Deasy et al., 2014).

Kaess et al. (2014) used the problem-behaviour theory to define risk behaviours as "behaviours that may compromise the physical or psychosocial adolescent development, and include a broad range of behaviours that often accompany adolescent development including substance abuse, withdrawal from school or unprotected sexual intercourse as a few examples" (p.612). According to Venning et al. (2013), at the adolescent stage, these youngsters are trying to discover their identity which makes risk taking behaviour a normal occurrence during this stage; however it becomes a huge problem when these behaviours begin to become more frequent and have the potential of having serious, long-term, and negative consequences to their health.

University students are a very vulnerable group when it comes to risky behaviours as this is the period whereby they are faced with the transition from adolescence to adulthood, which can be stressful for many, especially those lacking the ability to coping effectively (Deasy et al., 2015). Students experiencing distress may be faced with difficulties coping with social and academic demands resulted in their increased risk in engaging in risky behaviours (Kenney, Lac, LaBrie, Hummer, & Pham, 2013). With students being in the transitional stage of physical and mental development, they tend to be at a greater vulnerability for risky behaviours such as hazardous alcohol behaviours, which could in turn contribute to an increase in other risk behaviours such as risky sexual behaviours, violence, victimisation, and poor academic performance (Balogun, Koyanagi, Stickley, Gilmour, & Shibuya, 2014).

Research shows the association between mental health and risk behaviour, especially among adults experiencing severe mental illnesses such as major depression and schizophrenia to be well-recognised. Findings show obesity, substance abuse, and physical inactivity to be higher in persons experiencing severe mental illnesses compared to the general population (Arbour-Nicitopoulos, Faulkner, & Irving, 2012). Global reports show that 25% of youth smoke cigarettes, 72% use alcohol, and 50% of youth do not exercise (Venning et al., 2013).

Students experiencing negative affect states often make risky decisions and engage in risky behaviours to relieve them or escape from these negative emotions (Tull & Gratz, 2013). Findings by Deasy et al. (2015), suggest that students experiencing mental distress often use passive coping behaviour and as a result report risk behaviour such as unhealthy diet, low physical activity, and substance use.

Studies have shown people with depression being associated with engaging in risky behaviours such as smoking, alcohol and drug consumption, physical inactivity and poor diet (Buttery et al., 2015; Arbour-Nicitopoulos et al., 2012; Deasy et al., 2015). Depression has also been associated with risky sexual behaviours, violent or aggressive behaviours and delinquency (Basterfield, Reardon, & Govender, 2014). Individuals with major depressive disorders were found to more likely to engage in risky sexual behaviour as a result of difficulties with emotion regulation of their negative affect states (Tull & Gratz, 2013).

It has been found that many individuals suffering from depression tend to engage in risky behaviours that are associated with a high immediate reward, by acting in impulsivity, without considering the long-term risks or negative consequences of their maladaptive behaviours (Tull & Gratz, 2013). Violent behaviours seem to be associated with low psychological functioning (Asante et al., 2015). Preceding psychopathology is one of the strongest risk factors for criminal behaviours worldwide. The inability of many young individuals to cope with external stressors tends to result in their aggressive and criminal behaviour (Aebi, Giger, Plattner, Metzke, & Steinhausen, 2014).

Research suggests that depression is an untreated response to stress, resulting in poor coping that leads to the engagement of risky behaviours. It has been found that young adults tend to use risky behaviour as a form of avoidance or escapism from dealing with their stress and depression (Deasy et al., 2014; Kenney & LaBrie, 2013). For many, these risky behaviours are used as a quick fix to their mental distress, resulting in their perceptions of this behaviour being a helpful tool in managing their distress. This perception that young adults have of their

risky behaviours helping them deal with their distress is in fact increasing their distress and could be potentially be further damaging to their mental and also their physical health (Deasy et al., 2014).

Findings suggest that from the adolescent population, homeless youth are at a greater risk of both mental distress and risk behaviours due to the absence of financial, social, and psychological support to help them with the transition into adulthood. Homeless youth tend to engage in higher risk behaviour compared to housed adolescents and are found to have greater mental health problems (Asante et al., 2015). It was found that homeless youth seemed to be faced with a number of risk factors such as self-stigma, social stigma, violence, discrimination, negative stereotypes, and suicidal ideation resulting in their poor psychological functioning coupled with the lack of a protective nurturing environment which could lead to an increase in risky behaviours (Oppong Asante, Meyer-Weitz, & Petersen, 2016).

According to Kaess et al. (2014), findings suggest that the most common cause of disability among individuals between the ages of 10-24 years old are neuropsychiatric disorders, which have been shown to be associated with several risk behaviours. Although there are many risk behaviours associated with mental distress among university students, the main risk behaviour that will be tackled in this paper will be substance abuse.

2.4. The relationship between substance abuse and mental distress

There is a co-occurrence of substance abuse and mental distress among adolescents, often referred to as a dual-diagnosis (Battista, Pencer, McGonnell, Durdle, & Stewart, 2013; Sharma, & Bennett, 2015). The National Survey of Drug Use and Health (NSDUH) found that 25.7% of adults who presented with serious mental illnesses also reported having a substance abuse disorder (Rosenblum et al., 2014).

According to Rosenblum et al. (2014), the most severe and chronic form of disorders are generally co-occurring disorders rather than single disorders. The dual-diagnosis of mental distress and substance abuse is therefore a very challenging public health problem (Sharma, & Bennett, 2015). It was found that people with substance use disorder had reported a low distress tolerance for antisocial personality disorder (Tull & Gratz, 2013). The presence of substance use problems and mental distress among college students, have be known to result

in a variety of negative outcomes such as unemployment, serious social and educational impairments, and obesity (Pedrelli et al., 2015).

The most widely used psychoactive substance in the world is alcohol, with cannabis and tobacco use being the second most commonly used substance (Olashore, Ogunwobi, Totego, & Opondo, 2018). Hazardous alcohol consumption, cigarette smoking, and cannabis use are among the few risk behaviours that are a public health concern among university students (Deasy et al., 2015). Studies show that risk behaviours such as alcohol and nicotine use may be used by many students to deal with their negative mood and affect dysregulation (Arbour-Nicitopoulos et al., 2012). Research shows that alcohol and tobacco, being legal in most countries, are referred to as "soft drugs, and are often the "gateway drugs" to other psychoactive substances used by the youth (Olashore et al., 2018).

It was also found that parental and peer use of alcohol play a great role in influencing the use of alcohol among college students (Boyd, Corbin, & Fromme, 2014). Peers can influence alcohol use by actively offering a drink or passively modelling drinking behaviour (Schwinn & Schinke, 2014). According to Mahedy et al. (2018), moderate or high alcohol use among parents increases the likelihood of young adults consuming alcohol. Many students tend to use alcohol as a form of negative coping or conformity motive (Kenney et al., 2013).

Alcohol abuse is one of the main concerns among college students that could lead to alcohol-related disorders and is closely related to individuals experiencing poor mental health. It has been reported that there is a strong association between poor mental health and the risk of alcohol use among young individuals (Kenney et al., 2013). Research shows that students with a low distress tolerance experienced severe depressive symptoms and were more likely to report problematic alcohol use (Tull & Gratz, 2013). Individuals with high levels of mental distress indicated higher levels of alcohol-related consequences (Kenney & LaBrie, 2013).

Research shows that alcohol misuse is strongly linked to conduct disorders, anxiety, depression, and suicidal behaviour (Balogun et al., 2014). Alcohol abuse among college students is associated with impairments with the prefrontal cortex functions such as memory and attention, and has been found to lead to substance-related problems after college and the development of Alcohol Use Disorders later on in life (Pedrelli et al., 2015). According to Bao Giang, Van Minh, and Allebeck (2013), alcohol use causes 4% of the total global disease burden. Research shows that heavy episodic alcohol use among college students could lead

to physical, academic, legal, and sexual consequences (Kenney & LaBrie, 2013; Kenney et al., 2013).

Alcohol being the most commonly used substance among the youth can be attributed to its wide availability and social acceptability (Olashore et al., 2018). Religious or cultural beliefs and practices, availability and accessibility of alcohol, and the degree to which drinking laws are enforced are some of the possibilities for the increased rates of current alcohol use among university students (Balogun et al., 2014). It has been reported to have a causal relationship with over 60 medical conditions (Bao Giang et al., 2013). Alcohol abuse has commonly been associated with high levels of depression and anxiety, avoidant coping behaviours, and low self-efficacy (Kenney & LaBrie, 2013).

Cannabis use has been found to cause negative cognitive performance, memory problems, and low achievement motivation that lead to college dropout, low occupational attainment, and workforce failure. University students who are heavy drinkers are ten times more likely to smoke marijuana (Pedrelli et al., 2015). Non-medical use or misuse of subscription medication is also associated with college students in addition to substance and alcohol use, with many college students reportedly combining heavy drinking and the nonmedical use of subscription medication which can be dangerous as it may further inhibit activity in the central nervous system, and increased the risk of respiratory depression, over sedation, and death (Pedrelli et al., 2015).

The use of the majority of psychoactive substances begins between the ages of 15-18 years. This is problematic as substances such as alcohol, tobacco, and inhalants are easily accessible and readily available in the community in many African households and can be easily purchased. Findings suggest that a lower age debut of substances can result in higher rates of problems with substances such as dependence, other drug-related disorders, delinquency, and other mental disorders (Olashore et al., 2018).

University students are more likely to use escape avoidance as a coping strategy which often results in substance abuse and other health-risk behaviours. Substance abuse can increase the odds of an individual engaging in other risk behaviours including risky sexual behaviour and aggressive behaviour (Deasy et al., 2015; Basterfield et al., 2014). Research has shown that substance abuse could lead to multiple drug use which in turn could result in complications including rule-breaking, sexual and physical abuse, as well as several psychiatric disorders

(Olashore et al., 2018). According to Aebi et al. (2014), community-based studies have shown a relationship between early substance abuse and criminality.

Personality factors such as sensation seeking, impulsivity, anxiety sensitivity, and hopelessness could lead to substance abuse and co morbid mental disorders. These factors could lead to disturbances in brain motivation which could in turn lead to individuals being at a greater risk of abusing substances as a form of reinforcement (Battista et al., 2013). It was also found that individuals with substance use disorders reportedly experience difficulties in emotion regulation (Tull & Gratz, 2013).

Depression is one of the most common mental illnesses associated with substance abuse among adolescents, with nearly one-third of patients with major depressive disorder also being diagnosed with substance abuse disorders (Torikka, 2017). There has been a reported range from 25% - 69% of a clinical sample of substance abusers with co morbid depressive disorders (Torikka, 2017).

Adolescents and young adults are at a great risk of engaging in risky behaviours such as substance abuse due to the emotional shifts, completion of education, transition into employment, and the long-term intermit relationships they must deal with. This abuse of substances can co-occur with mental distress among adolescents and young adults (Hall et al., 2016). Findings suggest that substance abusers are more likely to have had anxiety disorders or major depression in their lifetime (Battista et al., 2013; Kenney & LaBrie, 2013). Furthermore, mental distress among adolescences has been found to predict the onset of depressive disorders and substance abuse later in life (Balogun et al., 2014).

Findings show that parental substance abuse could contribute to adolescent substance abuse with many adolescent substance abusers reportedly having family members with alcohol and drug use issues. Similarly, findings suggest that smoking and low family socio economic status seem to be associated, with cigarettes being easily accessible and cheap, making it easy for students with little financial resources to obtain (Olashore et al., 2018).

Although studies show that individuals experiencing mental distress usually turn to substance abuse as a coping mechanism, studies also prove that substance abuse can in turn enhance mental distress (Oppong Asante et al., 2016). Findings suggest that substance abuse has been reportedly used as a coping mechanism for homeless youth; however, substance abuse can also result in greater emotional or psychological distress (Asante et al., 2015). According to

Asante et al. (2015), substance use can lead to risky sexual behaviour, which in turn can lead to an increase in psychological distress.

2.5. Help-seeking behaviours of individuals experiencing mental distress

Many young adults are very reluctant to seek mental health support which makes it difficult for early intervention approaches (Wynaden et al., 2013). Some of the determinants of help-seeking behaviours include lacking the ability to recognise that the symptoms they experience are associated with mental health problems, lacking knowledge about forms of help-seeking, negative attitudes towards seeking help, perceived stigma, family reputation, and age (Wynaden et al., 2013; Pedrelli et al., 2015).

Unsupportive interactions such as blaming the individual, social distancing, or minimising the seriousness of the problem can also contribute to an individual's help seeking reluctance (Talebi, Matheson, & Anisman, 2016). Other factors that contribute to the lack of help-seeking among college students is the cost of help-seeking, the lack of time, confidentiality concerns, preference to seek help from informal sources, and lack of knowledge about the benefits of help-seeking (Czyz, Horwitz, Eisenberg, Kramer, & King, 2013).

Findings show that approximately 15% of new university students have mental illnesses that are untreated or undiagnosed (Talebi et al., 2016). Most universities offer a variety of support seeking services such as counselling, financial assistance, and academic support (Julal, 2013). According to Talebi et al. (2016), 70-80% of students faced with depression and anxiety symptoms are reluctant to seek help for their distress, despite the availability of on campus resources. Many students may also perceive that they lack the ability to overcome the barriers that prevent them from seeking help from these services (Czyz et al., 2013).

Research shows that students who seek-help for their distress are more likely to perform better at school and work, and become more successful in social relationships; as actively seeking solutions through help-seeking is effective for coping with socio-emotional problems (Aebi et al., 2014). It was found that early identification and treatment of mental health disorders could change the trajectory of the disorder. However, if the individual suffering from mental distress goes untreated for a long duration, this may result in long-term negative effects on the trajectory of their illness (Pedrelli et al., 2015).

If students perceive that important individuals in their lives are willing to provide social support, they may tend to be more likely to seek professional help for their distress, whereas

if they seek support from someone who responds in an unhelpful or unsupportive manner, they may have negative attitudes toward help-seeking (Talebi et al., 2016). Many students prefer seeking help from informal sources; however, this may result in students not receiving adequate, appropriate help that is needed for their problems (Czyz et al., 2013).

The fact that students are reluctant to seeking professional help for their mental distress, could be dangerous and persist into more severe mental disorders later on in life by affecting their social, emotional, and cognitive functioning at this very crucial developmental period of their lives (Czyz et al., 2013). Findings suggest that large numbers of adolescents have continuous life struggles due to emerging or undiagnosed mental disorders, with one of the main causes being stigma preventing their help seeking (Wynaden et al., 2013; Czyz et al., 2013).

There is a lot of stigma around mental illness. Stigma can be seen in the form of public stigma, personal stigma, perceived public stigma, and internalised stigma. Public stigma is when the general population holds negative beliefs and attitudes towards people with mental illnesses, often leading to forms of discrimination against the mentally ill. Personal stigma is the negative beliefs and attitudes towards people with mental illnesses held by everyone, which could influence public stigma. Perceived public stigma is the individual's perceptions of stigmatising attitudes and believes by the public, towards the mentally ill. Internalised stigma is the internalised feelings experienced by people with mental problems, associating the negative social perceptions with themselves (Lally et al., 2013). An individual may fear being stigmatized by others for seeking help which may be attributed to the perceived lack of support resulting in their reduced help-seeking intentions (Talebi et al., 2016).

Goffman's theory of stigma argues that individuals rely on stereotypes and categorizations by others to interact with strangers. He states that these categories form a virtual social identity that is shaped by expectations of that individual, therefore resulting in stigma due to discrepancies between an individual's virtual social identity and actual social identity. He also mentions that an individual can choose to stigmatise others or rise above stigmatising others (Bates & Stickley, 2013).

Goffman referred to those who have the ability to rise above stigma as being 'the wise', and made associations with nurses and other health care professionals being the wise seeing that they work closely with this stigmatised group and are able to gain their trust. This notion has however been challenged by research done with many stigmatised individuals indicating that

encounters with health care professionals were one of the most stigmatising, discriminatory, and distressing experiences they have faced with regards to their mental distress (Bates & Stickley, 2013).

Many people do not seek help because they do not want to be labelled as being mentally ill by their family and friends. The stigma associated with mental illness and the stigmatising attitudes towards people with mental illnesses are widespread which leads to many individuals choosing not to seek help as a protective mechanism from societal ridicule (Lally et al., 2013). In addition to the stigma associated with mental illness, the perceptions that seeking help is associated with the admission of a lack of control over the problem, prevents many from seeking treatment, especially in a society that places great value on self-reliance. This seems to be a concern for young people as they are at the age whereby, they are struggling to balance both depending on support from others and the need for independence and becoming competent, autonomous adults (Talebi et al., 2016). According to Czyz et al. (2013), 55% of college students suffering from mental health issues preferred solving their own problems rather than seeking help for their distress.

Due to the low help-seeking behaviour of adolescents and young adults, many go untreated for their mental illnesses, resulting in high rates of psychological distress among this particular group, creating barriers to accessing mental health services and treating mental health issues. The decrease in help-seeking behaviour leads to the mental health problem persisting and, in many cases, it also leads to severe psychological problems such as suicidal behaviour (Kaess et al., 2014). Suicide ideation, suicidal attempts, and self-harm have been found to be common among students that do not seek help for their problems (Deasy et al., 2014).

