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States of Senslessness:

An exploratory study of the social representations of ‘ukuhlanya’ (mental illness)

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ABSTRACT

This study aims to illustrate the manner in which the rural youth from KwaZulu-Natal view mental illness (‘*ukuhlanya’*). The study was embarked upon in order to expand on the available literature regarding the opinions of the youth about mental illness within rural Southern Africa. Literature on mental illness within Southern Africa has traditionally lacked focus on the rural youth, hence this study aims to investigate mental health and the opinions held on it within this particular group of people. The study was conducted on youth aged between 13 and 18 from the area of KwaNyuswa, Hillcrest. The study was adapted according to De Rosa’s 1987 study, whereby the participants drew pictorial representations of mentally ill individuals and engaged in semi-structured interviews. The findings of the study illustrate that the social representations of the youth in rural KwaZulu-Natal are underpinned by their educational and cultural backgrounds and the communities which they live in. The findings indicated that the African model of understanding mental illness is still present but in the case of the youth, it is coupled with higher literacy levels, thus, making the youth more sympathetic towards mentally ill individuals than their older counter parts. The study has offered insight into where the youth in rural KwaZulu-Natal are positioned in terms of understanding mental illness and what their views, values and practices towards mental health are. These findings can be used to promote healthy dialogue about mental illness at school level and in so doing, create greater awareness of mental health issues. In turn this will foster better mental health amongst the youth. The study is limited in that the sample was relatively small and from only one area, thus, the findings cannot be generalised across cultures or geographical areas.

CHAPTER ONE

INTRODUCTION

There has been much interest in Africa regarding mental illness and in attempting to transform the thinking around the promotion and prevention of mental health, especially within South Africa. In the last decade there has been extensive research into traditional healers, the African understanding of illness and the attitudes and views on mental illness within African communities. Several studies have investigated adults, community's traditional healers, University students and the like in relation to mental illness. South Africa's scarcity in literature reviewing perceptions and attitudes regarding mental illness are concentrated to specific mental disorders and population groupings. The present literature focuses on communities, and looks at the attitudes and perceptions expressed by community members regarding mental illness (Hugo et al, 2003). The present studies, indicate that few attempts have been made to look at the attitudes of the youth in rural South Africa – those born into a Democratic South Africa with significantly changed structures in dealing with mental health. The purpose of this study was to add literature and begin to explore the social representations of the youth from rural KwaZulu-Natal. This was done through ascertaining the opinions and experiences of the youth regarding mental illness, within their communities.

The thesis has been divided into five main sections. Chapter two reviews the existing literature and the context of mental health in South Africa from the early 1600s to the present day. Chapter three looks at the theoretical framework which is that of Social Representations Theory, the research aims and objectives, research design, data collection methods and instruments, data analysis techniques, dependability and credibility, limitations of the methodology and the ethical considerations of this study. Chapter four focuses on the discussion section, looking at integrating Social Representations Theory, the literature and the participant's narratives. The final chapter, chapter five is focused on concluding the study and discussing the findings and what these may imply for future research.

CHAPTER TWO

LITERATURE REVIEW

The South African population is one with vast differences, cultures, beliefs and opinions; it is widely known that within South Africa there are beliefs of traditional medicine and traditional explanations for occurrences such as ‘‘ukuhlanya’’ – mental illness. Thus further research will shed light on the belief systems of the representations of ‘‘ukuhlanya’’ by young individuals in South Africa.

Background of mental health in South Africa

Psychiatry in South Africa has been rooted in models which are adopted from overseas. The psychiatric development has been in three phases, the first being that of restraint and convienince; the second is the hospicentric phase and the third is the current phase of the modern era.

In early South Africa the mentally ill were housed in rudimentary housing and as the numbers of in patients grew, so hospitals were constructed. Somerset Hospital was the first of its kind providing reserved beds for the mentally ill. Robben Island and Valkenberg Hospital were also utilized. The isssues of overcrowding within psychiatric hospitals is one that has plagued South Africa for centuries (Gillis, 2012)

In the community of health care practitioners, the mentally ill were treated based on race due to the apartheid regime at the time. The practitioners exercised no empathy for the mentally ill, often leaving them in foul conditions. The mentally ill were referred to as ‘insane’, ‘mad’ or ‘lunatic’ and were seen as being possessed (Gillis, 2012). During this time there was no clear understanding of mental illness as a disease. This understanding only came about towards the end of the eighteenth century (Gillis, 2012).

The world began to move away from institutionalisation during the 1950s – 1990s, however, this shift was circumvented in South Africa (Lund, 2014).

The hospicentric and curative system in South Africa in the ninethenth century brought about a change in the infrastructure of mental institutions, and new legislation came into effect. Empathy for the mentally ill within the psychiatric community was changing

in South Africa. The lack of effective treatments, the chronicity of mental illness and the lack of sources within South Africa were factors that contributed to the overcrowding of the institutions (Gillis, 2012). Community service and effective treatments have provided relief to the psychiatric hospitals overcrowding status (Gillis, 2012).

Modern Psychiatry

The arrival of the 20th century brought with it the publication of the Diagnostic Statistical Manual and the ICD and these books proved to be good guides for the understanding and diagnosing of mental disorders (Gillis, 2012).

During the 1930s treatment also evolved. One of the evolutions was electroconvulsive therapy; later in 1935 the electroconvulsive therapy was joined by treatments such as the induction of seizures (Gillis, 2012). Further treatments involved the production of hyperthermia and the introduction of intravenous insulin in order to bring about hypoglycaemic comas in order to effectively deal with schizophrenia. However, the results of these treatments proved discouraging, thus, these treatments were stopped in the 1960s (Gillis, 2012). Through time, and knowledge these methods also soon faded but not without leaving a mark on the mentally ill and South Africa as a whole.

Western Literature

In looking at literature from a Western perspective it can be found that de Rosa's (1987) study highlighted that madness still produced ancient, outlandish and inexplicable images of the mentally ill whilst also presenting modern and medicalised imagery amongst the children and adolescents of Italy. De Rosa's study correlated with Foucault's history of madness.

In Jodelet's (1991) study there were descriptions of how the community members had labelled and treated the mentally ill individuals. This, in turn, had an impact on how the images of mentally ill people altered the routines of the private and public lives of the community members. This study also shed light on how community members can establish and maintain mental and social distances from the mentally ill individuals

within the community. Furthermore, Jodelet's (1991) study illustrated that madness always depicts itself to be a threat to the constancy of daily living.

More recent studies such as Morant's (1995) study present evidence of the social representations of mental health care professionals. Morant's study indicated themes of otherness and sameness in how mental illness was socially represented. Morant's research indicated that the mentally ill possess varied experiences which cannot be understood by the "normal" people thus the mentally ill are considered as the "Others" Morant (1995).

A study done by Petrillo's in 1996 looking at media research of mental illness identified three topics regarding mental illness – it is a form of deviance or illness; it is an individual and a societal phenomenon; it is both a mental and organic illness. This study is in line with the European ideology of mental illness – common knowledge being underpinned by common sense and scientific knowledge.

Foster's (2001) study supported the argument made by Morant of mental illness as "Otherness". According to Foster the representation of the mentally ill also includes unpredictability, violence, permanency and the concept of the other as central features (Foster, 2001). Thus the concept of madness as "the other" or "Otherness" in society also falls in line with Foucault's statements of common knowledge of madness in Europe.

Through reading Western literature and Western based studies we can note that the concept of madness, that throughout the centuries has been given many names and definitions, has been a misunderstood concept (Narter, 2006). Madness has been at points considered evil or considered to be part of moral issues (Narter, 2006). In each of these understandings the social practices are noted as having influenced the variations imposed on mental illness (Narter, 2006). Whilst mental illness has been packaged and disseminated as an important disease to society it has, however, been impacted by modernity (Narter, 2006). Modernity has been part of the evolution of the human being, thus it has instituted the definition of the human being as a rational object. The ability of society to intellectualize reason has played a part in the redefinition of mental illness over the decades to where it presently stands (Narter, 2006).

Categories of mental illness (Diagnosis)

Mental illness in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) is categorised into clusters of disorders which share the same characteristics. In looking at the DSM-5, the diagnosis of Schizophrenia Spectrum and Other Psychotic Disorders, Bipolar and Related Disorders, Depressive Disorders and Substance/Medication-Induced Disorders will be looked at in relation to the present study. According to the DSM-5 changes, schizophrenia and the other psychotic disorders are now seen as being neuropsychiatric in that they possess genetic and clinical features which begin in the stages of development which are predictable (American Psychological Association, 2013).

The diagnosis of schizophrenia spectrum disorders and the other psychotic disorders is reported by the DSM-5 (2013) to be characterised by delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behaviour (including catatonia), and negative symptoms. Delusions are persecutory in nature in that the individual believes that he/she may be harmed by someone else or an organisation; referential delusions involve the individual believing that comments or gestures which occur around them are directed at them. The nature of grandiose delusions presents itself in an individual who believes that they are gifted with special talents, wealth or fame. Erotomanic delusions occur when an individual incorrectly believes that another individual is in love with them. The nature of nihilistic delusions involve the individual believing that there will be a major disaster. Somatic delusions by nature are when an individual is excessively worried about their health and their internal organs (American Psychological Association, 2013).

Hallucinations are described in the DSM-5 (2013) as “perception like experiences which present themselves without any external influence. Hallucinations appear clearly as though they are part of the person’s normal perceptions and they occur involuntarily”. The hallucinations occur through the senses namely: auditory hallucinations – the individual experiences this through hearing voices and it is the most common symptom within the schizophrenia spectrum. Visual hallucinations are characterised by the individual reporting seeing people that only he/she can see. Tactile hallucinations are when the individual feels like there is an object touching their

skin. The olfactory hallucinations are characterised by the individual smelling things that are not present and gustatory hallucinations are characterised by the individual tasting things (American Psychological Association, 2013).

Disorganized thinking (speech) is also a key feature in the DSM-5 (2013) this indicates that the individual has a tendency to derail from topics, in that he/she switches from topic to topic, they are tangential in their responses in that they respond to questions with unrelated topics.