It has been proven that the second most common cause of death among individuals between the ages of 10- 24 years old is self-harm. Self-harm is often associated with individuals who exhibit emotional distress, poor coping mechanisms, and psychopathology (The Lancet, 2016). According to Czyz et al. (2013), over half of the college students that had suicidal ideations in the past year, did not receive professional help.

2.6. Coping behaviours of individuals experiencing mental distress

Coping can be defined as the cognitive, emotional, and behavioural strategies used by an individual to deal with internal and external demands and conflicts they may face, through

the use of coping skills such as active problem solving, emotional, and behavioural strategies to reduce, minimise, or prevent psychological or mental distress (Deasy et al., 2014; Aebi et al., 2014; Nielsen & Knardahl, 2014). Coping efforts are required to restore balance; therefore, deficits in coping efforts can result in psychological distress (Mutumba et al., 2017).

Reactive coping styles are used by students who have an overly emotional reaction to stressors preventing them from identifying the availability of help and seeking help. Suppressive coping styles are used by students who are in denial or avoid their difficulties which prevent them from seeking support and acknowledging that help is needed. Reflective coping styles are used by students who actively seek support through active coping strategies (Julal, 2013). Reactive and suppressive coping styles have been shown to result in more psychological symptoms such as depression and anxiety, and more stress, whereas reflective coping styles are associated with less psychological symptoms and less stress (Julal, 2013).

Coping behaviour can lead to active and passive responses. There are a variety of coping strategies that can be used by individuals, which can be categorised into adaptive coping strategies whereby the individuals functioning is being improved, or maladaptive coping whereby strain or psychological distress is maintained or increased (Nielsen & Knardahl, 2014). Coping strategies can also be problem-focused or emotion-focused. Problem-focused coping strategies are strategies used to actively attempt to eliminate the problem through problem solving or cognitive restructuring efforts, whereas emotion-focused strategies attempt to reduce discomfort by changing the individuals' perceptions of the problem through avoidance or emotional expression (Nielsen & Knardahl, 2014; Talebi et al., 2016).

Problem-focused coping can promote health behaviours and is usually associated with good mental health whereas emotion-focused coping can interfere with health behaviours and is usually associated with poor mental health (Basterfield et al., 2014; Nielsen & Knardahl, 2014). Emotion-focused coping can result in substance abuse as well as depression (Oppong Asante et al., 2016). Emotion-focused coping has been shown to have long-term positive effects on psychological wellbeing and are usually maladaptive in the long run due to the focus of these strategies being on changing the negative feelings of the situation rather than the actual cause of the problem. Problem-focused coping has been shown to have short term adaptive effects of psychological wellbeing as the focus of these strategies are on changing

the situation. Therefore, timeframe plays an important role in understanding the effectiveness of coping strategies (Nielsen & Knardahl, 2014).

Greater levels of social support have been found to be associated with increased problem-focussed coping and decreased maladaptive coping (Talebi et al., 2016). However, according to Mutumba et al. (2017), the quantity of social support was found to be associated with increased psychological distress whereas the quality or satisfaction of social support was associated with psychological well-being.

An individual uses engagement coping when attempting to deal with their emotions, and disengagement coping when attempting to escape their emotions. According to Nielsen and Knardahl (2014), "engagement coping includes problem-focused coping and some forms of emotion-focused coping such as support seeking, emotion regulation, acceptance, and cognitive restructuring. Disengagement coping includes passive and maladaptive responses which include avoidance, denial, substance abuse, and wishful thinking" (142). Disengagement coping can be harmful in most situations and can result in increased psychological distress (Nielsen & Knardahl, 2014).

Avoidant coping styles and secrecy, proven to be ineffective and damaging rather than beneficial, seem to be common coping strategies among adolescence experiencing mental distress (Talebi et al., 2016). Individuals tend to use cognitive and emotional avoidant coping to distract themselves from the problem, often with criminal behaviour or substance abuse. Avoidant coping is usually used due to the lack of problem-solving skills and could lead to increased distress in the long run (Aebi et al., 2014). According to Oppong Asante et al. (2016), avoidant coping can also be attributed to the lack of access to psychological and health care services, as well as the lack of knowledge and skills regarding coping strategies. Distractive and avoidant coping is common among adolescent boys due to the perceptions that positive emotional expression would make them look weak and it being a threat to their masculinity, as they were taught to avoid verbal emotional expression (Basterfield et al., 2014).

Students usually seek informal, formal, and spiritual support to cope with distress, with informal support being the most preferred option and formal support being the least preferred option. Informal support is often sought from the family and peers of the distressed, formal support is sought from a professional, while spiritual support is sought through prayer when dealing with distress (Deasy et al., 2014).

Religious coping can have a positive effect on psychological well-being due to religion playing an important role in many people's lives with many seeking social support from religious institutions. Although religious coping has been shown to have health promoting effects on psychological well-being, some aspects of religiosity can be detrimental to psychological well-being (Mutumba et al., 2017). Research shows that religion, especially Pentecostalism, can be the cause of increased psychological distress. These findings obtained from HIV-infected individuals from sub-Saharan Africa could be due to the religious congregation's discriminatory attitudes, resulting in stigma and lack of support which in turn causes psychological distress (Mutumba et al., 2017).

Coping can be both personality dependant and situation dependant and to some extent have either state-like properties or trait-like properties. The challenge of state-like coping strategies is that unhealthy, stable strategies become difficult to change; the challenge with trait-like coping strategies is the continual evaluation and adjustment of perceived strain and coping strategies (Nielsen & Knardahl, 2014).

Students may cope with psychological distress in several ways; responses to psychological distress could be successful or unsuccessful, conscious or unconscious, and could involve approaching the problem or avoiding the problem (Julal, 2013). Some university students tend to exit their academic programme due to the overwhelming challenge and lack of effective coping strategies, some adopt positive coping through seeking social support or engaging in leisure activities, while others adopt maladaptive strategies though escape/avoidance (Deasy et al., 2014).Individuals may therefore have dispositional, stable, and situation specific ways of coping (Julal, 2013).

2.7. Theoretical Framework

2.7.1. Introduction

This study makes use of two theoretical frameworks: Urie Bronnfenbrenner's ecological model, and Icek Ajzen's theory of planned behaviour. The ecological model is used in this study to explain the mental distress of the sample, while the theory of planned behaviour is used in this study to explain the substance use and self-stigma of seeking help of this sample. Both frameworks are explained below and will further be discussed in relation to the findings in chapter 5.

2.7.2. Bronfenbrenners Ecological Model

This study uses Urie Bronfenbrenner's ecological theory (Sallis, Owen, & Fisher, 2015). The ecological model basically explains that there are multiple influences on behaviour such as intrapersonal, interpersonal, institutional, community, and public policy influences. Community factors, institutional factors, and public policy are combined to form part of the community level (Rimer, Glanz, & National Cancer Institute (U.S.), 2005). All these influences can individually or cumulatively affect the mental health of university students (Sallis et al., 2015; Oppong Asante et al., 2016). The biopsychosocial ecological framework of Bronfenbrenner emphasises the biological, psychological and social influences on health behaviour. The intrapersonal level can have biological and psychological influences, while the interpersonal level can have social and cultural influences (Sallis et al., 2015).

Multiple factors can influence the behaviour, such as knowledge, attitudes, beliefs, and personality traits (intrapersonal level); family, friends, support, social identity and role identification (interpersonal level); rules and regulations, policies, informal structures, social norms and networks, and local, state, and federal policies and laws (community level) ;by either constraining or promoting the behaviour (Rimer et al., 2005). These multiple levels of influence interact across the microsystem, mesosystem, ecosystem, and macrosystem (Oppong Asante et al., 2016).

In biological science, the term ecology is defined as the interaction between organisms and their environment, therefore this model aims to discover the interaction between psychology student's mental distress and the influence their environment has on their distress (Sallis et al., 2015). This framework helps us recognise that the mental distress experienced by university students can be influenced by a variety of factors which aids us in our understanding of the issues at hand regarding mental distress. This framework also provides us with the tools needed to inform our decisions in terms of future interventions and recommendations regarding solutions to the mental distress among university students which not only assists us with the mental health problem but also the issue of substance abuse associated with these mental health issues.

2.7.3. Ajzen's Theory of Planned Behaviour

This study also uses Icek Ajzen's theory of planned behaviour to understand individual's help-seeking behaviours and substance abuse behaviours. The theory of planned behaviour is

an extended version of the theory of reasoned action, with the addition of the construct of perceived behavioural control (Rimer et al., 2005). The theory of planned behaviour focuses on constructs of behavioural intention, attitude, subjective norms, and perceived behavioural control (Montano & Kasprzyk, 2015). It assumes that behavioural intention is the best predictor of the behaviour (Sallis et al., 2015). This theory stipulates that an individual's attitude toward the performance of a behaviour, the subjective norms of the behaviour, and perceived behavioural control an individual has over the behaviour are direct determinants of that individual's behavioural intention (Montano & Kasprzyk, 2015).

The attitude construct determines an individual's personal evaluation of whether they see the behaviour as good, neutral or bad; the subjective norms construct determines the individuals beliefs about whether important people in their lives would approve or disapprove of their behaviour, influencing their motivation to perform the behaviour; the perceived behavioural control construct determines an individual's belief that they have the ability to control the behaviour; and the behavioural intention construct is an individual's perceived likelihood of performing the behaviour (Rimer et al., 2005). The attitude construct determines an individual's behavioural beliefs, the subjective norms construct determines an individual's normative beliefs, and the perceived behavioural control construct determines an individual's control beliefs. This model assumes that a causal chain relationship links behavioural beliefs, normative beliefs, and control beliefs to behavioural intention (Sallis et al., 2015).

This theory is useful in discovering individual's help-seeking behaviour. It will help us distinguish individual's attitude toward seeking help, the subjective norms associated with seeking help, and the perceived behavioural control they have over seeking help that will govern their intention to seek-help or not to seek-help. The theory is also useful in discovering why individuals abuse substances, by establishing individual's attitudes toward their abuse of substances, the subjective norms associated with substance abuse, and the level of control they have over their substance abuse behaviours that shape their intention to quit or continue abusing substances (Montano & Kasprzyk, 2015).

2.8. Chapter Summary

This chapter discusses the global concern of mental health problems among young individuals, and the various factors that contribute to this disease burden. It focuses mainly on college students (seeing that they seem to be at a greater risk) and their experiences with

mental distress and substance use. The chapter also covers the co-occurrence of mental distress and substance abuse among university students as well as how poor coping and reluctant help-seeking may lead to risky behaviours such as substance use. It also shows the variety of coping behaviours used by university students and the role of stigma in contributing to university student's reluctance to help-seeking.

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter will present an explanation of the approaches used in the research design of this research study, followed by the sampling method and procedures used. The chapter then discussed the research instruments used in this study, followed by a detailed description of the data collection and procedures. Thereafter, the analysis of the data will be discussed, including recoding of the data.

3.2. Research design

This study used a deductive approach based on a positivist paradigm. The Positivist paradigm is a scientific approach that involves careful empirical observations of individual behaviour and value-free research, used to discover causal laws that can be used to help people predict and control events (Neuman, 2014).

The positivist approach is often favoured in quantitative studies due to its well defined structure making the study more reliable and valid, its rigour, generalisability, replicability, and its objectivity as the researcher remains detached and neutral when measuring aspects of social life (Neuman, 2014; Rahman, 2017). The positivist approach has however been criticized for being weak in determining why individuals act the way they do and how their decisions are embedded in their social circumstances and relationships. Scientists argue against the positivist approach, stating that the social world differs from the natural world; therefore, it cannot be studied objectively. Another weakness is that the measures used by positivists are said to be artificial as they sometimes measure constructs of the researcher's interest rather than the interests of the participants (Rahman, 2017).

A quantitative approach of study was adopted, using a cross-sectional survey method. The cross-sectional survey method is used to capture information from data collected at one point in time, creating a 'snapshot 'of social life (Neuman, 2014). There are many advantages of using a cross sectional design, such as the fact that it is relatively inexpensive and not time consuming, it is useful in assessing risk factors as well as estimating the prevalence of the outcome, and it does not have loss to follow-up. Disadvantages of using cross sectional

design is the fact that you cannot analyse the behaviour over a period of time, and you cannot make causal inferences due to it only being a snapshot (Drummond & Murphy-Reyes, 2018).

3.3. Sampling

A convenience sampling approach was used by recruiting participants from wherever you find them in the university, in this case in a lecture venue. This sampling method is useful in selecting participants that are easy to reach, convenient, and readily available (Neuman, 2014). Some strengths of using a convenient sampling approach are it affordability, and the fact that it is easy and quick to obtain; however, a weakness to this sampling approach is the fact that it creates a non-representative sample (Neuman, 2014). The initial plan for recruitment involved approaching a psychology undergraduate class at UKZN with permission from the lecturer, including only those students who permitted their participation. As per student requests, an online survey was used instead. The online survey involved seeking permission from the lecturers and making arrangements to provide their psychology class with the link to the online survey, with only those who permitted their participation being included.

A large sample size was used of approximately 200 students, to minimise errors and maximise accuracy and efficiency; a large sample size therefore resulted in a smaller margin of error. According to Pallant (2013), if a large sample size of 100 or more participants is used, the power of the tests conducted will not be an issue. Such a large sample size was used in this study to increase the level of confidence in the sample estimates and provide more reliable results with greater precision and power. The sample included both males and females of different ethnicity from the University of Kwa-Zulu Natal, Howard College.

3.4. Research instruments

This study was conducted by administering self-reported questionnaires that comprised of a Demographics questionnaire, the Kessler Psychological Distress Scale (K10), the Brief COPE, a Substance Use questionnaire, and the Self-Stigma of Seeking Help Scale. The Brief COPE, K10, Substance Use questionnaire and Self-Stigma of Seeking Help Scale have all been used in the South African context before; therefore, these scales are valid and reliable for use among South African samples. Below are more details on each of the scales.

Demographics questionnaire

The demographic questionnaire included a variety of questions on the participant's demographic characteristics that were used to find out if demographics affected the study in any way. The demographic questionnaire included questions about the participant's gender, age, year of study, living arrangements, and household situation.

Kessler Psychological Distress Scale (K10)

The Kessler Psychological Distress Scale is a 10 item self-reported questionnaire based on the anxiety and depression experienced by individuals within the past 30 days (Anderson et al., 2013). This scale was developed for the redesigned US National Health Interview Survey (Kessler et al., 2002).

Each of the 10 items in this scale consist of a five-value response option (1= none of the time, 2= a little of the time, 3= some of the time, 4= most of the time, and 5= all of the time). The numbers indicated for each item is then added to determine the individual level score of psychological distress, with the total score ranging from 10-50 (Anderson et al., 2013). Individuals who score below 20 are likely to have no mental distress, individuals who score between 20-24 are likely to have mild mental distress, individuals who score 25-29 are likely to have experienced moderate mental distress, while individuals who score 30 and above are likely to have severe mental distress (Anderson et al., 2013).

The K10 scale is a valid and reliable scale for clinicians to use as it provides a good balance for the detection of true positives and true negatives for screening DSM-IV anxiety or affect disorders that occur in the past 30 days (Anderson et al., 2013). This is evident from the Receiver Operating Characteristics (ROC) curve analysis which showed the area under the ROC curve to be 0.86 suggesting good predictive power of the scale. A cut score of 15 was also found to be associated with the most equivocal sensitivity (0.78) and specificity (0.77) (Anderson et al., 2013).

Research from a telephone pilot sample reported a good inter-item correlation coefficient with a Chronbach's alpha of 0.93 (Kessler et al., 2002). The ROC curve analysis showed the area under the curve to be 0.88 for the K10 scale, suggesting a good discrimination and predictive power of the scale (Kessler et al., 2002). A South African stress and health study found that the K10 had a strong inter-item reliability coefficient, with a Chronbach's alpha coefficient of 0.84 for a 12-month disorder (Andersen et al., 2011).

The Brief COPE

The Brief COPE is a 28-item abbreviated version of the coping inventory that measures self-reported avoidant and active coping styles. The Brief COPE assesses an individual's coping responses to stressful events (Carver, 1997), with item response options ranging from 1 (I have not been doing this at all) to 4 (I've been doing this a lot).

The Brief COPE scale consists of 14 scales with 2 items in each (28 items). The scales assess active coping, planning, positive reframing, acceptance, humour, religion, using emotional support, using instrumental support, self-distraction, denial, venting, substance use, and behaviour disengagement of the individual and self-blame (Carver, 1997).