The DSM-5 (2013) indicates that grossly disorganized or abnormal motor behaviour (including catatonia) are characterised by catatonic behaviour whereby the individual would behave in a manner that has decreased reactions to the environment around them such as holding rigid and strange positions; negativism is seen in the individuals resistance to instructions; mutism and stupor are the individuals lack of verbal and motor responses and catatonic excitement is the individuals purposeful and excessive motor activity (American Psychological Association, 2013).

Negative symptoms include the individual's lack of emotional expression in their face i.e. eye contact and so forth which would provide expression to speech. Avolition is the individual's lack of interest in participating in activities which are self-initiated. Alogia is the individuals reduced conversational levels. In Anhedonia the individual is unable to experience pleasure or remember previously pleasurable experiences and finally Asociality refers to the individual having a lack of interest towards interacting socially.

Bipolar and Related Disorders in the DSM-5 have been placed between schizophrenia spectrum disorders and depressive disorders as they possess genetic, aetiological factors and symptoms which bridge the gap between the two diagnoses (American Psychological Association, 2013).

Bipolar 1 Disorder is noted as possessing the following symptomology a manic episode in which the individual may be observed as being easily distractible, being excessively talkative, having racing thoughts which would be noted in their speech, taking risks and having an inflated sense of self, as well as not sleeping and psychomotor agitation. The individual would also experience a major depressive

episode in which he/she would be depressed, tired, lack interest in activities, they may have weight loss or gain, sleep more than usual or not sleep at all, consider suicide, feel worthless or guilty however this is unjustified, psychomotor agitation or retardation and have trouble concentrating. A hypomanic episode may also occur in which the individual may feel as though they don't need to sleep, they're talkative, have racing thoughts, they get distracted easily, and the individual may get involved in everything and have an increase in their goal directed activities (American Psychological Association, 2013).

The diagnosis of Bipolar 2 requires that the individual have a hypomanic episode and a major depressive episode with the related symptoms.

The specific depressive disorders which will be looked at are major depressive disorder (including major depressive episode), and persistent depressive disorder (dysthymia).

Major depressive disorder consists of the above mentioned symptoms of a major depressive episode.

Persistent Depressive Disorder symptoms include the individual having no appetite and being tired or overeating and not being able to sleep. The individual may have a poor self-esteem and have difficulties with concentrating and feeling hopeless. The individual should not have experienced a manic or hypomanic episode (American Psychological Association, 2013).

The above mentioned disorders can be due to a substance or a medication that an individual may be taking. The individual may suffer from the same symptoms, however, there is evidence of a medication or substance that is the pre-cursor of the symptoms (American Psychological Association, 2013).

The presentations of individuals 'abahlanyayo' (who are mentally ill) clinically present in these manners stated above. It is important to consider the symptoms and in doing so consider the individuals physical presentation.

Stigma and Treatment

Mental illness has rapidly found itself as one of the most common conditions affecting health all over the world (Hugo; Boshoff; Traut; Zungu-Dirwayi & Stein, 2003). Africa has a limited number of studies and those which are present are within specific populations and within specific professional groups (Hugo et al, 2003). In Africa stigma and ignorance still frame mental health in a negative light (Hugo et al, 2003). Individuals that are mentally ill are, at present, still unaware that they can be diagnosed and treated effectively (Hugo et al, 2003).

Studies by Dear; Taylor and De Jong propose that the community's attitude plays a role in the help-seeking behaviour of individuals suffering from mental illness (Hugo et al, 2003). Lyons and Hayes have also observed that where there is a presence of negative community attitudes towards the disabled members of that particular community, there is a supreme amount of stigma attached to individuals who are deemed to be acting or behaving in a manner that is unpredictable or potentially dangerous (Hugo et al, 2003). Lack of resources which are directed at educating and addressing the negative belief systems, coupled with the fear and suspicion of the mentally disabled within communities, plays a huge role in the social rejection, isolation and abuse of people who suffer from psychiatric disorders (Hugo et al, 2003).

There are studies which have indicated that the community's attitudes and their perceptions of people with psychiatric disorders are majorly influential in the successful treatment and social reintegration of the mentally ill into their communities (Hugo et al, 2003).

South Africa has a scarcity of research on studies that are comprehensive in revealing public attitudes regarding the community knowledge of mental illness (Hugo et al, 2003). The limited number that is present to look upon is concentrated to certain population groups or diagnostic groups (Hugo et al, 2003).

In present day South Africa there are issues which are being faced which transcend the past. The 'revolving door' effects on mental health and the decentralization of care which is taking place around South Africa plays a role in the situation whereby the mentally ill within their communities have defaulted from medication. In addition, due to there not being enough beds within the hospital system; due to individuals feeling dehumanized and gaps in referral systems and so much more at the various levels of

care, the issue of mental health is not treated properly (Lund, Petersen, Kleintjies & Bhana, 2012).

The causation of mental illness contributes greatly to the stigma and the negative attitudes held regarding mental illness. A study done in Nigeria indicated that community members in the study believed that drug abuse was the cause of mental illness, this assumption was positive in the sense that it gave the community an understanding that substances caused some restrictiveness, however, with regards to mental illness, there is a limited number of patients who present due to substances (Gureje, Lasebikan, Oluwanuga, Olley and Kola, 2005). Further studies indicated causation to be due to God's will, a divine wrath, spiritual or magic possession, genetic dispositions, familial conflicts, trauma and poverty. There is an idea of individuals who abuse substances bringing upon themselves divine punishment which results in the development of a mental illness, thus the belief of supernatural entities (Kaber, Iliyasu, Abubakar, Muktar, Aliyu, 2004).

Thus, an individual displaying eccentric behaviours which attract the attention of the community is disruptive to the society and is subsequently viewed as being mentally ill which is seen as self-inflicted. So, instead of the community showing sympathy and understanding their reaction translates to condemnation and all mentally ill individuals are then stigmatized due to what is seen as "you have brought this upon yourself" (Gureje, Lasebikan, Oluwanuga, Olley and Kola, 2005).

Mental Illness in Africa

In looking at mental illness in Africa the literature indicated a number of studies done with specific population groups for example: traditional healers. In South Africa specifically, studies appear to be centred on traditional healers, university students, care givers and the like. Whilst looking at a study regarding traditional healers, a study done by Patel was indicated which displayed that the respondents in that study were able to identify the mentally ill through their observed inappropriate behaviours, such as impairments in self-care, aimless wondering and ingesting inedible or dirty products (Sorsdahl, Flisher, Wilson and Stein, 2010).

The literature further indicated that traditional healers' explanatory models of mental illness were separated into psychotic and non-psychotic. The psychotic disorders were viewed as the main example of mental illness and the non-psychotic disorders were explained by respondents as "thinking too much" (Sorsdahl, Flisher, Wilson and Stein, 2010). This particular study raises awareness in terms of the impact of culture and African traditions on the community and its understandings. African communities particularly in rural areas are still very much shaped and informed by traditional healers (Sorsdahl, Flisher, Wilson and Stein, 2010). In Nigerian communities mental illness is also viewed as a supernatural infliction, or as a divine punishment for bad behaviour, thus, mentally ill individuals deserve the lot they are served. This supernatural view of mental illness implies that the use of western medicine would be futile in dealing with the mental illness, thus, traditionalists would be engaged in the healing process (Gureje, Lasebikan, Oluwanuga, Olley and Kola, 2005). In Africa mental illness is a majority of the time viewed in relation to having to do with satisfying the ancestors, and witchcraft due to jealousy or pay back.

The manner in which mental illness is expressed as manifesting within Africa ranges from aggression, destructive behaviour, excessive talking, wandering around and being eccentric (Kaber, Iliyasu, Abubakar, Muktar, Aliyu, 2004). These are the observable behaviours that are noted within African cultures. The levels of sympathetic behaviour towards individuals presenting as mentally ill within communities appear to be low where mainly females appear to be more sympathetic. A study indicated that literacy also has an impact on the sympathy within individuals in a community. The study indicated that literate individuals within the community were more likely to exhibit positive feelings towards mentally ill individuals (Kaber, Iliyasu, Abubakar, Muktar, Aliyu, 2004).

The discrimination of the mentally ill within their communities can be direct or indirect, it can be concealed or blatant and it limits the individual's social, political and economic opportunities (Moomal, Jackson, Stein, Herman, Myer, Seedat, Madela-Mntla and Williams, 2009), in that the observations made by the communities create a distance between the community and the mentally ill leaving them unable to engage and flourish in the different experiences of life.

CHAPTER THREE

RESEARCH METHODOLOGY

In this chapter the research methodology which was utilised will be described. This chapter will look at the theoretical framework, research aims and objectives, research design, data collection methods and instruments, data analysis techniques, dependability and credibility, limitations of the methodology and the ethical considerations will be discussed as they pertain to this particular study.

The aim of this study was to explore the social representations of the youth from rural KwaZulu-Natal. This was to be done by ascertaining the opinions, and experiences of the youth within their communities, regarding mental illness. With this aim in mind qualitative research was utilized due to its ability to explore and discover rich information that can be used to extrapolate the meanings which individuals place on phenomena which they have experienced through interacting with the world around them (Merriam, 2002).

Qualitative research uses the researcher as the primary tool for the collection and analysis of data. Thus qualitative research provides a more flexible point of departure, allowing the researcher and participant relationship to be less formal. The researcher in this regard must also possess a level of reflexivity, through which they will be able to monitor their own biases and subjectivity in ensuring that the research is not influenced by these (Merriam, 2002).

The specific framework which was utilised in the present study came from the Social Representations Theory which is associated with social psychology theory; this theory looks at the shared, logical, daily representations that individuals use to orient themselves with the world in which they live (Wachelke, 2012). Social Representations Theory rejects the individualistic approach to the process of human thought, and is rather grounded in the community's inter-subjective world (Jovchelovitch, 2007). This makes Social Representations Theory appropriate for the use of examining public issues as exhibited in Jodelet's examination into the health sector (Wachelke, 2012).