Carver (1997) recommends selecting scales that are best suited for your sample especially if you have a much-focussed research interest or extreme time demands. It is possible to tailor the number of subscales used seeing that there is no overall coping measure and each item in the Brief COPE are assessed independently from each other (Lafarge, Mitchell, & Fox, 2013).The Brief COPE used in this study therefore excludes the behaviour disengagement item. Carver (1997) computed Chronbach's alpha inter-item reliability coefficients for each item of the COPE scale. The 13 items in the Brief COPE (excluding behavioural disengagement) have a Chronbach's alpha ranging from $\alpha = 0.50$ -$\alpha = 0.90$, and therefore has a fairly good inter-item correlation coefficient, proving its reliability (Carver, 1997).

A South African study done by Futterman et al. (2010) created a positive coping measure by summing the items that describe active coping, emotional support, venting, positive reframing, planning, humour, acceptance, and religion. The positive coping scale had a Chronbach's alpha of 0.70, resulting in the scale having a good inter-item correlation coefficient and making it a reliable scale to use, especially in the South African context. They however did not report on the negative coping measure. There is a paucity of studies that report on the Brief COPE as dichotomous positive and negative coping subscales. This study however reports the Brief COPE as such.

Substance Use prevalence

The items used in the Substance Use questionnaire were obtained from the Youth Risk Behaviour Survey (Reddy et al., 2013). This self-reported questionnaire consists of response items that use a Likert scale. This questionnaire focuses on lifetime, current, peer and parental substance use. Items 1, 2, 9, and 12 measure lifetime, current, peer, and parent cigarette use. Items 3, 4, 5, 10, and 13 measure lifetime, current, peer, and parent alcohol use.

Items 6, 7, 8, 11, and 14 measure lifetime, current, peer, and parent drugs and/ or substance use (See Appendix D).

Self-Stigma of Seeking Help Scale (SSOSH) for mental distress

The Self-Stigma of Seeking Help Scale has 10 items based on the self-stigma associated with seeking help for mental distress. This scale is an indication of how individuals perceive that their self-esteem would be threatened if they were to seek help (Vogel et al., 2013).

The SSOSH uses a five-point response option ranging from 1 (strongly disagree), 2 (disagree), 3 (agree and disagree equally), 4 (agree), and 5 (strongly agree). Participants who indicate higher scores are seen to have greater self-stigma while those with lower scores indicate lower self-stigma for seeking help for mental distress (Vogel et al., 2013).

This SSOSH scale showed a Chronbach's alpha inter-item reliability coefficient of $\alpha = 0.83$, and 95% confidence intervals for each sample with the reliability coefficients being between $\alpha = 0.82$ and $\alpha = 0.84$. This is an indication of high inter-item reliability coefficient and the reliability of the SSOSH scale (Vogel et al., 2013). A study with a sample of university students from Botswana suggesting an inter-item reliability coefficient of $\alpha = 0.66$, indicating that this scale is moderately reliable to use within the Southern African context (Pheko, Chilisa, Balogun, & Kgathi, 2013).

3.5. Data collection and procedures

Ethical clearance was obtained from the University of KwaZulu-Natal Human and Social Science Ethics Committee (protocol reference number: HSS/1564/018M). Gatekeeper's permission was then sought from the registrar and the ethics committee to conduct the study on the University of KwaZulu-Natal, Howard College students. An amendment was requested for the use of an online survey.

The lecturers were approached and sought permission by, to administer the questionnaires to their class during the lecture period. Data collection was planned to take 30 minutes, with 5 minutes being allocated for the introduction and instruction, therefore permission to use 30 minutes of class lecture times was sought. The plan was that once permission was sought, the instructions for the standardized self-reported questionnaires would be briefly discussed to a group of university students at the beginning of data collection, as well as the purpose of the study, the voluntary nature of the study, right to withdraw from the study and the

confidentiality and anonymity of the data. Participants would have then been informed that if at any point of the study, they should experience distress; they may seek support from the student counselling at UKZN as they are aware of my study. This information was also presented in the informed consent forms provided before the study. All participants needed to read and sign the form, indicating that they understood what their participation entailed and that they agreed to participate in my study.

However, as requested by some students, an online survey was used, using a link to the Google Forms platform. The research instruments as well as the informed consent document were the same as for the paper-based completion. The lecturers were provided with access to the online survey link and I was permitted to speak to the students about the online survey in the Psychology lectures as per arrangement with the relevant lecturers. Students did not have access to the instrument unless they had agreed to the ethical procedures outlined (as per the existing informed consent document). The exact replica of the paper based informed consent was provided at the beginning of the online survey. Before beginning the survey, the participants were then required to click "yes" if they agreed to participate in the study, with only those who permitted their participation included in the study. The survey could only be submitted at the end by clicking on the submit option, therefore should a participant decide to withdraw from the study they could simply omit to submit their information or exit the site. Each section of the survey contained clear instructions for the participants to read and respond to, with fast and easy response controls. The responses were anonymous and confidential with the participants unable to view any of the responses. All responses were sent solely to the researchers Google Forms account anonymously maintaining the confidentially of the participants and protecting the data of the surveys obtained.

This study obtained an acceptable response rate with no missing values. The reason for there being no missing values was due to the fact that the students had to complete each question in order to move on to the next response. The response rate can be explained by the fact that the online survey method was the most preferred method by students rather than paper-based questionnaires, as it is easier and more convenient to use when compared to paper based surveys. This response rate can also be attributed to the fact that all psychology students are currently being exposed to research, therefore their participation benefitted them in giving them experience and exposure to quantitative research. Many students may have also had a great interest in the topic due to their personal experiences with mental distress or substance abuse, resulting in the acceptable response rate.

3.6. Data analysis

Once the data was obtained from the Google Forms platform, a codebook was prepared, thereafter the data was transferred into an excel spreadsheet and imported into the SPSS 25 software for analyses. Data analysis included frequency analyses, reliability analyses, descriptive analysis, mean tests i.e. One Way ANOVA and a T-Test analysis; chi-square analyses, correlation analyses and backward multiple regression analyses as outlined below.

The frequency analyses were used to analyse the demographic data. Age was recoded into five categories i.e. 17-19 years, 20-22 years, 23-25 years, 26-28 years, and >29 years. The frequency analysis was also used to describe the nature and prevalence of mental distress as well as the nature and prevalence of substance abuse among psychology students. Current substance use was recoded into 'no' representing never, and 'yes' representing sometimes and every day. The frequency analysis was also used to test the frequency of the coping and self-stigma of seeking help for mental distress. Cross tabulations were performed to understand the relationship between age groups (five groups) and mental distress, as well as the relationship between student substance use and significant others substance use.

The reliability analyses were used to test the inter-item reliability coefficient of the K10 scale, positive and negative coping subscales, and SSOSH scale. The K10 scale was recoded into four categories i.e. psychological scores ranging from 14-19, 20-24, 25-29, and ≥30. The Brief cope scale was used as positive coping (active coping, planning, positive reframing, acceptance, humour, religion, emotional support, instrumental support, and venting) and negative coping (self-distraction, denial, substance use and self-blame). Item 17 was removed from the Brief COPE scale (negative coping) in order to increase the reliability strength (See Appendix D). Four items (items 2, 4, 5, and 7) of the SSOSH scale were reverse scored (See Appendix D). Descriptive statistics were performed on the K10 scale, positive and negative coping subscales, and the SSOSH scale.

A One-Way ANOVA was conducted to compare the mean scores among the different age groups on mental distress as measured by the K10. The five age groups were recoded into 3 groups according to their age (Group 1: 17-19 years; Group 2: 20-22 years; Group 3: ≥23 years). One-way ANOVA analyses were also conducted to compare the mean scores among age groups on positive and negative coping, mental distress on positive and negative coping, and mental distress on self-stigma of seeking help.

The T-Test analysis tested the mean scores between the gender groups (males and females) regarding mental distress. T-test analyses were also performed to test the mean scores between mental distress and substance use, gender and coping, substance use and coping, gender and self-stigma of seeking help, and substance use and self-stigma of seeking help. Three analyses were performed to test substance use i.e. current cigarette use, current alcohol use, and current drug use. Two analyses were performed to test coping i.e. positive coping and negative coping.

The chi square tests for independence analyses were used to explore the relationship between students current and lifetime alcohol use with parents' alcohol use. The chi square test for independence analyses were also used to explore the relationship between students current and lifetime alcohol use with peer alcohol use. For the purpose of the chi-square analyses, current alcohol use was recoded into yes (sometimes, and every day), and no (never); and peer alcohol use was recoded into none (none of them), some (few of them, and some of them), and most (most of them, and all of them).

The correlation analyses were used to test whether the relationship between mental distress and self-stigma of seeking help, mental distress and positive coping, and mental distress and negative coping were positively or negatively correlated. Lastly, backward multiple regression analyses were performed to assess the most parsimonious combination of gender, age groups, year of study, residence, and household situation in predicting mental distress; and the most parsimonious combination of positive coping, negative coping, SSOSH, current cigarette use, current alcohol use, and current drug use in predicting mental distress. Dummy codes were provided for age groups, year of study, residence, and household situation. Dummy variable codings are provided in the results section (See page 48).

3.7. Chapter Summary

This chapter explained the methodological procedures used in this research study. The cross-sectional quantitative survey method based on a positivist approach was explained first, followed by the use of a convenience sampling procedure. The research instruments were then explained, outlining the inter-item correlation coefficients of each scale, indicating its reliability and validity for use in this study. Thereafter, the data collection process and ethical procedures were outlined, as well as possible reasons for the high response rate obtained from

the study. The chapter lastly explained the data analysis techniques used that enabled answering the research questions in this study.

CHAPTER FOUR: RESULTS

4.1. Introduction

This chapter presents the results from the online survey responses of 200 psychology students, which were obtained by statistically analysing the data of the present research study. The socio-demographic results are provided first, followed by psychometric properties and descriptive statistics of the measures. Thereafter, the chapter reports the results of the statistical analyses in relation to mental distress, substance use, coping, and self-stigma of seeking help for mental distress. The findings reported in this chapter for mental distress include the rate of mental distress, age and gender differences regarding mental distress, and the relationship between mental distress and substance use. The findings reported for substance use include the rate of substance use, substance use of significant others, and the relationship between alcohol use and mental distress. The findings reported for coping include the rate of coping, age and gender differences regarding coping, the relationship between mental distress and coping, and the relationship between substance use and coping. The findings reported for self-stigma of seeking help for mental distress include the rate of self-stigma of seeking help, mental distress and gender differences regarding self-stigma of seeking help, and the relationship between substance use and self-stigma of seeking help. Lastly, Pearson product-moment correlation analyses on mental distress, coping behaviour, and self-stigma of seeking help is presented, followed by backward multiple regression analyses used to predict mental distress.

4.2. Socio-demographic background of participants

Table 1 below shows that most of the total sample of 200 participants, were females (85.5%, N=171). The majority of this study's participants (52.5%, N=105) belonged to the age group of 17-19 years old, while the minority of participants (2.5%, N=5) belonged to the age group of 26-28 years old. Most students (70%, N=140) were first year students, while the minority of (2.0%, N=4) were Third year students. Most of the psychology students from this sample (39.5%, N=79) resided with their parents or family. Most of the students (39.0%, N=78) described their household situation as having the basics but not enough money for expensive items, while the minority of the students (2.0%, N=4) indicated other. Of those students who

indicated other when asked about their household situation, explanations such as having enough money with some saved and living comfortably were provided.

Table 1

Participant demographics.

Characteristics	N	%
Age group		
17-19	105	52.5
20-22	78	39.0
23-25	11	5.5
26-28	5	2.5
>29	1	0.5
Gender		
Male	29	14.5
Female	171	85.5
Year of study		
First year	140	70.0
Second Year	22	11.0
Third year	4	2.0
Fourth year	34	17.0
Residence		
With Parent(s)/Family	79	39.5
UKZN Residence on campus	11	5.5
Residence off campus	64	32.0
Rent or share accommodation	42	21.0
With others	4	2.0
Household situation		
Not enough money for basics	35	17.5
Have money only for basics	51	25.5
Not enough money for expensive things	79	39.5
Have money to save and for luxuries	35	17.5

4.3. Psychometric properties and descriptive statistics of scales

K10 scale obtained a good inter-item reliability coefficient with a Cronbach alpha coefficient reported of 0.86 with a mean inter-item correlation of r=0.4.

For the SSOSH scale, four of the ten items were reverse scored so that higher scores indicate greater self-stigma in seeking help for mental distress. The SSOSH scale has fairly good inter-item reliability coefficient, with a Cronbach alpha coefficient reported of 0.62, and a mean inter-item correlation coefficient of r=0.2

Active coping, planning, positive reframing, acceptance, humour, religion, emotional support, instrumental support, and venting was combined to form the subscale “positive coping”, which reported a Chronbach alpha coefficient of 0.81. Self-distraction, denial, substance use

and self-blame were combined to form the subscale "negative coping". The negative coping subscale was recoded, removing item number 17 (see Appendix D), reporting a Chronbach alpha coefficient of 0.72, and a mean inter-item correlation coefficient of r=0.3.

The mean inter-item correlation coefficient may not be of concern for the K10 scale, and BCS subscales, as the Cronbach's alpha for these scales are above the suggested value of α =0 .7(Pallant, 2013). However if the number of items in a scale is less than ten (which is the case for the SSOSH scale and negative coping subscale) the optimal mean inter-item correlation coefficient needs to be r=0.2 to r=0.4 as suggested by Briggs and Cheek (Pallant, 2013).

Table 2

Descriptive statistics of measures

	N	Min	Max	Mean	SD	Skewness	Kurtosis	A
K10	200	1	4	2.99	1.094	-.586	-1.076	0.86
BC:Positive Coping	200	24	69	48.51	8.848	-0.441	-0.055	0.81
BC:Negative Coping	200	7	28	14.79	4.181	0.466	-0.206	0.72
SSOSH	200	11	42	22.72	5.952	0.364	-0.062	0.62

Table 2 above presents the descriptive statistics of the scales used after removing the outliers. The mean, 5% trimmed mean, standard deviation, skewness, kurtosis, Kolmogorov-Smirnov and Shapiro-Wilk tests of normality, as well as the histograms and normal Q-Q plots of the scores on each scale, and box-plots and outliers were generated examined. After the removal of outliers, the descriptive statistics of the scales used indicated an acceptable level of normality (Pallant, 2013).

4.4. Mental Distress

4.4.1. The nature and prevalence of mental distress among psychology students

When assessing the psychological distress experienced by the students over the past month, it was found that the highest responses to the 10 questions were "some of the time". Among the students that responded "All of the time" 17.5% (N=35) indicated feeling that everything was an effort, 15.5% (N=31) indicated feeling tired, and 14.5% (N=29) indicated feeling depressed. Among the students that responded "Most of the time" 31.0% (N=62) indicated

feeling tired, 30.0% (N=60) indicated feeling that everything was an effort, and 29.0% (N=58) indicated feeling nervous.

Table 3

Frequency analysis of mental distress experienced in the past 30 days.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Tired	8 (4.0)	32 (16.0)	67 (33.5)	62 (31.0)	31 (15.5)
Nervous	4 (2.0)	52 (26.0)	66 (33.0)	58 (29.0)	20 (10.0)
Could not be calmed down	56 (28.0)	68 (34.0)	43 (21.5)	25 (12.5)	8 (4.0)
Hopeless	31 (15.5)	53 (26.5)	49 (24.5)	45 (22.5)	22 (11.0)
Restless/fidgety	25 (12.5)	51 (25.5)	63 (31.5)	45 (22.5)	16 (8.0)
Could not sit still	59 (29.5)	63 (31.5)	44 (22.0)	23 (11.5)	11(5.5)
Depressed	34 (17.0)	48(24.0)	46 (23.0)	43 (21.5)	29 (14.5)
Everything was an effort	5 (2.5)	40 (20.0)	60 (30.0)	60 (30.0)	35 (17.5)
Sad	31 (15.5)	55 (27.5)	70 (35.0)	32 (16.0)	12 (6.0)
Worthless	57 (28.5)	41 (20.5)	34 (17.0)	41 (20.5)	27 (13.5)

4.4.2. Age and gender differences regarding mental distress

The psychology students in the study generally reported high levels of psychological distress. The majority of students that are <26 years indicated a total K10 score greater than 30, which is an indication of severe mental distress. Among the students with a K10 score greater than 30, 48 (45.7%) students were between the ages of 17-19 years old, 38 (48.7%) students were between the ages of 20-22 years old, and 5 (45.5%) students were between the ages of 23-25 years old. Three (60.0%) of the five students who were 26 years and older had K10 scores in the 14 to 19 range. The final student aged >29 was found to also have a K10 score ranging from 14-19.

Table 4

Frequency analysis of the total mental distress experienced over the past month

	Total K10 Score				
Age Groups	**14-19 N (%)**	**20-24 N (%)**	**25-29 N (%)**	**≥30 N (%)**	**Total N (%)**
17-19	16 (15.2)	21 (20.0)	20(19.0)	48(45.7)	105 (100.0)
20-22	5 (6.4)	18 (23.1)	17 (21.8)	38 (48.7)	78 (100.0)
23-25	1 (9.1)	2 (18.2)	3 (27.3)	5 (45.5)	11 (100.0)
26-28	3 (60.0)	1 (20.0)	0 (0.0)	1 (20.0)	5 (100.0)
>29	1 (100)	0 (0.0)	0 (0.0)	0 (0.0)	1 (100.0)
Total	26 (13.0)	42 (21.0)	40 (20.0)	92 (46.0)	200 (100.0)

The results of the One-Way ANOVA between the different age groups and mental distress did not indicate a statistically significant difference at $p<0.05$ level in the K10 scores of the three groups: $F(2, 197) = 1.85$, $p= 0.16$. Seeing that there was no statistical significance, the actual difference in mean scores between the groups was small, as the effect size using eta squared was 0.02. The Post-hoc comparisons using the Tukey HSD test was therefore not needed as Group 1: 17-19 years (M=2.95, SD=1.13), Group 2: 20-22 years (M=3.13, SD=0.99), and Group 3: ≥23 years (M=2.59, SD=1.28), did not differ significantly from each other, seeing that $p>0.05$.

An independent-samples t-test was conducted to compare the mental distress scores for males and females. There was no significant difference in the mean mental distress scores for males (M = 2.83, SD = 1.07) and females (M = 3.02, SD = 1.1; t (198) = -0.86, p = 0.39, two-tailed), therefore the magnitude of the differences in the means (mean difference = -0.19, 95% CI: –0.62 to 0.24) was very small (eta squared = 0.003).

4.4.3. The relationship between mental distress and substance use

An independent-samples t-test was conducted to compare the mental distress scores and current cigarette use. There was no significant difference in the mean mental distress scores for non-cigarette use (M = 2.98, SD = 1.07) and cigarette use (M = 3.06, SD = 1.21; t (198) = -0.41, p = 0.68, two-tailed), therefore the magnitude of the differences in the means (mean difference = -0.09, 95% CI: –0.51 to 0.33) was very small (eta squared = 0.0008).

An independent-samples t-test was conducted to compare the mental distress scores and current alcohol use. There was no significant difference in the mean mental distress scores for non-alcohol use (M = 2.91, SD = 1.08) and alcohol use (M = 3.10, SD = 1.10; t (198) = -1.16, p = 0.25, two-tailed), therefore the magnitude of the differences in the means (mean difference = -1.18, 95% CI: –0.49 to 0.13) was very small (eta squared = 0.006).

An independent-samples t-test was conducted to compare the mental distress scores and current drug use. There was no significant difference in the mean mental distress scores for drug use (M = 3.0, SD = 1.16) and non-drug use (M = 2.99, SD = 1.09; t (198) = 0.04, p = 0.97, two-tailed), therefore the magnitude of the differences in the means (mean difference = 0.01, 95% CI: -0.51 to 0.53) was very small (eta squared = $8x10^{-6}$).

4.5. Substance use

4.5.1. The nature and prevalence of substance use among the participants

From the sample of psychology students, table 5 below shows that the most common substance used was alcohol, with a lifetime prevalence of 68% (N=136). When assessing current substance use, most students (84.5%; N=169) indicated to have never smoked in the past month, never consumed alcohol in the past month (58%; N=116), and not consuming any other type of drug or substances in the past month (90.5%; N=181). There were however 9 students (4.5%) who indicated smoking every day in the past month, and 1 student (0.5%) who indicated consuming alcohol every day for the past 30 days. Current cigarette and alcohol use were presented in terms of Yes (sometimes, and every day) and no (never).

Table 5

Lifetime and current substance use

SUBSTANCES	LIFETIME		CURRENT	
	Yes N (%)	No N (%)	No N (%)	Yes N (%)
Cigarettes	80 (40.0)	120 (60.0)	169 (84.5)	31 (15.5)
Alcohol	136 (68.0)	64 (32.0)	116 (58.0)	84 (42.0)
Other substances	65 (32.5)	135(67.5)	181 (90.5)	19 (9.5)

While not in a table, of the 65 students (33%) who indicated to have used other drugs in their lifetime, the most common drug used was Marijuana (31.5%; N=63). Only one participant reported to have used Mandrax (0.5%; N=1), Whoonga (0.5%; N=1), and Heroine (0.5%; N=1) respectively. However, 9.5% (N=19) of the students indicated that they currently use other substances

4.5.2. Substance use of significant others

The findings in table 6 below show that most parents did not engage in any form of substance use, however those students who indicated that their parents engaged in substance use, alcohol seemed to be the most common form of substance used by parents (35.5%; N=71). With regards to peer substance use, most students indicated that none of their friends smoked cigarettes (43.0%; N=86), most of their friends consumed alcohol (30.0%; N=60), and none of their friends used drugs or any other substances (51.5%; N=103).

Table 6

Peer and parental substance use

SUBSTANCES	PARENTS		FRIENDS				
	Yes N (%)	No N (%)	None N (%)	Few N (%)	Some N (%)	Most N (%)	All N (%)
Cigarettes	34 (17.0)	166 (83.0)	86 (43.0)	103 (51.5)	35 (17.5)	11 (5.5)	3 (1.5)
Alcohol	71 (35.5)	129 (64.5)	27 (13.5)	57 (28.5)	39 (19.5)	60 (30.0)	17 (8.5)
Other substances	17 (8.5)	183 (91.5)	103 (51.5)	59 (29.5)	29 (14.5)	8 (4.0)	1 (0.5)

Current alcohol use was presented in terms of Yes (sometimes, and every day) and no (never). Among the students who indicated a lifetime alcohol use, 42.6% (N=58) indicated that their parents consume alcohol. Among the students who currently use alcohol 'sometimes', 41.0 % (N=34) indicated that their parents consume alcohol. The student who currently uses alcohol 'everyday' (N=1), indicated that their parents consume alcohol.

A chi-square test for independence (with Yates Continuity Correction) indicated no significant association between current alcohol use and parental alcohol use, X^2 (1, n = 200) = 1.96, p = 0.16, *phi* = -0.11.A chi-square test for independence (with Yates Continuity Correction) indicated a significant association between lifetime alcohol use and parental alcohol use, X^2 (1, n = 200) = 8.5, p = 0.03, *phi* = 0.22.

Table 7

Chi square on student alcohol use and parental alcohol use

	Parental use %		Parental none use %		P-chi square		Df	Continuity corr.		Phi
	Yes	No	Yes	No	Value	P		Value	P	
Current use	41.7	58.3	31.0	69.0	2.405a	0.121	1	1.963	0.161	-0.110
Lifetime use	42.6	57.4	20.3	79.7	9.481a	.002	1	8.531	0.003	0.218

Current alcohol use was presented in terms of Yes (sometimes, and every day) and no (never). Peer alcohol use was presented so that none represents "none of them", some represents "few of them" and "some of them", and most represents "most of them", and "all of them".

Among the students who indicated a lifetime alcohol use, 11.8% (N=16) indicated that all of their peers consume alcohol, and 36.8% (N=50) indicated that most of their peers consume

alcohol. Among the students who currently use alcohol 'sometimes', 13.3% (N=11) indicated that all the peers consume alcohol, and 47.0% (N=39) indicated that that most of their peers consume alcohol. The student who currently uses alcohol 'everyday' (N=1), indicated that most of their peers consume alcohol.

Table 8

Chi square on student alcohol use and peer alcohol use

Alcohol use	**None %**		**Some %**		**Most %**		**P-chi square**		**Df**	**Cramers V**
Peer use	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Value**	**P**		
Current use	1.2	22.4	38.1	55.2	60.7	22.4	37.779a	<0.001	2	0.435
Lifetime use	5.1	31.3	46.3	51.6	48.5	17.2	33.318a	<0.001	2	0.408

A chi-square test for independence indicated a significant association between current alcohol use and peer alcohol use, X^2 (2, n = 200) = 37.78, p = 0.00, *Cramer's V* = 0.44. A chi-square test for independence (with Yates Continuity Correction) indicated a significant association between lifetime alcohol use and peer alcohol use, X^2 (2, n = 200) = 33.32, p = 0.00, *Cramer's V* = 0.41.

4.5.3. The relationship between alcohol use and mental distress

Among the students who indicated a lifetime alcohol use, 51.5% (N=70) had a K10 score greater than 30, and 14.7 % (N=20) had a K10 score between 25-29. Among the students who currently use alcohol 'sometimes', 53.0 % (N=44) had a K10 score greater than 30, and 14.5% (N=12) had a K10 score between 25-29. The student who currently uses alcohol 'everyday', 100.0% (N=1) had a K10 score greater than 30.

Table 9

Alcohol use and mental distress

Total K10 scores	**Lifetime alcohol use**		**Current alcohol use**		
	Yes N (%)	**No N (%)**	**Never N (%)**	**Sometimes N (%)**	**Everyday N (%)**
14-19	19 (14.0)	7 (10.9)	16 (13.8)	10 (12.0)	0 (0.0)
20-24	27 (19.9)	15 (23.4)	25 (21.6)	17 (20.5)	0 (0.0)
25-29	20 (14.7)	20 (31.3)	28 (24.1)	12 (14.5)	0 (0.0)
≥30	70 (51.5)	22 (34.4)	47 (40.5)	44 (53.0)	1 (100.0)
Total	136 (100.0)	64 (100.0)	116 (100.0)	83 (100.0)	1 (100.0)

4.6. Coping

4.6.1. Coping behaviours of participants

Table 10 shows the frequency of negative coping behaviours used by psychology students. The most frequent negative coping behaviour used was "doing something to think about it less, such as going to the movies, watching TV, reading, daydreaming, sleeping, or shopping" (N=94; 47.0%). This item falls part of self- distraction. The second most common negative coping behaviour used was "blaming myself for things that happened" (N=54; 27.0%), followed by "criticizing myself" (N=42; 21.0%). Both items fall part of self-blame.

Table 10

Frequency of negative coping behaviours

Negative Coping	I haven't been doing this at all N (%)	I've been doing this a little bit N (%)	I've been doing this a medium amount N (%)	I've been doing this a lot N (%)	Mean	SD
1. Going to movies, watching TV, reading	11 (5.5)	31 (15.5)	64 (32.0)	94 (47.0)	3.21	0.898
2. Saying "this isn't real"	85 (42.5)	57 (28.5)	33 (16.5)	25 (12.5)	1.99	1.047
3. Refuse to believe it	81 (40.5)	63 (31.5)	33 (16.5)	23 (11.5)	1.99	1.017
4. Use alcohol or drugs to feel better	159 (79.5)	18 (9.0)	11 (5.5)	12 (6.0)	1.38	0.842
5. Use alcohol or drugs to get through it	160 (80.0)	23 (11.5)	9 (4.5)	8 (4.0)	1.33	0.743
6. Criticizing myself	49 (24.5)	59 (29.5)	50 (25.0)	42 (21.0)	2.43	1.077
7. Blaming myself	58 (29.0)	43 (21.4)	45 (22.5)	54 (27.0)	2.48	1.173

According to table 11 below, the most frequent positive coping behaviour used by the psychology students was "thinking hard about what steps to take" (N=90; 45.0%), followed by "praying or meditation" (N=82; 41.0%), and "learning to live with it" (N=79; 39.5 %). Thinking hard about what steps to take is part of the "planning" subscale, praying or meditating is part of the "religion" subscale and learning to live with it is part of the "acceptance" subscale.

Table 11

Frequency of positive coping behaviours

Positive Coping	I haven't been doing this at all N (%)	I've been doing this a little bit N (%)	I've been doing this a medium amount N (%)	I've been doing this a lot N (%)	Mean	SD
1. Doing something	13 (6.5)	45 (22.5)	82 (41.0)	60 (30.0)	2.95	0.887
2. Taking action	11(5.5)	35 (17.5)	84 (42.0)	70 (35.0)	3.07	0.863
3. Developing a strategy	15 (7.5)	31 (15.5)	81 (40.5)	73 (36.5)	3.06	0.906
4. Taking steps	13 (6.5)	31 (15.5)	66 (33.0)	90 (45.0)	3.17	0.918
5. Seeing things in a different light	10 (5.0)	40 (20.0)	89 (44.5)	61 (30.5)	3.01	0.842
6. Getting comfort and understanding	44 (22.0)	48 (24.0)	48 (24.0)	60 (30.0)	2.62	1.132
7. Accepting reality	12 (6.0)	37 (18.5)	76 (38.0)	75 (37.5)	3.07	0.894
8. Learning to live with it	11 (5.5)	48 (24.0)	62 (31.0)	79 (39.5)	3.05	0.926
9. Making jokes	61 (30.5)	40 (20.0)	49 (24.5)	50 (25.0)	2.44	1.168
10. Making fun	73 (36.5)	46 (23.0)	44 (22.0)	37 (18.5)	2.23	1.132
11. finding comfort in religion	36 (18.0)	48 (24.0)	45 (22.5)	71 (35.5)	2.76	1.123
12. Praying or meditating	27 (13.5)	41 (20.5)	50 (25.0)	82 (41.0)	2.94	1.075
13. Getting emotional support	41 (20.5)	70 (35.0)	57 (28.5)	32 (16.0)	2.40	.987
14. Getting comfort and understanding	42 (21.0)	57 (28.5)	56 (28.0)	45 (22.5)	2.52	1.061
15. Trying to get advice or help	54 (27.0)	47 (23.5)	65 (32.5)	34 (17.0)	2.40	1.060
16. Getting help and advice	52 (26.0)	62 (31.0)	60 (30.0)	26 (13.0)	2.30	0.997
17. Letting unpleasant feelings escape	54 (27.0)	54 (27.0)	48 (24.0)	44 (22.0)	2.41	1.108
18. Expressing negative feelings	63 (31.5)	65 (32.5)	50 (25.0)	22 (11.0)	2.16	0.993

4.6.2. Age and gender differences regarding Coping

The results of the One-Way ANOVA between the different age groups and positive coping did not indicate a statistically significant difference at $p<0.05$ level in the positive coping scores of the three groups: $F (2, 197) = 0.54$, $p= 0.59$. Even though there was no statistical significance, the actual difference in mean scores between the groups was large, with an effect size using eta squared of 5.41. Therefore, the Post-hoc comparisons using the Tukey HSD test was not needed as Group 1: 17-19 years (M=47.99, SD=9.0), Group 2: 20-22 years (M=48.85, SD=8.5), and Group 3: ≥23 years (M=50.18, SD=9.71), did not significantly differ from each other, seeing that $p>0.05$.

The results of the One-Way ANOVA between the different age groups and negative coping did not indicate a statistically significant difference at $p<0.05$ level in the negative coping scores of the three groups: $F (2, 197) = 0.95$, $p= 0.39$. Even though statistical significance was not reached, there was a large actual difference in mean scores between the groups, with an effect size using eta squared of 9.53. The Post-hoc comparisons using the Tukey HSD test was therefore not needed as Group 1: 17-19 years (M=14.68, SD=3.95), Group 2: 20-22 years (M=15.18, SD=4.43), and Group 3: ≥23 years (M=13.71, SD=4.44), did not significantly differ from each other, seeing that $p>0.05$.

An independent-samples t-test was conducted to compare the positive and negative coping scores for males and females. There was no significant difference in the mean positive coping scores for males (M = 47.34, SD = 7.97) and females (M = 48.71, SD = 9.0; t (198) = -0.77, p = 0.45, two-tailed), therefore the magnitude of the differences in the means (mean difference = -1.36, 95% CI: –4.87 to 2.15) was very small (eta squared = 0.002). There was no significant difference in the mean negative coping scores for males (M = 14.41, SD = 4.22) and females (M = 14.85, SD = 4.18; t (198) = -0.52, p = 0.60, two-tailed), therefore the magnitude of the differences in the means (mean difference = -0.44, 95% CI: –2.1 to 1.22) was very small (eta squared = 0.001).

4.6.3. The relationship between mental distress and coping

The results of the One-Way ANOVA between mental distress and positive coping did not indicate a statistically significant difference at $p<0.05$ level in the positive coping scores of the four groups: $F (3, 196) = 0.14$, $p= 0.94$. Considering that no statistical significance was reached, the actual difference in mean scores between the groups was small, with the effect

size using eta squared being 0.01. Therefore the Post-hoc comparisons using the Tukey HSD test was not needed as Group 1: scores between 14-19 (M=47.81, SD=11.47), Group 2: scores between 20-24 (M=48.07, SD=8.20), Group 3: scores between 25-29 (M=48.98, SD=7.95), and Group 4: scores ≥30 (M=48.71, SD=8.79) did not significantly differ from each other, seeing that p>0.05.

The results of the One-Way ANOVA between mental distress and negative coping indicated a statistically significant difference at p<0.05 level in the negative coping scores of the four groups: F (3, 196) = 16.25, p= 0.01. Seeing that statistical significance was reached, the actual difference in mean scores between the groups was large, as the effect size using eta squared was 0.2. The Post-hoc comparisons using the Tukey HSD test indicated that the mean score for Group 1: scores between 14-19 (M=11.08, SD=2.62) was significantly different from Group 2: scores between 20-24 (M=13.93, SD=3.98), Group 3: scores between 25-29 (M=14.08, SD=3.13), and Group 4: scores ≥30 (M=16.54, SD=4.17). Group 2: scores between 20-24 (M=13.93, SD=3.98) did not significantly differ from Group 3: scores between 25-29 (M=14.08, SD=3.13).