The beginnings of social representations arise from new objects appearing within society or when pre-existing objects pose some kind of a risk to the society (Garnier, 1999). According to Moscovici there are three conditions which bring about a social

representation: firstly there must be an object that is vaguely defined by the society, secondly, there ought to be a perceived need by society to surmise about the object and thirdly the object must hold some relevance for different members of the society (O'Conner, 2012). According to Moliner, there were added factors such as that the object ought to be a threat to the identity or social cohesion of the society (O'Conner, 2012). Flament and Rouqette also added some contributions to the understanding of social representation in commenting on conditions that would be considered such as that the object must be something that the society has comments about, and that there must be some association with the practices of the society (O'Conner, 2012).

In looking at the process of social representations, it is of significance to note that it is guided by the societies desire to *know* the world in which they live through the process of altering the unfamiliar to be familiar to them (O'Conner, 2012).This process is attained through two processes, the new trend is *anchored* into a trend that the society is already accustomed to and the meanings fixed into the familiar trend influence the manner in which the new trend is represented (O'Conner, 2012). Secondly the trend is *objectified*; the theoretical aspect of the new trend is made concrete through the substantiation of the representation in an evident object, concept or image (O'Conner, 2012).

Social Representations Theory looks at the manner in which scientific knowledge and expertise is disseminated through society and the transformation it undergoes within this process (O'Conner, 2012). Social Representations Theory acknowledges the presence of and influence of expert evaluations on society's representation – the expert evaluations are reframed, reconstituted and resisted through meaningful social interests (Jovchelovitch, 2008). Society does not approach new phenomenon having a blank slate, but rather observes it through the pre-existing sets of worldviews and representations that are held by the society, thus providing a broader range of concerns than those encountered in expert evaluations (O'Conner, 2012). The Social Representations Theory approach allows the emergence of these concerns enabling the establishment of insight into the broader concerns which encompass the experiences that people have regarding specified social contexts (O'Conner, 2012).

Social Representations are supported by the social and emotional motivations of a society (Joffe, 2003). One of the core motivational foundations of the process of social

representations is *identity protection* (Howarth, 2002). The function of identity is amplified when a community is confronted with a seemingly threatening occurrence, the risks are then projected into an 'other' or 'out-group', thus, the community protects itself from being "contaminated" (O'Conner, 2012). An example of this can be seen in literature at the pivotal moment of the HIV/AIDS pandemic, the disease was symbolized as a 'gay plague', and this facilitated the distancing of society from the threat of the disease and the societal implications of the disease (O'Conner, 2012). Social Representations Theory provides us with a useful manner of looking at identity dynamics in a society and how they feed into the public's reactions to an impending threat (O'Conner, 2012).

The appropriateness of Social Representations Theory was observed as this theory spoke to the aims of the study which were to explore the social representations of the youths. These included their belief systems, their community; cultural and personal motivations which were their pre-existing world views in looking at the phenomena of mental illness, although not a new phenomenon.

Research aims/objectives

This study explores the social representations of the youth from rural KwaZulu-Natal, South Africa regarding *'ukuhlanya'* (mental illness). This research aims to create a platform for further study into the social representations of South Africans with regards to *'ukuhlanya'* (mental illness) and to provide a platform for the development of promotion strategies for mental health that are suited for specific areas. Furthermore,, the research aims to describe the content of people's beliefs and knowledge regarding the state of being senseless, *'ukuhlanya'* (mental illness). The research is aimed at capturing the narratives of the youth in order to interpret and understand from the perspective of the youth:

The youths understanding of mental illness in their community contexts

The data collected may be used to add onto or to pilot further studies which are specific to South Africa regarding where we are positioned within various communities regarding mental health and how South Africa can develop programmes to assist the

promotion of mental health. The study is intended to shed light on where the understanding and knowledge of rural youths is placed, regarding mental illness.

Once the level of understanding and knowledge is acquired, this study can inform further research into mental health promotion programmes at school level, and at community level. This study aims at showing how mental illness is viewed and how it is understood at grass roots level, and how the community attitudes have or have not evolved through time. These findings can greatly assist in the beginning stages of ascertaining where there is a lack and ask the questions of what would be appropriate in these contexts in the area of developing appropriate mental health promotions, aimed at a school going level.

Research Design

Research Participants

The number of participants was determined by the intent of this study and the Social Representations Theory framework. Ten (10) participants were recruited for this study. The participants were High School students from two High Schools in the Valley of a Thousand Hills, in the area of KwaNyuswa, KwaZulu-Natal Province, South Africa. The High Schools included KwaNtebeni Comprehensive High School and Siyajabula High School. The participants were Peer Educators in the Hillcrest AIDS Centre Education Programme. Interviews and drawings were conducted with four (4) students at Siyajabula High school and six (6) students at KwaNtebeni Comprehensive High School. The participants included females (n=5) and males (n=5). The race group of the participants was Black/African (n=10).

Prior to their participation in the study each of the participants was provided with an informed consent form, and an information sheet with the HSSRC, supervisor and researchers contact details. The consent form and information sheet outlined the rights of the participants to decline or withdraw from participation in the study at any point in the process. Furthermore, the informed consent and information sheet outlined the aims and objectives of the study, confidentiality, and the requirements for willing participants. The participants were informed that their interviews would be recorded as part of the study.

Sampling

The sampling of the participants was conducted based on time constraints and the aims of the research. Non-probability sampling was utilised, the participants were not selected by chance. Judgement/Purposive sampling refers to a sampling strategy of utilising participants which by the researcher's judgement would provide a representative sample (Durrheim).

Participants were selected on the following criteria: 1) Participants had to be scholars 2) Participants had to be from the chosen rural area of KwaNyuswa, KwaZulu-Natal, South Africa 3) Participants had to be part of the Hillcrest AIDS Centre Trust, Education Programme as Peer Educators.

The researcher acknowledges that a larger sample size would have been more favourable. However, due to the researchers time constraints, and availability of participants due to school obligations this proved to be impossible. Therefore, the research was limited to the scholars who met the research criteria and who were available and willing to participate.

Data collection methods and instruments

Data Collection

The method of data collection was guided by Social Representations Theory. The instruction for the pictorial representation was unstructured – participants were instructed to "draw a picture of a mentally ill individual". This allowed for the participants to choose how they represented their individual on paper. The research questions were semi-structured, this allowed for the researcher to gain a better understanding of the participants pictorial representations of the phenomena and to be able to allow for any other information that the participants offered to be explored further. The usage of semi-structured interviews allowed for researcher and participant flexibility (Flick, 2009).

The interview questions were mainly open-ended with the inclusion of some close-ended questions. This style of interviewing gathered the required information, whilst, also allowing a conversation to transpire between the researcher and the participants.

Through this interchange, more in-depth information was gathered in line with the aim of gaining an understanding of the scholar's understanding and representations of mental illness within his/her community contexts. The scholars were able to speak more honestly, thus allowing their world views to be ascertained.

Semi-structured interviews allow for the researcher to have structure whilst also opening up avenues of further exploration through flexibility (Flick, 2009). The interviews were held at KwaNtebeni Comprehensive High School and Siyajabula High School in the area of KwaNyuswa. The drawings were allocated fifteen minutes (15). The interviews ranged from fifteen minutes (15) to thirty minutes (30), this was dependant on the scholars and how much each of them was willing to share.

The interviews and drawings were conducted in pre-requested vacant classrooms. In efforts to ensure confidentiality every attempt was made to have locations where the scholars would be able to speak openly without interruptions or distractions. The interviews were audio recorded and consent was obtained in writing and verbally from the participants prior to commencing the research. The audio recordings were transcribed following data collection and subsequently deleted off the audio recording device.

Composing the interview schedule

The research study utilised an interview schedule in order to gain open and non-directive discussion with the scholars regarding their understanding and representations. The interview schedule looked at 1) Exploring the scholar's pictorial representations 2) Exploring the scholar's understanding of mental illness 3) Exploring the scholar's influences on the development of their views 4) Exploring the scholar's own views of mental illness. Participants were encouraged to speak outside of the four categories which were outlined in order to gain more of their perspective.

Probing questions were also utilised in order to assist participants who had difficulty understanding the question, the probes were also utilised once participants had the opportunity to respond to the unstructured questions in order to discuss the questions more.

Techniques of data analysis

Thematic Analysis was utilised in order to capture the views and opinions of the participants regarding mental illness (*'ukuhlanya'*). Thematic analysis was chosen due to its qualitative nature and its ability to allow the researcher to become more familiar with the participants' narratives (Reissman, 2008). The process of thematic analysis is that of identifying themes and patterns in the participant's narratives. This is followed by the creation and development of a coding system. The coding system is then utilised in applying the codes to the narratives and interpreting the themes and sub-themes within the theoretical framework with which one will be working.

The beginning stage involves familiarizing oneself with the transcripts, identifying recurring themes and sub-themes and patterns in the narratives. The units of meaning which emerge assist in the development of themes. Similar units are called themes.

The themes are coded in order to be easily identifiable within the transcripts. A multilevel numbering system was utilised where sub-themes were numbered according to the main theme they fell under. Example *code 2* is the main theme indicating the '*description of the image'* and *2.1* is the sub-theme indicating *'physical appearance'.* The coding system allowed for the combination of themes, thus, it was easier to analyse the narratives of each of the interviews. The researcher worked with the codes in order to isolate quotes with precise terms used by the scholars which would fit onto the table (Gelo et al, 2008).

The themes which emerged through the scholar's narratives indicated how they viewed the representations of mentally ill individuals within their community. The themes which emerged prolifically through the narratives were that of physical appearance and witchcraft. Other themes indicated the positioning of mentally ill individuals in the community.

According to Jelsma & Clow (2005) reflexivity refers to the researcher's ability to continually observe himself/herself and the relationship which he/she shares with the participants of his/her study and how this may influence the outcome of the gathered and interpreted data. The researcher has to continually evaluate his/her own beliefs,

views, actions and perceptions in order to know the impact that the researcher may have on his/her study (Watt, 2007).

In this study reflexivity was utilised in order that the researcher continually reflect on his/her impact on the participants' responses as well as taking care to not influence the participants narratives with his/her own prejudices. Thus, the generated themes were in fact free of any of the researcher's beliefs.

Dependability and Credibility

In looking at this particular study it is qualitative in nature and thus in qualitative research the terms of validity and reliability are conceptualized differently than in quantitative research. Qualitative research utilizes terminology such as credibility, transferability and trustworthiness (Golafshani, 2003).

Qualitative research looks at generating understanding, exploration and discovery of the subjective human experience, thus, criteria such as credibility, transferability, dependability and confirmability are better suited to exploring the validity and reliability of the study (Guba, 1985; cited in Wang, 2008).

The credibility of the study as qualitative research is dependent upon the researcher's efforts, in that credibility looks at the findings/narratives and themes generated by the participants and the researcher's ability to attain participants who will be a true representative of the phenomena being studied (Golafshani, 2003). Furthermore, the researcher is the instrument and is integral in the co-creation of meaning. Dependability looks at the researcher being able to safeguard the research in that it complies with the rules and procedures of qualitative research with regards to replicating a study.

The experiences, views and beliefs of the participants ought to be represented in an authentic manner, thus the utilisation of thematic analysis allowed for this in that the themes which emerged from the narratives were all given consideration, and this ensured confirmability of the study (Whitemore et al, 2001).

The transferability of the study speaks to the ability to generalize the study. In qualitative research this looks at being conceptually sound for a specific context and population rather than being generalizable to a greater population.

The rigor of qualitative research is held within whether the research has looked at fairness, assisted in the development of understanding phenomena and various perspectives, empowered members and motivation of response or action (Seal, 1999, p.469). Thus credibility, dependability, confirmability and transferability are the standards of rigor to measure qualitative research.

Limitations of the methodology

The study had a number of limitations. The use of interviews may reflect subjectivity in the responses as the responses were participant specific. This limitation was countered through the use of semi-structured interviews in an effort to gain as much in-depth information from the scholars as possible.

The sample size may also be viewed as a limitation and the further withdrawal of one participant thus bringing the total number of used interviews to nine (9) rather than ten (10). A smaller sample size was opted for due to the scholar's scholastic schedules and availability, and the time constraints of the researcher. The aims of the study were not compromised as the relevant information was gathered and was adequate.

The small sample size may also be seen as a limitation in its impact on generalisability, however, this is bypassed by the fact that the data gathered was able to give insight into the possible views of individuals of the same age group and context.

Data was collected from a specific sample, in a specific area within KwaZulu-Natal, and this will also be positioned as a limitation, as the results cannot be generalised to other parts of KwaZulu-Natal and other provinces in South Africa.

A further limitation may be the translation of the responses from IsiZulu to English, this however was handled in the manner that the researcher's first language is isiZulu and the researcher is proficient in English as a second language, thus, the occurrence of error is minimised.

The inability to utilise the pre-organised facilities in order to carry out more confidential research may be observed as a limitation. Furthermore, this made the ability to host a focus group as part of data collection unattainable. This was worked through, through gaining access to relatively confidential rooms within the two high schools in order to uphold confidentiality for the participants.

The researcher's presence and hands-on approach with the data collection, analysis and interpretation may be viewed as a limitation. However the researcher's hands-on approach may be over-looked as it may be observed as a useful aspect in creating meaning which is what creates a distinction between qualitative and quantitative research.

Ethical Considerations

Ethical clearance for this study was granted by the University of KwaZulu-Natal's Humanities and Social Sciences Ethics Committee. Qualitative research looks at upholding principles of self-determination, the study being clear and worthwhile, ensuring prevention of harm and upholding justice.

The present study ensured self-determination by giving each of the participant's informed consent forms prior to participating. The informed consent forms provided information on the participant's right to withdraw at any time, the right to confidentiality, the purpose of the study and its aims and the contact details of the researcher, supervisor and the Humanities and Social Sciences Ethics Committee. Participants were referred to as *participant 1, 2, 3, 4, 5, 6, 7, 8, 9 & 10* – this ensured confidentiality was upheld through data collection, analysis, interpretation and write-up.

Justice was upheld through the constant noting to patients that they had the right to withdraw at any stage, subsequently *participant 5* did withdraw and their right to justice was upheld as well as their confidentiality. Power dynamics were minimized as much as possible between the researcher and participants.

A safe and secure atmosphere was constantly endeavoured for throughout the data collection stage. The researcher observed participants during data collection and was prepared to address any minor distress. Furthermore, a fellow M1 colleague was

retained in order to address any major distress thus ensuring the researcher was able to maintain reflexivity.

The factor of the research being worthwhile and the gathered information being of benefit to the participants was also shouldered by the researcher. The researcher gave the participants an opportunity at the end of data collection to ask about mental illness and provided some psycho-education to the participants. Thus, the participants were able to benefit from being part of the study.

CHAPTER FOUR

RESULTS

Summary of themes and sub-themes

1. **Demographics**

   The interviews and drawing exercise were conducted on ten scholars, five of which were male and five of which were female. All the research participants were Black/African.

2. **Description of the drawing**

2.1 Physical Appearance

The physical appearance as described by the participants in general was of a male, who was unkempt, and who appeared dishevelled. The participants all noted a lack of hygiene in the images namely, uncombed hair.

> *"Inwele zakhe lana ziyabonakala ukuthi nje uhlanya nje, ziyabonakala ukuthi umuntu ohlanyayo, coz akakamile. Bese kuthi la inyembezi, ezekhala la. Ungcolile, ngoba phela uhlanya alugezi" (**Participant 1)***
>
> *"From looking at his hair you can see that he is mentally ill, because his hair is not combed. He also has tears showing that he was crying. He is also dirty because mentally ill people do not bath"*
>
> *"Nezinwele zakhe ziyabonakala nje ukuthi umuntu ongekho right. Nezinwele ezingahlelekile" (**Participant 2)***
>
> *"You can see from his hair that he is not alright, his hair is dishevelled"*
>
> *"A male umentally disturbed" (**Participant 3)***
>
> *"A mentally disturbed male"*

*“Uhm inwele zakhe azikanyiwe nje akagundi, unentshebe akashefi ngalendlela yokuthi akasawezwa amafinyila ahamba phezu kwentshebe” (**Participant 4)***

“His hair is not combed and it is uncut, his beard has grown out so much that he is unable to feel snot running down his beard”

*“Intshebe yinde akasashefi and ekhanda izinwele zihliphizekile akakami” (**Participant 8)***

“His beard is long and unshaved; his hair is dishevelled and not combed”

*“Lomuntu engimudwebe lana akagezi, akagundi” (**Participant 9)***

“The person I have drawn here does not bath and he does not cut his hair”

2.2 Appearance of clothing

The depiction of the clothing by the participants indicated that a mentally ill individual wore clothing that was unclean and too big for them; the individual wears plastic packets to cover their body. The depiction by respondents was one which observed mentally ill individuals as not being groomed.

*“Bese kuthi la emqaleni ubophele amaphepha. Bese kuthi la ibulukwe nalo nje liphuphile elikhulu, ugqoke ibulukwe elikhulu. Mese kuthi aligqokile ngaphezulu. Lihamba ngey’nyawo futhi” (**Participant 1)***

“The person I have drawn has papers tied around his neck. His pants are worn out and too big for him, he is not wearing anything on his upper body and he is walking barefoot.

*“Ugqoke nebhulukwe elide komunye umlenze omunye mufishane” (**Participant 2)***

“He is wearing pants that do not have the same length legs; one leg is shorter than the other”

*“Ugqoka noma yini” (**Participant 3)***

“He is wearing anything”

*“Ubona izinto azigqokile zikhebukile, necleanliness, akanalo ikhaya so akanayo indawo ageza kuyona. Nekhanda lakhe, akasithole nje isikhathi sokuthi azinake” (**Participant 4)***

“The clothes he is wearing are torn, he is unclean as he does not have a home to have bath at. His hair is also dishevelled; he doesn’t get time to care for himself”

*“Ugqoke ingubo ezidabukile” (**Participant 6)***

“He is wearing torn clothes”

*“Nezingubo azigqokile zidabukile” (**Participant 8)***

“The clothes he is wearing are torn”

*“Akagqoke nezingubo nje, like ingubo ugqoka oplastiki futhi njengoba sigqoka akagqoki njengoba sigqoka uyagqoka nje” (**Participant 9)***

“He is not wearing clothing like we would wear, he is wearing plastic packets”

*“Egqoke oplastiki” (**Participant 10)***

“He is wearing plastic packets”

2.3 Relationships

The participant’s responses indicated that mentally ill individuals had no relationships that they are loners. One participant also indicated that mentally ill individuals are used by family or community members for monetary gain.

*“Ngidwebe nomuzi la ngadweba nomgwaqo, kukhombisa ukhona usemphakathini ngeke aze avele ahlale yedwa nje” (**Participant 2)***

“I have drawn a house and a road to indicate that he is in the community, he does not live alone”

*“Isiskahthi esininigi abanye bayobhalisa ukuthi umuntu uyagula ukuze bathole imali kodwa yena bebe bengamunakekeli” (**Participant 3)***

“Most of the time people apply for a care dependency grant in order to get money for the sick person, however, they do not take care of the person”

*“Uhlala emugwaqweni akanakhaya hes lonely, akanabangani, akanamuntu ahlala naye” (**Participant 4)***

“He lives on the streets; he is without family and friends. He has no one to live with and is lonely”

*“Uhleli ehlathini” (**Participant 7)***

“He is living in the bush”

*“Uhamba emgwaqweni uhamba ecela” (**Participant 8)***

“He is walking on the streets begging”

“Uyahamba nje akazi ukuthi uyaphi hlezi ehamba emugwaqweni” ***(Participant 9)***

“He is always walking around aimlessly, not knowing where he is going”

2.4 Behaviours

The participants indicated that mentally ill individuals engage in hoarding behaviours, disorganized behaviours, and at times violent behaviours. Participants indicated that mentally ill individuals do illogical things as well.