4.6.4. The relationship between substance use and coping

An independent-samples t-test was conducted to compare current cigarette use and coping. There was a significant difference in the mean positive coping for non-cigarette use (M = 49.20, SD = 8.56) and cigarette use (M = 44.74, SD = 9.57; t (198) = 2.62, p = 0.01, two-tailed), therefore the magnitude of the differences in the means (mean difference = 4.46, 95% CI: 1.1 to 7.82) was small (eta squared = 0.03). There was a significant difference in the mean negative coping for non-cigarette use (M = 14.30, SD = 3.94) and cigarette use (M = 17.45, SD = 4.52; t (198) = -4.0, p = 0.01, two-tailed), therefore the magnitude of the differences in the means (mean difference = -3.15, 95% CI: –4.70 to -1.6) was moderate (eta squared = 0.07).

An independent-samples t-test was conducted to compare current alcohol use and coping. There was no significant difference in the mean positive coping scores for non-alcohol use (M = 49.17, SD = 8.56) and alcohol use (M = 47.60, SD = 9.2; t (198) = 1.25, p = 0.21, two-tailed). Therefore, the magnitude of the differences in the means (mean difference = 1.58, 95% CI: -0.92 to 4.07) was very small (eta squared = 0.007). There was a significant difference in the mean negative coping scores for non-alcohol use (M = 13.88, SD = 3.48)

and alcohol use (M = 16.05, SD = 4.73; t (198) = -3.56, p = 0.01, two-tailed). Therefore, the magnitude of the differences in the means (mean difference = -2.17, 95% CI: –3.37 to -0.96) was moderate (eta squared = 0.06).

An independent-samples t-test was conducted to compare current drug use and coping. There was a significant difference in the mean positive coping scores for drug use (M = 43.11, SD = 8.33) and non-drug use (M = 49.08, SD = 8.73; t (198) = -2.85, p = 0.01, two-tailed), therefore the magnitude of the differences in the means (mean difference = -5.97, 95% CI: –10.11 to -1.84) was small (eta squared = 0.04). There was a significant difference in the mean negative coping scores for drug use (M = 18.58, SD = 5.36) and non-drug use (M = 14.39, SD = 3.85; t (198) = 3.32, p = 0.01, two-tailed), therefore the magnitude of the differences in the means (mean difference = 4.19, 95% CI: 1.55 to 6.82) was small (eta squared = 0.05).

4.7. Self-stigma of seeking help for mental distress

4.7.1. The nature and prevalence of self-stigma of seeking help

Among the students who responded ‘strongly agree’, (N=40; 20.0%) indicated that their view of themselves would not change if they sought professional help, (N=39; 19.5%) indicated that their self-confidence would not change if they sought professional help for a problem they could not solve, and (N=31; 15.5%) indicated that they would feel worse about themselves if they could not solve their own problems. Among those who responded with ‘agree’, (N=44; 22.0%) indicated that they would feel worse about themselves if they could not solve their own problems, (N=29; 14.5) indicated that their self-confidence would not change if they sought professional help for a problem they could not solve, and (N=28; 14.0%) indicated that their view of themselves would not change if they sought professional help.

Students with the least amount of self-stigma of seeking help for mental distress responded “strongly disagree” to the self-stigma of seeking help response items. Among the students who responded ‘strongly disagree’, (N=132; 66.0%) indicated that seeing psychological help would not make them feel less intelligent, (N=109; 54.5%) indicated that they would not feel inferior to ask a therapist for help, and (N=101; 50.5%) indicated that they would not be less satisfied with themselves if they went to a therapist.

Table 12

Self-stigma of seeking help

	Strongly Disagree N (%)	Disagree N (%)	Agree and Disagree Equally N (%)	Agree N (%)	Strongly Agree N (%)	Mean	SD
1. Feeling inadequate	75 (37.5)	37 (18.5)	50 (25.0)	20 (10.0)	18 (9.0)	2.35	1.313
2.Self-confidence NOT threatened	86 (43.0)	41 (20.5)	34 (17.0)	19 (9.5)	20 (10.0)	2.23	1.355
3.Feeling less intelligent	132 (66.0)	41 (20.5)	13 (6.5)	7 (3.5)	7 (3.5)	1.58	1.004
4.Increased self-esteem	67 (33.5)	58 (29.0)	45 (22.5)	15 (7.5)	15 (7.5)	2.27	1.213
5.Unchanged view of self	51 (25.5)	31 (15.5)	50 (25.0)	28 (14.0)	40 (20.0)	2.88	1.453
6.Feeling inferior	109 (54.5)	39 (19.5)	40 (20.0)	6 (3.0)	6 (3.0)	1.81	1.050
7.Feeling okay about the choice	84 (42.0)	54 (27.0)	35 (17.5)	18 (9.0)	9 (4.5)	2.07	1.167
8.Less satisfied with myself	101 (50.5)	62 (31.0)	25 (12.5)	3 (1.5)	9 (4.5)	1.79	1.027
9.Unchanged self-confidence	38 (19.0)	40 (20.0)	54 (27.0)	29 (14.5)	39 (19.5)	2.96	1.376
10.Feeling worse if I cannot solve my own problems	56 (28.0)	32 (16.0)	37 (18.5)	44 (22.0)	31 (15.5)	2.81	1.447

4.7.2. Mental distress and gender differences regarding self-stigma of seeking help

The results of the One-Way ANOVA between mental distress and self-stigma of seeking help indicated no statistically significant difference at $p<0.05$ level in self-stigma of seeking help of the four groups: $F (3, 196) = 0.67$, $p= 0.57$. Even though there was no statistical significance, there was a large actual difference in mean scores between the groups, with an effect size using eta squared of 0.1. The Post-hoc comparisons using the Tukey HSD test was not needed as Group 1: scores between 14-19 (M=21.77, SD=6.08), Group 2: scores between 20-24 (M=23.74, SD=5.5), Group 3: scores between 25-29 (M=22.38, SD=6.23), and Group 4: scores ≥30 (M=22.67, SD=6.02), did not differ significantly from each other, seeing that $p>0.05$.

An independent-samples t-test was conducted to compare self-stigma of seeking help for males and females. There was a significant difference in self-stigma of seeking help for males (M = 25.72, SD = 6.69) and females (M = 22.21, SD = 5.68; t (198) = 3.0, p = 0.01, two-tailed), therefore the magnitude of the differences in the means (mean difference = 3.51, 95% CI: 1.20 to 5.83) was small (eta squared = 0.04).

4.7.3. The relationship between substance use and self-stigma of seeking help

An independent-samples t-test was conducted to compare current cigarette use and self-stigma of seeking help. There was no significant difference in self-stigma of seeking help for non-cigarette use (M = 22.46, SD = 5.84) and cigarette use (M = 22.13, SD = 6.44; t (198) = -1.44, p = 0.15, two-tailed), therefore the magnitude of the differences in the means (mean difference = -1.67, 95% CI: -3.96 to 0.62) was small (eta squared = 0.01).

An independent-samples t-test was conducted to compare current alcohol use and self-stigma of seeking help. There was no significant difference in self-stigma of seeking help for non-alcohol use (M = 22.09, SD = 5.98) and alcohol use (M = 23.60, SD = 5.84; t (198) = -1.78, p = 0.08, two-tailed), therefore the magnitude of the differences in the means (mean difference = -1.51, 95% CI: -3.18 to 0.16) was small (eta squared = 0.02).

An independent-samples t-test was conducted to compare current drug use and self-stigma of seeking help. There was no significant difference in self-stigma of seeking help for drug use (M = 25.0, SD = 5.83) and non-drug use (M = 22.48, SD = 5.93; t (198) = 1.76, p = 0.79, two-tailed), therefore the magnitude of the differences in the means (mean difference = 2.51, 95% CI: –0.3 to 5.34) was small (eta squared = 0.02).

4.8. The relationships between mental distress, coping, and self-stigma of seeking help

The Pearson product-moment correlation coefficient indicated that there was a weak negative correlation between mental distress and positive coping, r=-0.04, n=200, p<0.01, with a weak linear relationship showing increased levels of mental distress being associated with decreased levels of positive coping. There was a moderate positive correlation between mental distress and negative coping, r=0.43, n=200, p<0.01, with a moderate linear

relationship showing increased levels of mental distress being associated with increased levels of negative coping.

The Pearson product-moment correlation coefficient indicated that there was no correlation between mental distress and self-stigma of seeking help, r=0.00, n=200, p<0.01. There was however a weak negative correlation between self-stigma of seeking help and positive coping (r=-0.2, p<0.01), and a weak positive correlation between self-stigma of seeking help and negative coping (r=0.26, p<0.01). This indicates that as self-stigma of seeking help increases, positive coping decreases and negative coping increases.

Table 13

Correlation analysis

Variables	**1**	**2**	**3**	**4**
1. K10	1			
2. P. Coping	0.038	1		
3. N. Coping	0.429**	-0.020	1	
4. SSOSH	0.002	-0.197**	0.256**	1

**. *Correlation is significant at the 0.01 level (2-tailed)*, P. coping= Positive coping, N. Coping= Negative coping.

4.9. Best predictors of mental distress

A backward multiple regression was conducted to identify a parsimonious combination of positive coping, negative coping, SSOSH, current cigarette use, current alcohol use, and current drug use in predicting mental distress. Assumptions of linearity, normally distributed errors, and uncorrelated errors were checked and fulfilled. The means and standard deviations and parsimonious predictor variables are presented in Table 14. The beta weights and significance values for model 4 is presented in Table 15. The model with the most parsimonious predictor variables includes negative coping, SSOSH, and current drug use, *F(3,196)=17.57, p<0.01*, adjusted R^2 = 0.200. This indicates that 20.0% of the variance in mental distress can be explained by this model, which according to Cohen (1988) is a medium effect. The equation for the model was: Mental distress= 0.613 + 0.129 Negative coping - 0.020 SSOSH + 0.481 Current drug use + e. Negative coping was the only variable that significantly contributed to the final model (t= 7.260, p<0.001).

Table 14

Mental distress and predictor variables

Variable	M	SD	1	2	3
Mental distress	2.99	1.094	1		
Predictor variables					
1. N. Coping	14.79	4.181	0.429	1	
2. SSOSH	22.72	5.952	0.002	0.256	1
3. C. Drug	1.91	0.294	-0.003	-0.294	-0.124

Note*; N. Coping= Negative coping, C. Drug=Current drug use.*

Table 15

The beta weights and significance values for model 4

Variables	B	Std. Error	β	R^2	Δ R^2
Model 4				0.212	-0.003
N. Coping	0.129	0.018	0.495		
SSOSH	-0.020	0.012	-0.109		
C. Drug	0.481	0.247	0.129		
Constant	0.613	0.648			

Note*; N. Coping= Negative coping, C. Drug=Current drug use.*

A backward multiple regression was conducted to identify a parsimonious combination of gender, age groups, year of study, residence, and household situation in predicting mental distress. Dummy variables were created for age groups i.e. 17-19 years=1 and all others=0; 20-22 years=1 and all others=0; ≥23 years=1 and all others=0. Dummy variables for year of study were as follows: first year=1 and all others=0; second year=1 and all others=0; third year=1 and all others=0; fourth year=1 and all others=0. Dummy variables were created for residence i.e. With parents/family=1and all others=0; UKZN residence on campus=1 and all others=0; Residence off campus=1 and all others=0; Rent or share accommodation=1 and all others=0;With others=1 and all others=0. Dummy variables created for household situation were: not enough money for basics=1 and all others=0; have money only for basics=1 and all others=0; not enough money for expensive things=1 and all others=0; have money to save and for luxuries=1 and all others=0.

Assumptions of linearity, normally distributed errors, and uncorrelated errors were checked and fulfilled. The means and standard deviations and parsimonious predictor variables are presented in Table 16. The beta weights and significance values for model 5 is presented in Table 17. The model with the most parsimonious predictor variable was household situation, specifically those having money to save and for luxuries, *F13,198)=1.169,p=0.281,*adjusted

R^2 = 0.001. This indicates that 0.1% of the variance in mental distress can be explained by this model, which according to Cohen (1988) is a small effect. The equation for the model was: Mental distress= 2.952 + 0.220 have money to save and for luxuries + e. However, having money to save and for luxuries did not significantly contribute to the model

Table 16

Mental distress and demographic predictor variables

Variable	M	SD	1
Mental distress	2.99	1.094	1
Predictor variable			
1. Have money to save and for luxuries	0.18	0.381	0.077

Table 17

The beta weights and significance values for model 5

Variables	B	Std. Error	β	R^2	Δ R^2
Model 5				0.006	-0.004
Have money to save and for luxuries	0.220	0.203	0.077		
Constant	2.952	0.085			

4.10. Chapter Summary

This chapter reported on the results obtained from various statistical techniques used in this study. Frequency analyses, reliability analyses, descriptive statistics, a One-Way ANOVA analysis, a T-test analysis, Chi-square analyses, correlation analyses, and backward multiple regression analyses were among the various statistical analyses used to answer the research questions.

CHAPTER FIVE: DISCUSSION

5.1. Introduction

This chapter presents the discussion of the research findings obtained from the data analyses. Previous research is used to discuss the contrast between the findings of past research and the present research study. This chapter aims to discuss the findings obtained, identify whether the findings have decreased, increased, or are consistent across past and present research studies, and to identify possible explanations for the results obtained.

5.2. Socio-demographic characteristics

Obtaining the socio-demographic characteristics of the sample of psychology students involved categorising people into different socio-demographic groups in order to identify whether or not certain socio-demographic characteristics influence mental distress, substance use, coping, and help-seeking behaviour. The findings suggested that most of the psychology students that agreed to participate were predominantly female students (85.5%) between the ages of 17-19 years. The gender distribution reflects the demographics of psychology students at the University of KwaZulu Natal while the age distribution is common for first year to fourth year university students. The gender distribution is also due to female students being more willing to respond to and assist in the study than males. Most of the participants lived with their parents/family while 39.5% indicated not having enough money for expensive things, showing the fairly average socio-economic status of this group of participants.

5.3. Psychometric properties of the measures

Examining the Chronbachs alpha reliability coefficient for the total K10 scale we can deduce that there is a very strong inter item reliability coefficient of the K10 scale for this sample of psychology students as α=0.86. If we were to compare the present study with the South African study by Andersen et al. (2011), which obtained a Chronbach's alpha of 0.84, it is evident that the present study yielded a slightly higher Cronbach's alpha for the K10 scale, suggesting a better model fit and construct validity. These results indicate the validity and reliability of the use of this scale within the South African context.

The positive coping subscale reported a very strong inter-item correlation coefficient of α=0.81. When compared to the South African study by Futterman et al. (2010), which reported a positive coping Chronbach's alpha of 0.70, the present study yielded a higher Chronbach's alpha for the positive coping subscale, suggesting a better model fit and construct validity. The negative coping subscale reported a Chronbach's alpha of α=0.72 which indicates a good inter-item reliability coefficient. This scale is therefore recommended for use in the South African context as it is a reliable and valid scale.

The SSOSH scale reported a Chronbach's alpha of α=0.62 which is similar to the Chronbach's alpha coefficient obtained from the study by Pheko et al. (2013) that reported a Chronbach's alpha of α=0.66. The SSOSH scale in the present study also reported an optimum mean inter-item correlation coefficient of r=0.2, indicating that this scale is a valid and reliable scale to use in the South African context.

5.4.1. The nature and prevalence of mental distress among psychology students

The findings of this study suggested that most students felt that everything was an effort, tired, and depressed all of the time. These constant feelings expressed by the students are some of the symptoms listed in the DSM-5 as symptoms of depression (Austin et al., 2012). The findings therefore indicate high levels of depression among this group of university students. This is consistent with studies by Pedrelli et al. (2015) that state that more than half of all depression cases occur during childhood, adolescence, and young adulthood, with one in every five individuals suffering from depression reportedly having their first onset before the age of 25.

A possible explanation for these students' likely experiencing symptoms of depression could be due to their parent's genetic history of depression, excessive life stressors, lack of social support, poor socio-economic circumstances, or lack of proper help-seeking (Torikka, 2017). Other possible reasons for some of these students experiencing depressive symptoms may be due to familial discord, academic stressors, grief, abuse or neglect, or relationship issues that they are faced with (Austin et al., 2012).

5.4.2. Age and gender differences regarding mental distress

Many psychology students in the present study obtained mental distress scores above 30, which is an indication of severe psychological distress (Anderson et al., 2013). The results show that most students between the ages of 17 and 25 years of age had very high levels of psychological distress, with most of the students between 26 years and above experiencing lower levels of psychological distress. The high levels of mental distress among these students may put students at a greater risk of low academic performance and variety of negative consequences (Basterfield et al., 2014).