“Nokucosha amaphepha yena usuke ewacosha ewaletha kuyena instead of ewacoshe ewalahle kodwa uyawaphatha yabo” ***(Participant 1)***

“When he picks up papers, he hoards them. Instead of throwing them away he keeps them”

“Uyakhala, okungenzeka nokuthi akazi ukhalelani. Nezilwane zimenza noma yini ngoba umuntu ongacabangi. Uphethe nenduku, siyazi ukuthi ezinye inhlanya ziyashayana, ngisho ungezanga lutho” ***(Participant 2)***

“He is crying and he doesn’t know why he is crying. There are animals that are doing whatever they want to him this shows that he is a person that doesn’t think straight. He is carrying a stick and as we know mentally ill people hit other people, even when others have done nothing wrong”

“Udla noma yini ahambe noma ikephi. Acoshe noma yini nje eseduze kwakhe .abantu abaningi engseke ngababona bathanda ukushaya kakhulu. Bashaya bonke abantu ngisho bengenzanga lutho. Abanye bavesane bahambe ungazi bayaphi. Kwenye inkathi bangabuyi, kwenye inkathi babuye emva kweminyaka” ***(Participant 3)***

"He eats anything and wanders around. He picks up anything around him and most people I have seen like to hit a lot. They are physically abusive to others even though they have done nothing. They wander and disappear; at times they return and at other times they never return"

"Uphethe isagila since elonely akasitholi isikhathi sokuthi abe nabantu afunde ukuhlalisana nabantu so yena mebona umuntu ubona isitha that's why ephethe isagile ukuthi abashaye. Lesi esinye isandla uphethe udoti since ementally disturbed ucosha noma yini ahlangana nayo" ***(Participant 4)***

"He is carrying a knob kierie; he finds no time to be with other people, thus, he is lonely and does not know how to interact with people. When he sees others, he sees them as enemies; he carries the knob kierie in order to hit them. In his other hand he is carrying garbage, because he is mentally disturbed he picks up anything"

"Uhleka into angayazi. Uphethe udoti" ***(Participant 6)***

"He is laughing and carrying garbage"

"Uhleka ubala" ***(Participant 7)***

"He is laughing at nothing"

"Uphethe uplastiki ugcwele amaphepha namakopi" ***(Participant 8)***

"He is carrying a plastic packet filled with papers and tins"

"Uphethe nenduku akayazi ukuthi uyiphatheleni" ***(Participant 9)***
"He doesn't know why he is carrying a stick"

"Kodwa but in mind uyabuza ukuthi if akayenzanga lento ngabe akekho la. Umuntu ohlanyayo ocosha amaphepha. Ojwayele nokuphatha

induku. Akhulume yedwa omunye nje ahambe ehleka nje indela yonke" ***(Participant 10)***

"He has it in his mind that had he not done it then he would not be here. He is a mentally ill person picking up garbage, carrying a stick, speaking alone, and laughing inappropriately"

3. **What is 'ukuhlanya'?**

3.1 Descriptions of 'ukuhlanya'

Participant's responses indicated that mental illness is doing things that well-adjusted people would not do. They indicated that it is being senseless.

"'ukuhlanya' ngingathini. Kunezindlela ezihlukene. 'ukuhlanya' isifo esike sihlasele ingqondo yomuntu. Agcine enze into engahlelekile kodwa yena usuke engazi ukuthi wenza into engalungile konke kusuke kukuhle kuyena engazi ukuthi wenza into engalungile" ***(Participant 1)***

"I would say mental illness, has different ways. It is an illness that attacks someone's brain, leading him to have disorganized behaviour, he is unaware whether he is doing a good or bad thing. It all appears good to him"

"Ngicabanga ukuthi ukwenza izinto abantu abangakaze bacabange ukuthi umuntu angazenza. Ukwenza izinto nje ezihlukile izinto nje ziqale ngawe. Kodwa ayi ukuthi bonke abantu abaqala izinto bayahlanya. Kodwa phela izinto ezingahlelekile" ***(Participant 2)***

"I think that it is doing things that others would never think would be done. It is doing different things, with you being the first to do them, however, not to say that everyone who initiates new things is mentally ill, but it is things that are disorganized"

“Ya. Ngoba hlampe umuntu osanganayo angasheshe asizakale kunohlanyayo. Ya, ohlanyayo kuthatha isikhathi eside alungiseke naye ingqondo yakhe icabange njengabanye” ***(Participant 3)***

“Yes, a person who is mentally ill may receive help quicker than a person who is mentally disabled. It takes a long time to help a mentally disabled person, so that they can begin to think like other people”

“Ukungaboni izinto ngendlela abantu abanormal ababona ngayo ukubona izinto ngenye indlela. Which leads ekutheni ugcina usuwenza nawe ngenye indlela abanye abangenzi ngayo” ***(Participant 4)***

“It is to not see things the way that normal people see things, this leads to the person doing things that other people would not do”

“Uhlanya kusuke kumuntu uyaphile njengabanye abantu kodwa wenza izinto ezingafani njengezabanye abantu. Mina njengoba ngingahlanyi nje ngyageza, akagezi lomuntu. Uhleka ubala, udla emqonyeni. Abantu abaningi abagula ngengqondo abakhulumi basebenzisa izandla kuphela ayi ukuthi bayakhuluma” ***(Participant 7)***

“A mentally ill person is one who is a human being like others, however, he does things differently from other people. I am not mentally ill, this is seen in the fact that I bath, they do not bath, and he laughs at nothing, eats from the dust bin. Most mentally ill individuals do not speak they use their hands”

"'ukuhlanya' umuntu okhubazekile ngokomuqondo owenza izinto ezihlukile njegalo engimudwebile. Izinto azenzayo izinto ezingajwayele ukwenziwa abantu so yena wenza izinto ezihlukile kodwa ngendlela thina esithi iyabheda ngokuthi manje izingubo azigqokile zidabukile kwase kuthiwa uyahlanya" ***(Participant 8)***

"Mental illness is a person whose brain is disabled thus they do things that are different, like the person I have drawn here. He does things that are not done by other people, the different things he does, are seen as not good. Since he wears torn clothes, thus he is called mentally ill"

"'ukuhlanya' umuntu esuke engekho right kahle engqondweni. Ingqondo yakhe isuke ingasebenzi kahle isuke ingekho ezingeni eliphezulu ukuthi engacabanga izinto eziright. Umuntu nje akacabangi uyenza nje" ***(Participant 9)***

"Mental illness is when a person does things that are wrong, his mind does not function well and he is unable to consider good things. He acts without thinking"

"'ukuhlanya' singakubona in different way njengo kuthi nje umbone umuntu obelungile umbone umuntu kuhambe lomuntu usecosha amaphepha engesenahoe. Esehamba edlalisa noma ubani ngendlela engajwayelekile, esehamba edla izinja ezifile edla yonke into le esnaaks, ubona ngomuntu esengena emugqomeni edla emugqomeni and futhi abanye basuke bethakathiweke njengoba sengishilo" ***(Participant 10)***

"We can see mental illness in different ways such as seeing someone doing well in life, as life continues you eventually see them picking up

garbage, being oddly playful with anyone, eating dead dogs, eating out of dust bins. Others have been bewitched, like I said"

3.2 Causes of mental illness

Participants indicated varied causes of mental illness. They ranged from genetic disposition, substance abuse, thinking too much, bewitchment to having a difficult childhood.

"Phela ukugula ngekhanda sikuthatha ngo… Vele ukugula ngekhanda kuchaza ukuthi uyahlanya angithi, ngiku-understand kanjalo. Ukuthi nje once wagula ngekhanda uyahlanya. Noma yinto vele ebikhona emqondweni wakhe ebikhona kancane yagcina iya ngokukhula. Yagcina imaffecta wagcina ehlanya. Ngicabanga ukuthi usuke enenkinga vele engqondweni. Usuke enenkinga engqondweni eya ngokukhula" ***(Participant 1)***

"We see having something wrong with your mind as being mentally ill, that is how I understand it. Once there is something that happens in your mind then you become mentally ill. It is something that has been in your mind, which has escalated and has led to mental illness"

"Ngicabanga ukuthi ukucabanga kakhulu, kuyamenza umuntu ahlanye. Ukucabanga nezinto eziningi nengqondo yakhe, angazi ngzothi iyasindelwa noma injani" ***(Participant 2)***

"I think, thinking too much makes someone mentally ill, thinking about a lot of things becomes too heavy for their mind"

"Bebandakanye namadrugs hlampe abanye bawasebenzise ngokweqile. Umuntu agcine engasakwazi ukucabangisisa kahle, abanye

mengabe bezanyelwa usizo hlampe beyiswa kuma rehab bazibuyele mese baphinde bazosebenzisa amadrugs mese imizimba yabo ingasakwazi ukwenza ngendlela ejwayelekile mese ingqondo nayo iyadamejeka ngenye indlela nje. Ngoba amadrugs anezinto ezingadingeki emzimbeni" ***(Participant 3)***

"They were using substances, and may have been abusing them until they were unable to think straight. Others are placed in rehab and they abscond and return to abusing substances until their bodies are unable to function and their minds become damaged because drugs contain elements which should not be in the body"

"Mina istory esengisizwile abantu bengichazela why lo esenje I think okuningi benziwa abantu. But okunye bathi kwenziwa hlampe ukuthanda into kuze kweqe ugcine usuhlezi wenza leyonto, kuze kudlule kube sengathi awusathathi kahle ekhanda" ***(Participant 4)***

"The stories I have been told indicate that mental illness is inflicted by others on an individual. Other stories indicate that mental illness occurs due to an individual being obsessed with something until they do that one thing over and over again until it becomes a habit then you seem as if you are mentally ill"

"Kuyenzeka ukuthi uzalwe nakho. Kuwufuzo or ngesikhathi ekwiprocess ezalwa kwabakhona into eyenzeka, yaaffectha ingqondo yakhe. Noma umawakhe hlampe esaseswini khona izinto azidla or something. Kodwa uzalwa nakho" ***(Participant 6)***

"One can be born with a mental illness, it can be genetically inherited or during childbirth there may be a complication or whilst the mother was

pregnant she may have eaten something which lead to the child being born mentally ill"

"Kokunye umuntu ugcina hlampe esehlanya isimo esisuke sisekhaya hlampe uyahlukumezeka, nayo futhi indlala" ***(Participant 8)***

"Due to a person's home circumstances and hunger they may develop a mental illness"

"'ukuhlanya' as in umuntu like uma enze something umuntu ahambe aye enyangeni ethi as long as engakalikhiphi iqiniso akenze into eyokuthi, ephambene" ***(Participant 10)***

"Mental illness can be caused by a person being bewitched by another in the hopes that he will eventually tell the truth about whatever they have done to them"

3.3 Different types (Names)

Participants appreciated the fact that there are varied mental illnesses however they did not have words for them e.g. "diagnosis". Participant's responses indicated that some mentally ill individuals were hoarders, others were unhygienic, some were senseless, they expressed persecutory delusions, were verbally or physically abusive.

"Abanye omunye uthole ukuthi akalona loluhlanya oluthwalayo. But uloluhlanya olungcolayo. Ngicabanga ukuthi indlela yena agula ngayo, ayifani nale yabanye. Ngicabanga ukuthi bagula ngezindlela ezingafani" ***(Participant 1)***

"You find that others are mentally ill but they do not hoard, they instead are just unhygienic. I think it has to do with the nature of their illness, it is not the same as the others. They have different mental illnesses"

"Umuntu omentally disabled. Ngokucabanga kwami igama leli gama leli ayi ukuthi umuntu ongacabangi kahle kodwa indlela enza izinto ngayo ihlukile kunabanye abantu. Umuntu ohlukile kunabanye abantu. Akafani ngendlela esicabanga ngayo thina abantu nje. Mmm ngathi umuntu ya umuntu owenza izinto ngendlela yakhe nje" ***(Participant 2)***

"I think that a mentally disabled person this is a name which doesn't mean a person cannot think clearly but rather it means he behaves differently to other people and is different to other people. He is not the same as us; he doesn't think like us and does things his own way"

"Lona umentally disturbed. Aphazamiseka khona ngokwenqondo. Ukusangana. Lichaza 'ukuhlanya'. Osanganayo, uthanda ukuthetha, naye futhi uthanda ukushaya, uthanda ukublamer abantu ngisho ingekho into embi oyenzile kodwa nje efune ukulokhe exabana nawe" ***(Participant 3)***

"This person is mentally disturbed. His mind is disturbed. He is mad and has hallucinations. A hallucinating person shouts a lot, he is physically aggressive, he is paranoid and blames others and wants to cause arguments"

"Mehluko walaba abanodlame nalaba abaright? I think owalaba abanenkinga it because mhlampe back then umuntu esaright hlampe khona lento eyamhurtha angakwazanag ukuthi ayikhulume yagcina isimuphendula ukuthi engabe esaba ilomuntu ayewuyena. And leyonto

iyona emucontrollayo ukuthi agcine esebona abantu sengathi abantu ekumele alwe nabo. Nabantu njengeylwane" ***(Participant 4)***

"The difference between physically aggressive ones and those that are okay? I believe that the aggressive ones have gone through some traumatic or hurtful experiences whilst they were okay and they were unable to speak about it until he became someone else. That experience controls him to see others as enemies and animals"

"Umehluko ukuthi. Umuntu ohlanyayo ngengoba sengichazile ukuthi wenza izinto ezingenziwa omunye umuntu. Omentally disturbed kuyenzeka ukuthi uzalwe nakho ingqondo yakhe mhlampe isebenza slowly kodwa yona iyasebenza" ***(Participant 6)***

"The difference as I have said a mentally ill person does things that other people would not do. A mentally disturbed person can be born with a mind that is slow, however, his mind works"

"Ngingathini. Umqondo wakhe awufunctini kahle, khona izinto azenzayo. Njengoba ehleli ehlathini, egqoke ingubo ezidabukile, umuntu ophilile kahle ngeke agqoke izinto ezidabukile. Ngeke futhi angagezi, uyazithanda, uyashefa, uyaxubha" ***(Participant 7)***

"I would say his mind does not function properly. There are things he does like living in the forest, wearing torn clothing, a sane person would not dress like that, they would also bath, shave and brush their teeth."

"Ngingamutshela ukuba umuntu ohlanyayo ilo ozomufica engagezile. Ongazwani nokugeza agqoke izingubo ezingcolile njalo ezidabukile ongazwani nekama and futhi indlela a-actha ngayo ihlukile ngoba

abanye bake bakushaye hlampe muzohlala naye acoshe amatshe akushaye" ***(Participant 8)***

"I would tell them that a mentally ill person is someone who has not bathed, who is wearing dirty clothes that are torn and who doesn't comb their hair. The way they act is different from others; some will throw rocks at you and hit you"

3.4 Personal Understanding

Participant's responses indicated the sense of 'Ubuntu', i.e. participants appear to care for mentally ill individuals. However, some participants indicated that mental illness is something one visits upon themselves, and it's a choice. Whilst others indicated that mental illness is mainly one's behaviour.

"Ayimina ngicabanga ukuthi nje noma kuthiwa khona umuntu ohlanyayo kumele umphathise njengabanye abantu ngoba naye usawumuntu nje" ***(Participant 2)***

"I believe that even if there is a mentally ill person you should treat them the same as anyone else because they are human too"

"'ukuhlanya' ukungacabangi njengabanye abantu. Uyibonele izinto ngendlela yakho ehlukile kodwa engajwayelekile nje" ***(Participant 3)***

"Mental illness is not thinking like others, you see things your own way that's abnormal"

“KwiEnglish its specific mentally disturbed kushuthi kuyasho ukuthi uhlukumezeke ngokwengqondo. Kanti ngokwesiZulu uyahlanya it’s like uyazenza vele, it’s just a decision uvuke wayithatha ukuthi ngzohlanya. Ngzovele ngenze izinto ngalendlela abantu benza ngayo, ngzokwenza into ngendlela yami” ***(Participant 4)***

“In English the word mentally disturbed is specific to being mentally impaired however in isiZulu mental illness is something you have done to yourself, it is a decision you woke up and took. That you would do things your own way and not like others”

“Omentally disturbed, ingqondo yakhe ayifunctini njenge yawonke umuntu. ‘ukuhlanya’ ukwenza izinto eziabnormal into engenasidingo euseless” ***(Participant 6)***

“A mentally disturbed person’s mind does not function like everyone else’s. Being mentally ill is engaging in abnormal behaviour that is useless”

“Njengoba bese ngichazile ukuthi bona umuntu ohlanayayo bambuka njengomuntu owenza izinto ezihlukile kodwa futhi lento abangayenzi futhi abangayi funi. So into edala ukuthi bangatholani ukuba bona, lento yena ayenzayo ile bona abangafuni ukuthi bayenze abathi iyabheda. So manje ngeke wena wenze into engingayifuni mese siyezwana” ***(Participant 8)***

“Like I said earlier, they see a mentally ill person as someone who is doing things differently from them which they do not approve of. What causes them to not get along is the fact that mentally ill people do things

that others don't like, they see is as stupidity. So there can be no relationship if you are doing something I don't like"

"Ngamutshela ukuthi uhlanya umuntu osuke ekhubazekile emqondweni, ohlala emugwaqweni hlezi engcolile, akayinaki, izinto azenzayo sometimes ugcwele amaphepha, akazi uwacoshelani thole ukuthi iwagaxe la kuyena. Uyinto nje engazinakekeli nhlobo" ***(Participant 9)***

"I would tell them that mentally ill persons have a mental disability, they live on the streets, they are always dirty and they do not take care of themselves. They hoard papers and have no sense of self-care whatsoever"

"Sibu-understanda as in like sometimes umuntu ozenzile, owenza something engahambiselani nenye into. As in umuntu odlwengulayo amaphoyisa ajike futhi aphikelwe aphume masekuthi umzali waleyomuntu maseyahamba ayomhlanyisake. See understanda as in nje umuntu ozenzile noma umuntu owenziwe ukuthi mhlampe umuntu beyinto eright empilweni mase beyamhlanyisake ngoba befuna ukuthatha something yakhe mhlawumbe" ***(Participant 10)***

"We understand it as in someone has brought it upon themselves by doing something wrong, such as raping someone and they are held unaccountable by the law then the victim's family will take the law into their own hands and bewitch them. Or the person becomes bewitched due to jealousy or envy over something they have"

4. **Community Perceptions**

4.1 Treatment by community members

Participant's responses indicated that mentally ill community members were not treated well in the community.

> *"Ababatreathi ngendlela mabebona umuntu ohlanyayo nje ngathi babona istranger abanye bayamhleka. Bemhleka, nje. Abathathiswa nje kwabantu"* ***(Participate 1)***

> *"They do not treat them right, it's as if they see strangers when they see the mentally ill and they laugh at them and don't treat them like human beings"*

> *"Ubabuka njengabantu abangasile. Abantu nje ongasho ukuthi umadakeni. Babathume, most of the time bajwayele ukubenza nje hlampe ngingasho ukuthi igqila zabo. Babathume, hlampe babnikeze imali encane. Ababaphathi nje kahle"* ***(Participant 2)***

> *"They see them as people who are not within their right minds, as people you could say are filth. They are treated like slaves, sometimes they are given a small amount of change but all in all they are not treated well"*

> *"Abantu abaningi ababanaki abantu abahlanyayo. Ababazameli ngisho abantu bakubo ababazameli usizo mebebona umuntu akekho right. Kodwa nje kuvele kuthiwe uyahlanya kuphele kanjalo. Abamfuneli usizo, abazami ukukhuluma naye bambuze ukuthi yini ewrong hlampe ubonani. Bayamziba nje, ahlale ehlanya enjalo"* ***(Participant 3)***

"Most people do not pay any attention to the mentally ill, they do not even assist them in finding their relations so that they may get assistance. They offer no assistance to them, nor do they try locate some kind of help for them or speak to them to try ascertain the difficulties"

"Babasebenzisa ukuthi bona bathole imali. Like ukuthi bayabathatha bahlale nabo babalungisele yonke into nempesheni but uthole ukuthi lomuntu lo ulala emnyango, isikhathi esingingi endlini akanakwa kodwa labantu bayahola. Abathengelwa ingubo, bahlezi begqoke ingubo ezizodwa kodwa labantu bayahola, bahlala nomuntu ophilile ekhanda" ***(Participant 4)***

"They use them to get money, they take them to apply for a disability grant, however, when at home the mentally ill individual sleeps outside, nobody takes care of him, they don't buy him clothing or anything yet their carer gets the disability grant and they are sane"

"Bayahlukunyezwa bayashawa. Noma ethi uyafika ekhaya uzocela amanzi uyancishwa" ***(Participant 7)***

"They are ill-treated and beaten, even when they come ask for water at someone's house they do not give them any to drink"

"Ubdlelwane wabantu abasemphakathini nabantu abahlanyayo, abubuhle ngoba angisho ukuthi bonke, abubuhle ngoba mawuzohlala nomuntu ohlanyayo abanye hlampe bake bamshaye" ***(Participant 8)***

"The relationship between the community and the mentally ill is not good, because if you go and engage with one of them some community members would go and physically assault him"

“Mhlambe amthuke athi akahambe nje egcekeni lakwakhe” ***(Participant 10)***

“They swear at them and tell them to go away”

4.2 Bewitchment

Participant’s responses showed a strong presence of the use of ‘umuthi’ to make people become mentally ill.