According to Pedrelli et al. (2015), 75% of those with mental health disorders have reportedly had their peak onset during young adulthood, before the age of 25. This can explain why individuals in this study between the ages of 17-25 years have experienced high levels of psychological distress. The high levels of psychological distress among the 17 to 25 age group can also be explained by the fact that younger students are more likely to employ maladaptive responses to their distress by ignoring their psychological health (Deasy et al., 2014). It is also possible that due to the fact that young adults have a higher sensitivity to their surroundings and have a constant need to meet expectations of themselves and others, they tend to be more vulnerable to excessive distress (Lin & Yusoff, 2013).

There seemed to be no significant difference between age and mental distress from this sample of participants. There also seemed to be no significant difference between gender and mental distress from this sample of participants. This is consistent with findings by Buttery et al. (2015) that show no significant association between age and frequent mental distress among both males and females. Previous studies also suggest no significant difference between gender and distress (Lin & Yusoff, 2013; Ward, Wiltshire, Detry, & Brown, 2013).

In contrast, it has been reported that psychological distress are more likely experienced by college women than college men (Kenney & LaBrie, 2013). These findings also contradicted with findings by Bor et al. (2014) that found that adolescent girls are at a higher risk for internalising problems due to their possible early sexualising that result in poor self-esteem and depression, and the fact that they are more socio-emotionally attentive than adolescent boys. Also contradicting with the current findings are that of Pedrelli et al. (2015), which found that early age onset of mental health issues can predict a poor outcome and the

presentation of increased mental health problems later on in life, with the identification of mental illness among children and adolescents having a harmful course of illness.

A possible explanation for the current findings could be the fact that these high levels of mental distress experienced by the students may be due to the biological and socio-cultural factors instead. It could also mean that gender stereotypes or age have less of an effect on the internalising and externalising disorders of the young population (Boyd et al., 2015).

5.4.3. Mental distress and substance use

The present findings indicated no significant difference between mental distress and substance use (current cigarette use, current alcohol use, and current drug use). This indicates that the high rates of substance use among this sample may not be related to the increased levels of distress, but instead be due to other factors. Some possible factors that may influence the distress among this population could be social, emotional, and academic demands (Wynaden et al., 2013). A possible factor related to substance use among this population could be the lack of perceived coping abilities (Deasy et al., 2014). Previous findings however suggest a relationship between substance use and mental distress (Olashore et al., 2018; Kenney & LaBrie, 2013)

Mental distress and substance use can also be co-occurring disorders (Sharma, & Bennett, 2015). Therefore, it is possible that an increase in substance use among this sample of students may be considered as a substance use disorder due to its frequency. It is also possible that the increased levels of mental distress experienced by these students may not lead to their use of substances but may instead result in other risky behaviours such as risky sexual behaviours, suicidal ideation, violence and aggression, poor academic performance, or delinquency (Czyz et al., 2013; Balogun et al., 2014; Basterfield et al., 2014).

5.5. 1. The nature and prevalence of substance use among the participants

The findings indicated that alcohol seemed to be the most frequently used lifetime and current substance among the group of university students in this study. These findings support the research of Kenney and LaBrie (2013), who found alcohol use, especially heavy episodic drinking, to be a huge concern among college students. The findings from this study are also supported by that of Olashore et al. (2018) where alcohol was found to be the most

common psychoactive substance used by college students with 31.9% of current alcohol users.

The high levels of alcohol use could be due to the social, economic, political, and traditional roles (Olashore et al., 2018). Alcohol is socially acceptable in many settings, and many people use alcohol in their cultural or traditional rituals or celebrations making it easily available and accessible. It is easy for adolescents to purchase alcohol as people are more interested in their economic gain rather than the negative impact alcohol is having on these young adults (Hall et al., 2016). There are also poor policies around the use of alcohol, including poor policies on the media's representation of alcohol use. College students may also be more likely to use alcohol, due to socially based motives such as drinking during a celebration of a special occasion, and enhancement based motives such as drinking for the fun and excitement of it (Kenney et al., 2013).

15.5% of students indicated currently smoking cigarettes. This is lower than the current prevalence of tobacco use found by Olashore et al. (2018), of 18.7%. However, it is still a concern that 4.5% of students smoke cigarettes every day. A possible reason for the lower rates of cigarette smoking could be due to the legislations put in place restricting direct forms of tobacco advertising. However, for those with high levels of tobacco use, peer pressure or the inability to cope with the stress of university, may contribute to their cigarette smoking habits (Olashore et al., 2018).

Of those who indicated using other substances in their lifetime, when asked what drugs were used, most people indicated using marijuana, with the rest indicating mandrax, whoonga, and heroine**.** The present findings are consistent with the findings of Olashore et al. (2018) that indicated that cannabis was globally the mostly commonly used illicit drug. The findings are also consistent with the findings of Pedrelli et al. (2015) that reported marijuana as being very prevalent among college students with 30% of college students admitting to have used marijuana before entering college, explaining the lifetime prevalence of marijuana in this sample of university students.

Many people believe that cannabis has medicinal properties; therefore, it is possible that many students use cannabis as a means of treating their physical and psychological difficulties due to their perceptions of its medicinal properties (Olashore et al., 2018). Some students may also smoke marijuana in order to feel accepted by their peers and adapt to their environment (Kaess et al., 2014).

Findings from previous studies also suggest that alcohol use and cannabis use can co-occur among college students, with heavy drinkers being approximately ten times more likely to use marijuana (Pedrelli et al., 2015). This further explains the high frequency of alcohol use and marijuana use among this group of university students.

A possible reason for the substance use among college students is the fact that they are faced with a variety of social, cognitive, and physical changes during this period. It has also been found that low educational attainment due to poor academic performance or educational difficulties contributed to alcohol, tobacco, or drug use, (Hall et al., 2016). It is also possible that because college aged students are still trying to discover their identity; they are more susceptible to engage in risky behaviours such as substance abuse (Venning et al., 2013).

5.5.2. Peer and Parental substance use

Most students indicated that their parents did not use substances; however, of those students who indicated that their parents used substances, the most common substance used was alcohol. The most common substance used by the student's peers was alcohol, with 30% of students indicating that most of their peers consume alcohol and 8.5% indicate that all of their peers consume alcohol.

With the most common substance used by both peers and parents being alcohol and alcohol being the most common substance used by the students; peer and parental alcohol use may be a contributing factor to this university student's alcohol use. To test whether peer and parent alcohol use is a contributing factor toward the participants alcohol use, chi-square analyses were performed; the results are discussed below.

5.5.3. Student alcohol use and significant others use of alcohol

The present study found no significant relationship between current and parental alcohol use, however, there was a significant relationship between lifetime and parental alcohol use. This indicates that parental alcohol use can explain the student's lifetime alcohol use. This is consistent with research by Boyd et al. (2014), which suggest that parental drinking habits can directly or indirectly influence college students drinking habits; with familial drinking habits during the college senior year reportedly influencing college student's alcohol use a year later. It has also been reported that parental attitudes towards alcohol use, as well as drinking habits, can predict alcohol abuse among adolescent and college students, with a

family history of alcohol problems being linked to alcohol use disorders among this age group (Boyd et al., 2014).

Possible reasons for the association between lifetime alcohol use and parental alcohol use can be the provision of alcohol by the parents, low quality of parent-child relationships, and modelling of parent's alcohol behaviours (Mahedy et al., 2018). Low levels of monitoring and lack of communication by parents could also influence lifetime alcohol use, as a lack of communication and monitoring could lead to students not understanding the consequences of alcohol use and gaining easy access to their parents alcohol (Boyd et al., 2014). Parent's attitudes toward alcohol use could also result in alcohol use among this population of students, as parents positive attitudes toward alcohol use could contribute to student's attitudes that govern their alcohol consumption (Boyd et al., 2014; Mahedy et al., 2018).

It was also found that there was a significant relationship between current and peer alcohol use, as well as lifetime and peer alcohol use. This indicates that peer alcohol use can explain both current and lifetime alcohol use of university students. This is consistent with Boyd et al. (2014) that reported a link between peer alcohol use and college student's alcohol use.

Findings by Deasy et al. (2015) show that there was an increase in alcohol use by students residing in student accommodation, indicating that living with peers was associated with alcohol use among college students. Adolescents also tend to hold greater importance to peer acceptance and can be easily influenced or pressured into drinking, with a greater need to fit in with their peer groups and feel included in peer activities regardless of how harmful they may be (Hall et al., 2016). Another possible explanation for the link between peer and student alcohol use, is the fact that many students tend to select peer groups with similar drinking habits with many continuing to socialise with these types of peer groups even after college (Boyd et al., 2014). It is also possible that a lack of parental support could lead to parental disengagement and involvement with deviant peers resulting in students being easily susceptible to alcohol abuse (Schwinn & Schinke, 2014).

5.5.4. The relationship between alcohol use and mental distress

The findings of this study show 51.5% of students with lifetime alcohol use having severe mental distress and 53.6% of students with current alcohol use having severe mental distress. With over half of the students with lifetime or current alcohol use experiencing severe mental distress, this is a cause for concern. This is consistent with findings by Kenney and LaBrie

(2013) that found a high prevalence of depression and anxiety as well as greater levels of mental distress among college students resulted in greater levels of alcohol related consequences.

A possible explanation is low distress tolerance by the students. According to Tull and Gratz (2013), low distress tolerance leads to psychological vulnerability for various forms of psychopathology and maladaptive coping mechanisms or risky behaviours such as substance use, as a form of emotional avoidance. Sensation seeking, impulsivity, anxiety sensitivity, and hopelessness are a few possible personality risk factors of substance use among these students (Battista et al., 2013). Some other possible explanations for alcohol use among students experiencing mental distress is the use of alcohol as an avoidant coping strategies, an increase in the prominence of alcohol use, and lowered self-efficacy to refuse or stop the use of alcohol (Kenney & LaBrie, 2013).

5.6.1. Participant coping behaviours

The most common positive coping behaviours were those within the subscales of planning, religion, and acceptance. People were more likely to think about what steps to take, pray or meditate, and learn to live with their mental distress. These students who indicated more positive coping behaviours tended to use more adaptive coping strategies as appose to maladaptive coping strategies (Deasy et al., 2014). Previous findings suggest that religious coping is the most preferred type of coping and can have health promoting effects on adolescent well-being (Mutumba et al., 2017; Ward et al., 2013). However, according to Nielsen and Knardahl (2014), the severity and effect of mental health problems influence the type of coping behaviours used. It is also important to note that some coping strategies that are perceived to be helpful coping behaviours for mental distress, might in some cases increase mental distress or prolong an individual's recovery from the stressor (Deasy et al., 2014).

The most common negative coping behaviours were those within the subscales of self-distraction, and self-blame. People were more likely to distract themselves from their distress by going to the movies, watching TV, reading, daydreaming, sleeping, or shopping. Some people were also more likely to criticize themselves and blame themselves for things that happened. This is consistent with research by Lin and Yusoff (2013) that suggest self-blame and self-distraction as being two of the most frequent coping behaviours employed. Self-

blame was found to be associated with a greater risk of psychological distress, indicating that those employing self-blame coping behaviours are more likely to develop mental distress (Lin & Yusoff, 2013). It was also found that cultural and social norms may play a huge role in student's maladaptive coping behaviours such as avoidance or self-blame, by emphasizing appropriate behaviours and not recognising distress as an issue that governs help-seeking as a form of effective coping (Al-Bahrani, Aldhafri, Alkharusi, Kazem, & Alzubiadi, 2013).

5.6.2. Age and gender differences regarding coping

The findings suggest that there was no significant difference between age and gender on both negative and positive coping. Therefore, age and gender do not significantly influence the type of coping behaviours used. According to the findings of Al-Bahrani et al. (2013), adaptive and maladaptive coping seemed to increase with age; however other studies found no age differences with coping remaining stable over time.

Consistent with these study findings, Julal (2013) found no significant association between gender and coping. Findings by Al-Bahrani et al. (2013) suggested that there was no significant difference between gender and adaptive coping; however, females tended to use more maladaptive coping than males. It is however important to note that coping is situation specific regardless of their age or gender; for example, if a student felt that they were incapable of managing their stressors they would be more likely to employ emotion-focused coping, whereas someone who feels as if they have control over their stressors will be more likely to employ problem-focussed coping (Lin & Yusoff, 2013).

5.6.3. Mental distress and coping

There seemed to be no significant difference between mental distress and positive coping; however, there was a significant difference between mental distress and negative coping. The findings indicate that the higher the levels of mental distress these students experienced, the less positive coping strategies and more negative coping strategies were used. This is consistent with the findings of Basterfield et al. (2014) that found that excessive stress may lead to students using escape avoidance. Research shows that students with high levels of mental distress tend to use maladaptive coping strategies (Deasy et al., 2015). Findings by Nielsen and Knardahl (2014), show that people with high levels of long-term mental health issues are more likely to use passive disengagement coping.

Both internal and external stressors can affect a person's stress coping capabilities (Lin & Yusoff, 2013). Research shows that students experiencing mental distress tend to employ negative coping behaviours such as poor diet, low levels of physical activity, risky sexual behaviour, violent and aggressive behaviours, substance use, and delinquency (Deasy et al., 2015; Basterfield et al., 2014). Seeing that these students do not use substances as a negative coping strategy for their mental distress, it is possible that they could be using one or more of the mentioned negative coping strategies to deal with their distress. Another possible explanation for the relationship between distress and negative coping could be that these students may believe that their distress will resolve on their own resulting in them using avoidance coping as a strategy (Ward et al., 2013)

The findings can also imply that students who used more negative coping tended to have more distress, whereas those who employed more positive coping strategies experienced less distress. Research found that students who used ineffective problem-coping had a higher likelihood of experiencing increased mental distress (Julal, 2013).

5.6.4. Substance use and coping

There was no significant difference between current alcohol use and positive coping; there was however a significant difference between current alcohol use and negative coping. Therefore, students with current alcohol use tended to use more negative coping and less positive coping strategies. This is consistent with research by Deasy et al. (2014), which showed that students tend to have difficulties coping with stressors and are often reluctant to seek help for their distress, by choosing to instead ignore their problem and use escapism through alcohol consumption as a coping strategy.

There was a significant difference between current cigarette use and both positive and negative coping. It was found that students with current non cigarette use tended to use more positive coping strategies, and students with current cigarette use used more negative coping strategies. Research indicates that students with high levels of psychological distress tend to be more likely to employ passive coping and escape avoidance coping such as smoking and alcohol use. Alcohol and tobacco use are common negative coping strategies often perceived as stress relievers (Deasy et al., 2015).

There was a significant difference between current drug use and both positive and negative coping behaviours. It was found that students with current non-drug use were more likely to

employ positive coping behaviours and students with current drug use were more likely to employ negative coping behaviours. These findings are consistent with previous research on incarcerated youth that suggest that drug use and dependency is associated with avoidant coping behaviours (Aebi et al., 2014).

Research showed that current tobacco smokers, current alcohol uses, and current cannabis smokers use escape avoidance coping more frequently (Deasey et al., 2014). This is consistent with the current findings that show current cigarette, alcohol and drug use being associated with negative coping. Many students have been found to use substances are a form of self-medication (Ullman, Relyea, Peter-Hagene, & Vasquez, 2013). According to Lin and Yusoff (2013), people who employ problem focussed coping are less likely of developing and more likely of overcoming substance use issues. However, this study reported an association between substance use and negative coping, implying that the students from this sample could develop substance use problems or have difficulties overcoming their substance use problems in the future (Lin & Yusoff, 2013). The relationship between substance use and negative coping is therefore very problematic as people who may use substance as a form of avoidance coping may experience an increase in substance use issues and mental health issues in the future (Ullman, Relyea et al., 2013).

5.7.1. Self-stigma of seeking help for mental distress

The students in this study employed positive help-seeking behaviours, with most students showing very little self-stigma of seeking help. This is evident by the fact that most students indicated strongly agree to an unchanged view of themselves, and an unchanged self-confidence. Even though most students indicated very little self-stigma for seeking help, a high percentage of 15.5% and 22% of students (strongly agree and agree) indicated that they would feel worse about themselves if they could not solve their own problems. This indicates that some of these students may feel as if they lack control over their lives or mental distress if they were to seek help, with many of these college students placing great value on self-reliance and independence (Talebi et al., 2016). The preference for self-management by these college students can contribute to their stigma associated with seeking professional help (Talebi et al., 2016; Czyz et al., 2013). According to Czyz et al. (2013), most college students who sought help for their mental health problems had low stigma and positive beliefs about help-seeking.

5.7.2. Mental distress and gender differences regarding SSOSH

According to Wynaden et al. (2013), students with a lack of knowledge about help-seeking, negative attitudes toward help-seeking, and the need to protect the family reputation by not seeking help, may have an increased self-stigma of seeking help which could result in the increase in mental distress. However there seems to be no significant difference between mental distress and self-stigma of seeking help among this sample of students. A possible explanation for this could be because this sample composed of psychology students. The fact that these students are interested in mental health and mental health promotion, and are educated on the importance of help-seeking, could result in their being no significant relationship between them experiencing mental distress and their self-stigma of seeking help (Talebi et al., 2016).

Another possible explanation is the fact that negative coping is associated with the increase in mental distress of these students instead of stigma of seeking help (Aebi et al., 2014). Findings also suggest that stigma is correlated with several social issues such as poverty, social isolation, poor educational attainment, and poor physical health (Bates & Stickley, 2013). This could indicate that the self-stigma of seeking help may not be related to mental distress, but instead be related to social problems.

Even though it is widely believed that people with less self-stigma of seeking help are more likely to seek help we cannot conclude that the lack of significant relationship between distress and self-stigma of seeking help indicates that students with increased distress and less help seeking stigma will be likely to seek help. Research by Ward et al. (2013) found that African Americans had positive attitudes toward help-seeking, however it was also determined that the lack of self-stigma of seeking help did not indicate their help-seeking behaviour.

The findings suggest that there is a significant difference between gender and stigma. It was found that males had more self-stigma of seeking help for mental distress than females. The present findings are consistent with research by Deasy et al. (2014), which show that females tend to seek social support for their distress more frequently than males. A study by Talebi et al. (2016) also found that males report more self-stigma of seeking help than females. A possible reason for males being less likely to seek emotional or psychological support is due to the fact that they are taught to avoid verbal expression of their emotions and feelings in

order to appear strong (Basterfield et al., 2014). Many men may have high self-stigma of seeking help due to their views on experiencing or accepting mental distress as an indication of weakness or lack of inner strength, which in turn can result in them being reluctant to seek help for their distress (Ward et al., 2013).

5.7.3. Substance use and self-stigma of seeking help

The findings suggest that there is no significant difference between substance use (current cigarette use, current alcohol use, current drug use) and self-stigma of seeking help. This indicates that substance use may unlikely increase self-stigma of seeking help. It is possible that some students with an increase in substance use may not have self-stigma of seeking help but may also not seek help (Ward et al., 2013). Another possibility could be that self-stigma of seeking help may be due to their substance use rather than their distress; this can be explained by the fact that in many societies, substance use is moralised and self-stigmatizing attitudes are accepted, with many using substances as a form of self-medication (Ward et al., 2013; Kulesza, Larimer, & Rao, 2013).

5.8. The relationship between mental distress, coping, and self-stigma of seeking help

Increases in mental distress lead to a decrease in positive coping and increase in negative coping. This is consistent with research done by Julal (2013) that found that reflective coping is negatively correlated with mental distress and reactive and suppressive coping is positively correlated with distress. It is reported that those students who employ ineffective problem-focused coping styles or dispositional ways of coping have a higher likelihood of reporting mental distress (Julal, 2013).

These findings could be due to the fact that many people faced with mental distress tend to also use negative coping such as disengagement coping strategies in an attempt to reduce their distress, which does not address the issue or existence of the threat or its eventual impact. It is also possible that these students are more likely to use more emotion focussed coping behaviours and less problem focussed coping behaviours to deal with their distress (Nielsen & Knardahl, 2014). For many, social support is a critical resource for effective coping; therefore reduced perceptions of support may result in these students employing negative coping strategies such as emotion focused coping rather than positive coping such as problem focused coping behaviours (Talebi et al., 2016). Some students may also use escape

avoidance, denial, or self-controlling coping strategies to deal with their distress resulting in an increase in their distress due to these negative coping behaviours (Deasy et al., 2014).

There seemed to be no significant relationship between mental distress and self-stigma of seeking help. However, it was found that as self-stigma of seeking help increased, positive coping decreased, and negative coping increased. Therefore, it is possible that students with an increased self-stigma of seeking help employ negative coping behaviours instead of seeking professional help for their distress, which in turn results in their increased levels of distress. Findings by Talebi et al. (2016) indicate that depressed students are more prone to adopt coping strategies that exacerbate self-stigma of seeking help.

Some students with increased self-stigma of seeking help may employ negative coping due to the lack of access or availability to proper mental help care, and poor quality of mental health care, which governs their stigma of seeking-help and results in them using ineffective coping strategies to deal with their distress (Ward et al., 2013). The use of ineffective coping strategies could in turn result in an increase in mental distress among these students. Another possible explanation could be that increased mental distress could be associated with a lack of social support, and family responses to mental distress resulting in increased self-stigmatizing help-seeking attitudes which in turn results in an increase in negative coping (Talebi et al., 2016; Crowe & Lyness, 2014).

5.9. Predictors of mental distress among university students

The best predictors of distress were negative coping, self-stigma of seeking help, and current drug use, with a 20% variance explaining mental distress. The findings of this study indicate that students who employ negative coping, have self-stigma of seeking help, and use drugs have a 20% likelihood of experiencing mental distress. However, it was found that negative coping made the most significantly unique contribution to predicting mental distress while self-stigma of seeking help and current drug use made less of a unique contribution to predicting distress. This may be due to an overlap between self-stigma and current drug use in this model (Pallant, 2013).

Studies show that drug use is associated with various mental health problems, with cannabis use having a negative influence on cognitive performance, memory, and achievement motivation of college students (Olashore et al., 2018; Pedrelli et al., 2015). Previous research found that students with increased self-stigma of seeking help are more likely to have

increased mental distress due to their reluctance to seek professional help for their distress by employing ineffective coping strategies, resulting in an unchanged distress or increase in distress (Talebi et al., 2016; Julal, 2013). It is possible that the interaction of both self-stigma of seeking help and drug use by these students could result in students increase in distress. Many students may have self-stigma of seeking help that prevents them from receiving treatment for their distress, resulting in them engaging in risky behaviours such as drug use in an attempt to reduce their distress; this ineffective coping strategy may instead lead to the increase in their mental distress (Asante et al., 2015).

Negative coping seems to be significantly related to mental distress among these students. Research has found that students who employ negative coping, such as avoidant coping behaviours, are at a greater risk of experiencing increased levels of distress (Deasy et al., 2014; Aebi et al., 2014). Students who employ negative coping strategies are more likely to have poor school, work and social relationships which in turn impact their distress (Aebi et al., 2014). Students have been reported to employ a variety of negative coping strategies such as risky sexual behaviours, substance use, and poor dietary habits to deal with their distress instead of employing proper help-seeking behaviour as a form of effective coping (Basterfield et al., 2014). The increase of negative coping among students experiencing mental distress can also be due to the lack of support or the self and social stigma associated with mental distress that influence the lack of help seeking and use of negative coping (Talebi et al., 2016).

The best demographic predictor of distress is having enough money to save for luxuries, with a 0.1% variance explaining mental distress. This indicates that those students from higher income households have a 0.1% likelihood of reporting more distress. Even though having enough money to save and for luxuries was the best demographic predictor of mental distress, it did not make a significant unique contribution to predicting mental distress (Pallant, 2013).

Various research studies have shown that people from lower economic household situations are more likely to have mental distress due to the immense financial anxiety and household debt that they face (Sweet, Nandi, Adam, & McDade, 2013; Archuleta, Dale, & Spann, 2013). Students from low income households tend to have higher levels of stress due to the costs of living, college fees, cost of food and financial debt and uncertainty (Archuleta et al., 2013).

This study however found that people from higher income households tended to report more distress. This could be due to higher income households having enough money to spend but a lack of family satisfaction and emotional closeness, and a change in the family environment resulting in distress such as depression and isolation (Crowe & Lyness, 2014). The findings could also be due to the influences of western culture, whereby those from wealthy households are more likely to be exposed to westernization resulting in them experiencing more distress. Another possibility could be the fact that people from higher income households tend to have money for luxuries such as new technology which results in them being more likely to have an increased screen time and social media and internet usage; this has reportedly been linked to the increase in mental distress (Bor et al., 2014; Arbour-Nicitopoulos et al., 2012).

5.10. Substance Use explained by Ajzen's Theory of Planned Behaviour

Attitude: The student's attitude toward substance use was explained by their lifetime and current substance use. With a high prevalence of lifetime and current substance use, specifically lifetime and current alcohol use, it is evident that these students have positive attitudes toward substance use. Most students could therefore be reluctant to perceiving their alcohol use as being problematic (Czyz et al., 2013).

Subjective norms: For many students, their alcohol use contributed to the subjective norms of their parents and peers. With most of the students who had a lifetime alcohol use having parents who consumed alcohol, and most students with both lifetime and current alcohol use having peers who consumed alcohol. This also indicates that these university students' parents and, peers especially played a huge role in eliciting the subjective norms of the acceptability of alcohol consumption (Boyd et al., 2014).

Perceived behavioural control: Many students from this sample lacked the perceived behavioural control over their alcohol use as a high prevalence of students currently consumes alcohol. One student completely lacked perceived behavioural control over their alcohol use as the student reported currently consuming alcohol daily. Nine students lacked a perceived behavioural control in regard to cigarette use as they indicated smoking cigarettes daily.

Intention: This lack of perceived behavioural control from this sample of students resulted in their intention to consume alcohol. This high prevalence of lifetime alcohol use and current

alcohol use among these university students indicates that their intention to use alcohol may persist into future alcohol use. Many students also continued to use cigarettes and other substances, indicating their behavioural intention not to quit using substances.

5.11. Help-seeking explained by Ajzen's Theory of Planned Behaviour

Attitude: The university student's attitude toward help-seeking was explained by their self-stigma of seeking help, meaning that if students reported a high self-stigma of seeking help, they would likely have low help-seeking behaviours. It was found that self-stigma of seeking help seemed to be one of the best predictors of mental distress in the future. In addition to perceived stigma toward help-seeking, these students may also have negative attitudes towards help-seeking and poor education about effective forms of help-seeking (Wynaden et al., 2013).

Subjective norms: According to Talebi et al. (2016), social stigma could contribute to a person's self-stigma of seeking help. Therefore, it is evident that the subjective norms influencing the social stigma associated with mental health and help-seeking tend to make students more vulnerable to self-stigma of seeking help, and in turn more reluctant to help-seeking.

Perceived behavioural control: The fact that a lot of students indicated that they felt worse if they could not solve their problems on their own, is an indication of help-seeking behaviours being influenced by the student's perceived lack of control over their mental distress. As those students who felt that they had control over their mental distress are more likely to seek professional help, whereas those students who felt that they lacked control over their mental distress are less likely to seek help and more likely to have self-stigma of seeking help (Talebi et al., 2016).

Intention: The lack of perceived behavioural control from this sample of students resulted in their self-stigma of seeking help being positively correlated with negative coping, resulting in the intention not to seek help and engage in negative coping behaviours instead. However, with less self-stigma of seeking help being reported from the prevalence of the individual item analyses, it is possible that the student's intention to seek help in the future may increase (Lally et al., 2013).

5.12. Mental distress explained by Bronfenbrenner's Ecological Model

Intrapersonal level: There are multiple biological and psychological influences of mental distress at an intrapersonal level. This sample reported high levels of mental distress, which could be attributed to their biological history of mental distress with a possible history of mental illnesses in the family explaining these students' current mental health issues (Bor et al., 2014). Even though the genetic history of mental distress was not examined in this study, it was discovered that age and gender do not directly influence mental distress among these psychology students.

It was found that most of these students between the ages of 17-26 reported extreme psychological distress scores of 30 and above. This sample of psychology students reported frequent distress for distress items that were common with symptoms of depression, indicating that depression could be a possible psychological influence of the high levels of psychological distress reported among this group of university students (Austin et al., 2012).

Interpersonal level: There are multiple social and cultural influences of mental distress within the interpersonal level. Seeing that this sample of students are university students, a social influence of their mental distress could be due to the immense social stress they experience from home, university, and the social pressures associated with young adulthood (Pedrelli et al., 2015). These students increased internet and social media exposure could also contribute to their mental distress (Bor et al., 2014). For many, being a psychology student may also result in added expectations and perceptions toward mental distress, resulting in higher levels of mental distress due to their reluctance to seek help and having to admit a lack of control over their mental health. The social and cultural stigma associated with mental distress and help-seeking could also contribute to these individuals increased levels of mental distress (Talebi et al., 2016).

Community level: The community and the public policy can play a huge role in the influence of mental distress among university students. It is a possibility that many of these students are not exposed to an environment and policies that promote mental health. A lack of proper exposure to mental health education, cost effective help-seeking facilities, and public policies addressing mental health stigma could influence the rate of mental distress among university students.

5.13. Chapter Summary

This chapter discussed the findings obtained from the study and found consistencies with a variety of past literature. This group of students were found to have very high psychological distress, with alcohol being the most widely used substance among this population and parental and peer alcohol use contributing to student's risky alcohol behaviour. The theory of planned behaviour and ecological model was also used in explaining the findings obtained.

CHAPTER SIX: LIMITATIONS, RECOMMENTATIONS, AND CONCLUSION

6.1. Introduction

This chapter will look at the strengths and limitations, followed by future recommendations of the study. The strengths and limitations of the study will assist future researchers on how they could improve the study. The recommendations for the study will provide suggestions for future research as well as possible interventions that could be employed to improve the issue of mental distress, substance use, poor coping, and poor help-seeking among university students, in the future. The chapter then ends with a conclusion of the research study report.

6.2. Strengths and Limitations of the study

A big advantage to this study was that it consisted of a large sample of 200 participants with an acceptable response rate and no missing values. The fact that an online survey was used was a strength as it was cost effective, easy and quick to use, resulting in the acceptable response rate. However, even though the response rate was acceptable, the response time was much longer than it would have been for paper-based surveys.

The fact that the study consisted of a diverse population of students was also an advantage. Considering that the study used self-reported questionnaires was a strength, as students were able to respond to questions based on themselves, maintaining the accuracy of the responses, as no one knows yourself better than you do. Although the study had many strengths, there were however some limitations.

The first limitation to this study is the fact that it had a big sample size with big differences in the demographic characteristics such as age group, gender sample sizes, and year of study. With the demographic samples not being similar in size, a possible limitation could be the fact that generalisations were made across demographic groups as some groups were much smaller than others. Furthermore, the study only used psychology students at the University of Kwa-Zulu Natal and could therefore not be generalised to the wider population of university students or psychology students (Neuman, 2014). The fact that this study uses a cross-sectional survey method, limits its generalisability. This makes it difficult to infer the

cause-effect relationship between the variables and outcome of the study (Basterfield et al., 2014).

The second limitation to this study could be due to respondent recall, with many people finding it difficult to recall certain events such as past substance use, mental distress, and coping behaviour. However, the furthest the students had to recall was for a month across all scales used (Neuman, 2014). For the substance use scale, item 5 (See Appendix D) was ignored due to possible respondent recall limitations.

The third limitation is the fact that there is no way to verify the honesty of the responses, as all responses were self-reported and there is a possibility of response bias affecting the credibility of the findings. Some may have also been reluctant to answer all questions honestly, by under reporting issues that were sensitive to them in order to protect their positive self-image and ego. There is also a possibility of participant bias, whereby the participants may have responded the way they assume the researcher may want them too, having known what the study entails (Neuman, 2014).

The fourth limitation is the possibility of social desirability bias, as some students may have responded to questions regarding their mental distress, substance use, coping and self-stigma of seeking help in relation to the social norms governed by their psychology class, family, or the wider community in which they live. Seeing that an online survey was used, there is a possibility that these surveys were answered with friends, which could result in social desirability bias (Neuman, 2014).

6.3. Recommendations for the future

This study helps us understand mental distress and substance abuse of university students as well as their coping and help-seeking behaviours and attitudes, however there is still a need to further research around this area of study in the South African perceptive. Even though the study obtained a large sample, it is recommended that a larger sample size be used for more reliable results, and considering the use of a quota sampling method according to demographic characteristics in order to accurately compare the relationships between the different demographics on mental distress and substance use. A mixed method study is also recommended in the future in order to provide both numerical data and a more indebt understanding of the factors related to mental distress and substance use as well as the barriers preventing many students from seeking help (Neuman, 2014).

This study only focussed on psychology students. It is possible that psychology students being exposes to mental health and help-seeking education and promotion may have impacted the findings of the study. It is recommended that future studies focus on more diverse student populations in order to address generalisability issues.

Seeing that student's mental distress was high, there is a possibility of lack of education on the importance of help-seeking as well as self and public stigma that provides a barrier to help-seeking. There therefore needs to be interventions in place to improve the public's knowledge on mental distress and the benefits of help-seeking in an effort to change the negative attitudes and beliefs toward mental distress and help-seeking. This can also be beneficial in helping students recognise their distress and when it warrants help-seeking (Choi, DiNitto, & Marti, 2014).

One of the main barriers to help seeking may be due to the cost of help-seeking. Seeing that these are students, they may be reluctant to seek help due to the lack of affordability. Most universities provide social support to students free of charge, however many are not aware of the availability of these resources, it is therefore essential that these resources are brought to the knowledge of all students in the form of posters or pamphlets, creating awareness of the resources available by these institutions (Julal, 2013). It is also recommended that students be provided with no-cost resources either through online support, telephone support services, or self-management programs, which can assist them with their mental distress and substance abuse problems (Choi et al., 2014).