“Omunye usuke enziwa, so uzwe kuthiwa, hawu yazi lo weright, unezitifiketi, unamaqualifcation kodwa mbuke lesenjalo .abanye njengeyigebengu, uyafika emzini womuntu agqekeze antshontshe then beseke bayahambe ke abantu abakholwelwa enyangeni, bese bayahambe bayobaloya then bahlanye” ***(Participant 1)***

“Others have been made by someone else to be mentally ill, you often hear people saying that the person was alright previously, they had some kind of qualifications or they were involved in criminal activities and they go to someone’s home and steal and the home owners go to a witch doctor and use witchcraft against them”

“Ukuthi kwesinye isikhathi bake basho ukuth hlampe umuntu uhlanyiswe omunye. Hlampe ukuthi bamsebenzisele imithi yabo hlampe izinto ezinjalo” ***(Participant 2)***

“They sometimes say a person has been made mentally ill by others through the use of muthi and witchcraft”

“Kodwa abanye abantu bathi umumtu usuke eloyiwe, kodwa angazi ukuthi kanjani” ***(Participant 3)***

“Others say that a person has been bewitched, I don’t know how though”

“Abanye basho ngalendlela yokuthi wena mawuxoxelwa musubona sengathi lo wazenza vele ukuthi agcine esehlanya. Abanye uma bexoxa baxoxa kube sengathi wenziwa abantu. Like halmpe abanye back then babejealous ngendlela aweyeyona so mase bamenazake ukuthi abe nje” ***(Participant 4)***

“People have often told me that mentally ill people have brought the illness upon themselves or it has been done to them by some else out of jealousy for the way they were or things they had”

“‘ukuhlanya’ ukugula. Kodwa sometimes because siphila in the rural areas kuyenzeka ukuthi umuntu wayethakathiwe then wahlanya. Wayephile eright engenalutho. Maybe wantshontsha then bese bamthakatha mese wahlanya ingqondo yakhe yangabe isasebenza completely” ***(Participant 6)***

“Mental illness is a sickness but because we live in the rural areas it does happen that a person is bewitched. They may have stolen something and been bewitched and then their mind was never the same again”

“Abantu abaningi basuke benziwe abanye abantu ngoba basuke benomona ngento anayo, abanye hlampe usuke ekhule nakho from abazali bakhe” ***(Participant 7)***

“A lot of mentally ill people have been exposed to witchcraft due to jealousy and envy from others whilst some have grown up with it, they genetically inherited it from their parents”

“Kusukela as in mhlambe wenze something, hlambe wangaboshwa as in hlambe umuntu waya enyangeni yamhlanyisa” ***(Participant 10)***

“It comes from the person committing a crime, not being dealt with accordingly in the justice system and then the victim going to a witch doctor to have them cursed”

4.3 “The Other”

Participant’s responses indicated that mentally ill individuals were not seen as part of the greater community. One participant responded in that they saw a mentally ill individual as a possible family member.

“Nje abantu abahlala nje emphakathini wabo bodwa” ***(Participant 1)***

“They are people who live in their own separate world”

“Mengabe ngibona umuntu osanganayo nomuntu ohlanyayo angiphatheki kahle ngiphatheka kabuhlungu ngoba ngike ngicabange sekuthiwa umuntu ohlanyayo hlampe ukhona hlampe nasemndenini wami noma umngani wami ashintshe naye asangane. Nje angiphatheki kahle kodwa ngisuke ngingazi ukuthi ngingamusiza kanjani lomuntu” ***(Participant 3)***

"When I see someone mentally disturbed and someone mentally ill, it makes me sad because I always think that they could be in my family or a friend. I am saddened by their circumstance but I never know how to help"

"Abantu will always be people. Abanye they're big in judgements abanye bathi lo wazenza, wenza ukuthi nokuthi. Abanye bakha itory ukuthi lo umbona wayewukuthi, waqale wenza ukuthi manje usenje" ***(Participant 4)***

"People will always be people, others are judgemental, and others say it's self-inflicted or that they did the wrong things and ended up like this"

"Baba treater like strangers or abantu abaharmful. Bayabasab sometimes mabe babona bayababalekela. Ingane ziyabahlupha nje azikhombisi irespect towards them" ***(Participant 6)***

"They treat them like strangers or as if they are harmful. They are scared of them and they run away from them when they see them and the younger children do not show them any respect, they annoy them"

"Emphakathini, abantu abamentally disturbed abaphathwa njengabantu nje" ***(Participant 7)***

"In the community mentally disturbed individuals are not treated like human beings"

"Noma bafele amathe ukutshengisa ukuthi abafuni nje into ezobahlanganisa naye" ***(Participant 8)***

“They are spat on, this is to show that the community doesn’t want them there”

“Abanakiwe, abanakekelwa nje. Bayaziphilela nje emugwaqweni” ***(Participant 9)***

“They are not cared for and no one cares about them, they just live on the streets”

“Abanye nje umbona sebemukhipa njengomuntu abangamazi” ***(Participant 10)***

“They throw others out like they don’t know them”

5. **Influences**

5.1 Cultural and Traditional influence and practice

Some participants responded in that their culture, and upbringing influenced how they observed and understood mental illness.

“Ngoba nakhu umuntu egula. Musa ukumthathisa sengathi akayena umuntu ngoba naye umuntu ofana nawo. Inkinga ukuthi unenkinga” ***(Participant 1)***

“Just because a person is ill that does not mean you must treat them as if they are not human, because they are human just like you the only difference is that they have a problem”

“Ngike ngibone abantu abahlanayo behanjiswa eynangeni hlampe behlala 3 months babuye sebengcono. Abanye babuya baberight hlampe isikhashana babuyele. Abanye babuye seberight sebengase nalutho” ***(Participant 3)***

“I often see mentally ill people being taken to the medicine man where they remain for three months and return better. Others are better for a little while and have to go back and others are never go back because they are okay”

“My culture and my tradition makes me believe ukuthi we all the same ukuthi umuntu ukuthi akumele wena umthathe ngenye indlela just because ubona engezi into, ubona engazenzi lezinto ozenzayo, cha naye unjengawe. Wena mawuzwa ubuhlungu naye uyabuzwa, wena mawufuna ukujabula naye uyafuna ukujabula. Wena ngoba ufuna ukwamukelwa ngendlela oyiyona naye uyakufuna lokho. So iyangifundisa ukuthi akumele ngitreathe wonke umuntu differently just because ngimubona ngendlela ehlukile” ***(Participant 4)***

“My culture and traditions make me believe that we are all the same, we shouldn’t treat people differently because they are not doing the same things as we are. They feel pain just like us, they want to be happy just like us, and they also want to be accepted as they are. My culture and traditions have taught me not to treat others differently just because they are not like me”

“Kufana njengomuntu osuke eloyiwe entshonthsile. Coz kwezinye indawo umuntu metshontshile uthi uyabona nakhu usebanjiwe, sometimes usuke eshayiwe omunye, ashawe aze alimale engqondweni ahlanye ngomqondo. Abanye baba paralysed bahambe

ngamawheelchair, kufana nomuntu ojamile ongenzi lutho. Bahlukene" ***(Participant 9)***

"It is like a person who has been bewitched due to stealing. In other places when a person has stolen something, they are caught and beaten until there is damage to their mind, others become paralysed"

"Ya kodwa kuyadephenda ukuthi lomuntu loyo osuke uyomhlanyisa usuke nje ufuna ukumenza something bad uya kumuntu onjani. Kodwa kwesinye isikhathi thina maZulu engbaziyo into enje abayenze hlambe nje bayamshaya umuntu kuphele kanjalo noma aboshwe. Kodwa imost yabo bayasho ukuthi yabona lo njengoba engeze into eyukuthi ngizohamba ngyomenza ukuthi ahlanye. Uyoze alikhiphe mhlamoe iqiniso lokuthi leyonto uyenzile, uma kukuthi akayenzanga ngike ngingazi ukuthi kwenzekalani" ***(Participant 10)***

"It depends on what you want to do to the person you're bewitching. However, the Zulu people I know normally hit the person or have them arrested, but most of them say that since that person has done something bad to them they will go and make them mentally ill until they confess. If the person really hasn't done anything I'm not sure what happens to them"

5.2 Other Influence

Some participant's responses indicated that their opinions and understanding were formed through their observations, and their experiences within the community.