Seeing that alcohol seemed to be the most widely used substance among this population of university students, there should be health promoting programs and policies put in place to reduce college student's alcohol consumption. The university institutions may also use anti-alcohol campaigns to help reduce the prevalence of alcohol use among its students and increase security and campus legislations to ensure that there is no alcohol consumption within the premises of the university or student accommodations (Balogun et al., 2014).

Peer and parent alcohol use seems to influence student's alcohol use. Longitudinal studies can help us better understand the lasting effects of peer and parental influences on alcohol use as students leave their homes or exit university (Schwinn & Schinke, 2014). Family based interventions are therefore required to increase university student's self-efficacy to abstain for consuming alcohol; through family support and focusing on improving parent-child relationships with the aim of reducing or preventing alcohol use (Balogun et al., 2014). This

study focuses on parental and peer alcohol use; however, additional variables should be researched in the future, such as the influence of family and peer attitudes toward alcohol use, parent support, parent-child relationships, and parent monitoring and communication should be researched in the future (Boyd et al., 2014).

It is recommended that the universities employ interventions promotion positive coping strategies that can assist students in coping with distress and substance use. More importantly, these interventions should educate individuals on the most effective and adaptive coping strategies they could employ, as not all coping strategies are beneficial to this particular population and are effective for mental distress or substance abuse (Basterfield et al., 2014).

Lastly interventions used should be based on what would be most effective among this population or would be more likely to have a higher success rate. Seeing that this population consists of university students, the use of 21st century approaches such as the use of technology can be greatly beneficial to this population. One such intervention that has been proven to be effective is the mobile phone intervention to monitor and provide support to those suffering from mental distress and substance abuse through mobile phone text messaging. This intervention could be effective, feasible and easily accessible as many students possess mobile phones (Sharma & Bennett, 2015).

6.4. Conclusion

The aim of this study was to understand the mental distress, coping, help-seeking behaviours and substance abuse of psychology students at the University of Kwa-Zulu Natal. In doing so we were able to discover the relationship between mental distress and substance use, as well as the coping behaviours used by students and their self-stigma of seeking help that affects their help-seeking behaviours. The findings indicated a high prevalence of mental distress as well as alcohol use among this group of university students. It was found that there was no significant relationship between mental distress and substance use, however there was a significant relationship between mental distress and negative coping behaviours. This high prevalence is a huge concern as it can affect student academic and social success as well as lead to the long-term effects of mental distress debilitating these students' health and well-being.

It was also found that there was a relationship between parental and student lifetime alcohol use as well as peer and student lifetime and current alcohol use. This is concerning as students tend to hold great importance to peer and parent acceptance, they do so by mimicking their peer and parents alcohol behaviour which puts them at a huge risk for future alcohol related problems (Boyd et al., 2014). It is important to address this issue and change the narratives about the acceptability of alcohol use, especially among family settings and peer groups.

The increased frequency of alcohol use by students, peers and parents is an indication that alcohol is becoming more accessible and affordable in South Africa. This is very problematic and could be due to the media and societies narratives around alcohol consumption, which indicates a need for better alcohol policies in South Africa especially around the media's influence on alcohol consumption (Bao Giang et al., 2013).

Students tended to use negative coping to deal with their mental distress and reported high levels of self-stigma due to their negative coping behaviours. This could indicate low help-seeking for their mental distress. The fact that many students are unaware of effective coping strategies is very problematic as it contributes to the prolonged distress faced by many students (Talebi et al., 2016). In addition, there is a lot of stigma associated with mental distress that still needs to be addressed, most of the stigma around mental distress comes from the society and often influence the self-stigma of seeking help by students (Bates & Stickley, 2013). With more students becoming reluctant to seek help for their distress, distress becomes more prevalent among this population. It is important to promote proper coping and help-seeking behaviours to university students in order to curb this growing issue and reduce or prevent mental distress among college students going unnoticed or untreated.

The gender differences regarding self-stigma of seeking help is also very problematic. Seeing that males seem to have more self-stigma of seeking help, there is a need to break the barriers that may contribute to males stigmatizing attitudes. It is possible that culture and societal norms play a huge role on men's views on help-seeking, therefore it is essential to change the narratives that seeking help indicates weakness and to promote help-seeking (Basterfield et al., 2014). The media should also consider using male figures in the promotion of help-seeking in an attempt to demolish stigma of seeking help among males.

The correlation between stigma of seeking help and negative coping could result in poor help seeking behaviour. This could indicate that these students reluctance to seek help for their

distress may be due to them being more concerned about the short term benefits of their negative coping behaviours in relieving their distress and are possibly unaware of the long term dangers of their negatively coping with their distress instead of seeking professional help.

There is a need for future research, especially within the South African context, in order to create awareness on mental distress among the youth, the dangers of substance use, and the importance of proper coping and help-seeking behaviours. In addition to future research, the wider social, economic, and political factors need to change in order to improve the current issues of mental distress and substance use among university students. Proper interventions need to be put in place in order to help curb this growing concern of mental distress and substance use, specifically alcohol use among South African university students. In implementing such interventions, a needs analysis needs to be done at each university in order to provide effective interventions for the particular population as students from different universities may face different issues and be influenced by different factors. With university students being a very vulnerable group, these issues need to be addressed before they persist into late adulthood and become more serious.

6.5. Chapter Summary

This chapter addressed the many strengths and limitations of this study. It also discussed recommendations for the future that could not only improve the study results but also help curb the growing problem through suggested interventions. The chapter then concluded by touching on the concerns of the findings and the need for future research, awareness, and effective solutions within the South African context.

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APPENDIX A

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

24 August 2018

Deantha Pather (SN 214530673)
School of Applied Human Sciences
College of Humanities
Howard College Campus
UKZN
Email: meyerweitza@ukzn.ac.za

Dear Deantha

RE: PERMISSION TO CONDUCT RESEARCH

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

"Understanding mental distress, coping, help-seeking behaviours and substance abuse of university students."

It is noted that you will be constituting your sample by handing out questionnaires to students on the Howard College campus.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book. Identity numbers and email addresses of individuals are not a matter of public record and are protected according to Section 14 of the South African Constitution, as well as the Protection of Public Information Act. For the release of such information over to yourself for research purposes, the University of KwaZulu-Natal will need express consent from the relevant data subjects. Data collected must be treated with due confidentiality and anonymity.

Yours sincerely

MR SS MOKOENA
REGISTRAR

Office of the Registrar
Postal Address: Private Bag X54001, Durban, South Africa
Telephone: +27 (0) 31 260 8035/2206 **Facsimile:** +27 (0) 31 260 7824/2204 **Email:** registrar@ukzn.ac.za
Website: www.ukzn.ac.za

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APPENDIX B

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

24 October 2018

Ms Deantha Pather 214530673
School of Applied Human Sciences – Psychology
Howard College Campus

Dear Ms Pather

Reference number: HSS/1564/018M
Project title: Understanding the mental distress, coping, help-seeking behaviours and substance abuse of psychology students.

Full Approval - Full Committee Reviewed Application
With regards to your response received on 05 October 2018 to our letter of 28 September 2018, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully
.....
Prof S Singh

/px

cc Supervisor: Prof Anna Meyer-Weitz
cc Academic Leader Research: Dr Maud Mthembu
cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee
Professor Shenuka Singh (Chair)/Dr Shamila Naidoo (Deputy Chair)
Westville Campus, Govan Mbeki Building
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APPENDIX C

Information Sheet and Participant Informed Consent

School of Applied Human Sciences – Psychology

Research Topic: Understanding mental distress, coping, help-seeking behaviours and substance abuse of psychology students

Dear Participant

My name is Deantha Pather and I am Health Promotion masters student in the School of Applied Human Science, Discipline Psychology, Howard Campus, University of KwaZulu-Natal. I am conducting research as part of my Health Promotion Master's degree. My supervisor if Prof. Anna Meyer-Weitz, in the School of Applied Human Sciences, Discipline of Psychology at the University of KwaZulu-Natal. The study will aim to understand the coping, help-seeking behaviours and substance use of university students experiencing mental distress. You have been identified as a possible participant for the research as you are a student in UKZN.

Participation in the study is completely **voluntary** and you are allowed to withdraw from the study at any time. Refusal to participate in the study, or withdrawal from the study, will involve no penalty or loss. Participants will not be asked to provide their name and all information you provide will be kept **confidential and anonymous**. If at any point of the study, a participant should experience distress, they may seek support from the student counselling at UKZN as they are aware of my study.The findings will be used for research purposes and might be published.

The results obtained from your participation in this study will increase your understanding of mental distress and substance abuse among university students; with the goal of altering the future trajectory of mental distress and substance abuse as well as the coping behaviour and help-seeking behaviour of university students, assisting in the prevention thereof. The results from this survey will also inform counselling services of the outcome and help provide a guideline for future interventions.

Ethical Clearance has been obtained from the Humanities and Social Science Research Committee of the University of KwaZulu-Natal. You may also make contact with the Research Office if you so wish.

HSSREC Research Office

P. Mohun

Contact Details:

Phone number: +27 31 260 4557

Email: mohunp@ukzn.ac.za

For any further information please feel free to contact the researcher or supervisor of the study.

Kind Regards

Deantha Pather

Contact details of Researcher

Deantha Pather
0780099819
Email: deantha95@gmail.com

Supervisor

Prof. Anna Meyer-Weitz (PhD)
SAHS, Psychology, Howard College
University of KwaZulu-Natal

Email: meyerweitza@ukzn.ac.za

Tel: 031 260 7618

Declaration of Informed Consent

- I have been informed about the nature, purpose and procedures for the study: Mental distress, coping, help-seeking behaviours and substance abuse of psychology students.

- I have also received, read and understood the written information about the study. I understand everything that has been explained to me and I consent to take part in the study.

- I understand that I am free to withdraw from the research at any time, should I so desire. The information that I provide will be anonymous and confidential and only be used for research purposes.

Participant:

_____

Signature Date

APPENDIX D

RESEARCH QUESTIONNAIRE

Introduction

Thank you for your willingness to participate in this research study. The success of the research depends on you answering the questions as **honestly** as possible. This questionnaire has four parts and you are requested to read each question carefully and follow the instructions in each section as they differ.

Instructions: Please mark the correct option by using a ✓ (tick)

Section A: Demographic information

Please provide your answer in the given space (tick on the number of your choice).

1. Gender

Male	1
Female	2

2. Age

3. Race

Black	1
Indian	2
White	3
Coloured	4
Other, Specify:	5

4. Year of study

First year	1
Second year	2
Third year	3
Fourth year	4

5. Where do you stay

With Parent(s)/Family	1
UKZN Residence on campus	2
Residence off campus	3
Rent or share accommodation	4
With others	5

6. Which one of the following statements best describes your household situation? (*Mark only one*)

1	Not enough money for basic things like food, clothes	1
2	Have money for food and clothes but short on many other things	2
3	We have the basics but not enough money for expensive items	3
4	Have money to save or buy expensive things	4
5	Other (specify) :	5

Section B: K10

Instructions: These questions concern how you have been feeling over the past 30 days. You will rate this from None of the time=1, A little of the time=2, Some of the time =3, Most of the time =4 and All of the time = 5. Please tick (✓) a box next to each question that best represents how you have been in the past 30 days.

In the past 30 days:	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
1. How often did you feel tired out for no good reason?	1	2	3	4	5
2. How often did you feel nervous?	1	2	3	4	5
3. How often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. How often did you feel hopeless?	1	2	3	4	5
5. How often did you feel restless or fidgety?	1	2	3	4	5
6. How often did you feel so restless you could not sit still?	1	2	3	4	5
7. How often did you feel depressed?	1	2	3	4	5
8. How often did you feel that everything was an effort?	1	2	3	4	5
9. How often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. How often did you feel worthless	1	2	3	4	5

Section C: BCS

Instructions: These questions concern how you cope with stressful experiences. You will rate this from I haven't been doing this at all=1, I've been doing this a little bit=2, I've been doing this a medium amount=3, and I've been doing this a lot=4. Please tick (✓) a box next to each question that best represents how you cope with stressful experiences.

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1. ACTIVE COPING				
I've been concentrating my efforts on doing something about the situation I'm in.	1	2	3	4
I've been taking action to try to make the situation better.	1	2	3	4
2. PLANNING				
I've been trying to come up with a strategy about what to do.	1	2	3	4
I've been thinking hard about what steps to take.	1	2	3	4
3. POSITIVE REFRAMING				
I've been trying to see it in a different light, to make it seem more positive.	1	2	3	4
I've been getting comfort and understanding from someone.	1	2	3	4
4. ACCEPTANCE				
I've been accepting the reality of the fact that it has happened.	1	2	3	4
I've been learning to live with it.	1	2	3	4

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
5. HUMOUR				
I've been making jokes about it.	1	2	3	4
I've been making fun of the situation.	1	2	3	4
6. RELIGION				
I've been trying to find comfort in my religion or spiritual beliefs.	1	2	3	4
I've been praying or meditating.	1	2	3	4
7. USING EMOTIONAL SUPPORT				
I've been getting emotional support from others.	1	2	3	4
I've been getting comfort and understanding from someone.	1	2	3	4
8. USING INSTRUMENTAL SUPPORT				
I've been trying to get advice or help from other people about what to do.	1	2	3	4
I've been getting help and advice from other people.	1	2	3	4
9. SELF DISTRACTION				
I've been turning to work or other activities to take my mind off things.	1	2	3	4
I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.	1	2	3	4

	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
10. DENIAL				
I've been saying to myself "this isn't real".	1	2	3	4
I've been refusing to believe that it has happened.	1	2	3	4
11. VENTING				
I've been saying things to let my unpleasant feelings escape.	1	2	3	4
I've been expressing my negative feelings.	1	2	3	4
12. SUBSTANCE USE				
I've been using alcohol or other drugs to make myself feel better	1	2	3	4
I've been using alcohol or other drugs to help me get through it.	1	2	3	4
13. SELF-BLAME				
I've been criticizing myself.	1	2	3	4
I've been blaming myself for things that happened.	1	2	3	4

Section D: SSOSH

Instructions: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

Please indicate your response to each question with a ✓ (tick)

	Strongly Disagree	Disagree	Agree and Disagree Equally	Agree	Strongly Agree
1. I would feel inadequate if I went to a therapist for psychological help	1	2	3	4	5
2. My self-confidence would NOT be threatened if I sought professional help	1	2	3	4	5
3. Seeking psychological help would make me feel less intelligent	1	2	3	4	5
4. My self-esteem would increase if I talked to a therapist	1	2	3	4	5
5. My view of myself would not change just because I made the choice to see a therapist.	1	2	3	4	5
6. It would make me feel inferior to ask a therapist for help.	1	2	3	4	5
7. I would feel okay about myself if I made the choice to seek professional help.	1	2	3	4	5
8. If I went to a therapist, I would be less satisfied with myself.	1	2	3	4	5
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.	1	2	3	4	5
10. I would feel worse about myself if I could not solve my own problems	1	2	3	4	5

Section E: Substance Use

Instructions: This questionnaire consists of questions about your experience with substances. Please indicate your response to each question with a ✓ (tick)

1. Have you ever smoked a cigarette?

- ☐ Yes
- ☐ No

2. How often have you smoked cigarettes in the past month?

- ☐ Never
- ☐ Sometimes
- ☐ Everyday

3. Have you ever drunk an alcoholic beverage?

- ☐ Yes
- ☐ No

4. How often have you drunk alcohol in the past month?

- ☐ Never
- ☐ Sometimes
- ☐ Everyday

5. Over the past 12 months, how many times did you drink roughly five or more drinks?

☐

6. Have you ever used any drug or substance in your life?

- ☐ Yes
- ☐ No

7. If yes, tick below the drugs you have ever used:

- ☐ Marijuana (Dagga, Weed, Dope, Gunja, Cannabis, Doobie, Mary J)
- ☐ Glue
- ☐ Mandrax (Buttons, MX, White Pipe)
- ☐ Whoonga, Nyaope
- ☐ Ecstasy ("E", MDMA, "X", Beans, Candy, Disco Biscuits, Molly)
- ☐ Crack/Cocaine (Coke, Rock, Sugar, Blow, Bubble-gum, Crackers)
- ☐ Crystal Meth (Tik, "Crystal", "Meth", Ice)
- ☐ Heroine (H, Smack, Brown Sugar)
- ☐ I have not used drugs

8. Have you used a drug in the past month?

- ☐ Yes
- ☐ No

9. How many of your friends smoke cigarettes?

- ☐ None of them
- ☐ Few of them
- ☐ Some of them
- ☐ Most of them
- ☐ All of them

10. How many of your friends drink alcohol?

- ☐ None of them
- ☐ Few of them
- ☐ Some of them
- ☐ Most of them
- ☐ All of them

11. How many of your friends use substances?

- ☐ None of them
- ☐ Few of them
- ☐ Some of them
- ☐ Most of them
- ☐ All of them

12. Do your parents or guardians smoke cigarettes?

- ☐ Yes
- ☐ No

13. Do your parents/ guardians drink alcohol?

- ☐ Yes
- ☐ No

14. Have your parents/ guardians used substances?

- ☐ Yes
- ☐ No

THANK YOU FOR YOUR PARTICIPATION!