"Ukuthi vele ngijwayele ukuba bona ngoba bakhona la emphakathini. Ngikholelwa ekutheni uNkulunkulu osuke evumile vele ukuthi ayi

kungcono ahlanye ngoba sonke vele sidlawe uyena. Konke kwenzeka yena masevumile" ***(Participant 2)***

"I normally see them because we have them in the community. I believe it is God who has allowed them to be mentally ill, because he has created us all, all things happen as per his permission"

"Ngaba indawo engikhulele kuyona nabantu engikhule bengisurroundile nangendlela ebengikhula ngizwa ngayo mekuchazwa umuntu ohlanyayo" ***(Participant 6)***

"It can be the area in which I was raised and the people I grew up surrounded by and the stories I grew up hearing about mentally ill people"

"Imicabango yami iqhamuko ezintweni engizibona zenzeka khona lempakathini" ***(Participant 8)***

"My thoughts come from the things I see happening in the community"

"Indlela uhm njengalo esijwayele ukumbona lana, ugqokile ibhulukwe alifasiwe uhlezi elibambile, mnyama, ayikho nje into ayicabangayo kugcwele amaphepha lana. Like ingqondo yakhe ayisebenzi nje nhlobo, akazi naye uwacoshe lani yona ndlela engicabanga ngayo" ***(Participant 9)***

“There is one that I always sees around here, he’s dark, always hungry, there’s always papers around him, he doesn’t think. His mind doesn’t work; he doesn’t know why he’s picking them up. That’s what I think”

CHAPTER FIVE

DISCUSSION

This is the section which will look at discussing the themes and literature in interpretively evaluating the results which have been gathered from the interviews conducted with the participants from the area of KwaNyuswa in KwaZulu-Natal, South Africa. The participants were from two high schools, KwaNtebeni Comprehensive High School and Siyajabula High School. The purpose of the study was to explore the social representations of the youths in rural South Africa in relation to mental illness (*'ukuhlanya'*). In this chapter the themes which were identified in the study will be looked at. The themes will be used to look at the understanding, perceptions, opinions, influences and views of the participants regarding mental illness (*'ukuhlanya'*); these will further show where the mental health knowledge and understanding is positioned within the interviewed population.

Description of the drawing

Particular reference was paid to this theme due to the pictorial representations of the participants. The usage of the pictorial representation provided the participants a non-threatening way to make the unfamiliar, familiar, which is a key premise of Social Representations Theory. The sub-themes which emerged from the participants' narratives were that of *physical appearance, appearance of clothing, and relationships* and *behaviours.* These indicated much of how the scientific knowledge of mental illness has become socialised into everyday common sense.

In looking at the sub-themes of *physical appearance and appearance of clothing* the narratives of the participants indicated a social construct of observing the appearance of an individual in the community, thus, assigning the label of '*ukuhlanya'* (mentally ill person) to the individual. The literature shows that throughout Africa the observable characteristics of the mentally ill are what underpins the social development of the understanding of what is happening with the particular individual. The appearance of the mentally ill has been anchored in the communities pre-existing ideas of how the 'normal' and 'abnormal' should appear as seen in this quote: *"akagqoke nezingubo nje, like ingubo ugqoka oplastiki futhi njengoba sigqoka akagqoki njengoba sigqoka uyagqoka nje" (Participant 9)*

"He is not wearing clothing like we would wear, he is wearing plastic packets", thus, the concept of mental illness is provided an identity and the community's unfamiliarity with mental illness is reduced because they are able to place identifying ideas on mental illness. In the literature review a study done by Patel was indicated which displayed that the respondents in that study were able to identify the mentally ill through their observed inappropriate behaviours, such as impairments in self-care, aimless wondering and ingesting inedible or dirty products (Sorsdahl, Flisher, Wilson and Stein, 2010). This research study indicates the idea of mental illness being a phenomena that is marked by what the community observes as 'abnormal' behaviours such as lack of self-care. This seemed to be a significant qualifier for mental illness, with an intense preoccupation with how one's hair was kept, this was indicated in these quotes from the participants narratives: *"Inwele zakhe lana ziyabonakala ukuthi nje uhlanya nje, ziyabonakala ukuthi umuntu ohlanyayo, coz akakamile. Bese kuthi la inyembezi, ezekhala la. Ungcolile, ngoba phela uhlanya alugezi" (Participant 1)*

"From looking at his hair you can see that he is mentally ill, because his hair is not combed. He also has tears showing that he was crying. He is also dirty because mentally ill people do not bath"

"Nezinwele zakhe ziyabonakala nje ukuthi umuntu ongekho right. Nezinwele ezingahlelekile" (Participant 2)

"You can see from his hair that he is not alright, his hair is dishevelled".

All the participants noted hair as being a signifier of the lack of self-care, not bathing was also noted by a couple of the participants *"Lomuntu engimudwebe lana akagezi, akagundi"* (Participant 9)

"The person I have drawn here does not bath and he does not cut his hair".

In looking at the theme of *appearance of clothing* participants noted that mentally ill persons clothing was unkempt and unclean, oversized or made of unconventional products like plastic packets "*Bese kuthi la emqaleni ubophele amaphepha. Bese kuthi la ibulukwe nalo nje liphuphile elikhulu, ugqoke ibulukwe elikhulu. Mese kuthi aligqokile ngaphezulu. Lihamba ngey'nyawo futhi" (Participant 1)*

“The person I have drawn has papers tied around his neck. His pants are worn out and too big for him, he is not wearing anything on his upper body and he is walking barefoot.

“Ugqoke nebhulukwe elide komunye umlenze omunye mufishane” (Participant 2)

“He is wearing pants that do not have the same length legs; one leg is shorter than the other”.

The communities developed a social representation underpinned by what they observe as ‘abnormal’ it has constructed an identification criteria based on the appearance of a specific group and the appearance translates into the diagnosis of *‘ukuhlanya’.*

The sub-theme of *relationships* also came through in the participant’s narratives, in literature it has been noted that mentally ill persons are not regarded within their communities; the communities are unsympathetic towards mentally ill individuals. Research from Lyons and Hayes has also observed that where there is a presence of negative community attitudes towards the disabled members of that particular community, there is a great amount of stigma attached to individuals who are deemed to be acting or behaving in a manner that is unpredictable or potentially dangerous (Hugo et al, 2003) *“ngidwebe nomuzi la ngadweba nomgwaqo, kukhombisa ukhona usemphakathini ngeke aze avele ahlale yedwa nje” (Participant 2)*

“I have drawn a house and a road to indicate that he is in the community, he does not live alone”.

The participant’s narratives indicated that in this particular community mentally ill persons are within the community, however, they are separate from the community as a whole. One participant noted that mentally ill persons are used for their care dependency grant *“Isiskahthi esininigi abanye bayobhalisa ukuthi umuntu uyagula ukuze bathole imali kodwa yena bebe bengamunakekeli” (Participant 3)*

“Most of the time people apply for a care dependency grant in order to get money for the sick person, however, they do not take care of the person”

There appears to be an anchored representation of mentally ill individuals as separate from the rest of the community. This is observed as identity protection within Social

Representations Theory – the community appears to be faced with a potentially contaminating and threatening occurrence, thus, the mentally ill have been separated from the rest of the community in the form of an 'out-group' (O'Conner, 2012*) "uhlala emugwaqweni akanakhaya hes lonely, akanabangani, akanamuntu ahlala naye" (Participant 4)*

"He lives on the streets, he is without family and friends. He has no one to live with and is lonely", as observed in the narrative of participant 4. This is similar to the occurrence of HIV/AIDS in that the society distanced itself from the disease and whatever the implications of the disease may have been on the community (O'Conner, 2012). It is being observed in the participants narratives that mental illness is observed as a potential threat to the community's identity to a certain degree, thus, the community distances itself and there appears to be a feeling that mentally ill individuals distance themselves through leaving their original homes as seen in participant 7's narrative of a mentally ill individual living in the bush *"uhleli ehlathini" (Participant 7)*

"He is living in the bush".

It does not seem for the most part that the community attempts to reintegrate the mentally ill into the community much aside from reintegrating them into families in order to gain access to the care dependency grant. This also speaks to the possible levels of poverty within communities that although they want to be separated from their ill family member, they would 'tolerate' the association in order to gain monetary means of survival.

The final sub-theme which appeared in this theme was that of *behaviours of the mentally ill.* The participants noted behaviours of mentally ill persons as being those of violence, hoarding behaviours, eating inedible things, talking to oneself, and wandering about the community *"nokucosha amaphepha yena usuke ewacosha ewaletha kuyena instead of "ewacoshe ewalahle kodwa uyawaphatha yabo" (Participant 1)*

"When he picks up papers, he hoards them instead of throwing them away he keeps them"

"Udla noma yini ahambe noma ikephi. Acoshe noma yini nje eseduze kwakhe .abantu abaningi engseke ngababona bathanda ukushaya kakhulu. Bashaya bonke abantu

ngisho bengenzanga lutho. Abanye bavesane bahambe ungazi bayaphi. Kwenye inkathi bangabuyi, kwenye inkathi babuye emva kweminyaka" (Participant 3)

"He eats anything and wanders around. He picks up anything around him and most people I have seen like to hit a lot. They are physically abusive to others even though they have done nothing. They wander and disappear, at times they return and at other times they never return"

"Uphethe isagila since elonely akasitholi isikhathi sokuthi abe nabantu afunde ukuhlalisana nabantu so yena mebona umuntu ubona isitha that's why ephethe isagile ukuthi abashaye. Lesi esinye isandla uphethe udoti since ementally disturbed ucosha noma yini ahlangana nayo" (Participant 4)

"He is carrying a knob kierie, he finds no time to be with other people, thus, he is lonely and does not know how to interact with people. When he sees others, he sees them as enemies, he carries the knob kierie in order to hit them. In his other hand he is carrying garbage, because he is mentally disturbed he picks up anything"

"Uhleka into angayazi. Uphethe udoti" (Participant 6)

"He is laughing and carrying garbage"

The above quotes indicate the results observed in other African countries of how mentally ill individuals are seen. Literature showed that mental illness is expressed as manifesting as aggression, destructive behaviour, excessive talking, wandering around and being eccentric (Kaber, Iliyasu, Abubakar, Muktar, Aliyu, 2004). The above mentioned behaviours are a clear example of how this community has seen scientific knowledge and has anchored it within their context and community attributing familiar aspects to the category of mental illness like in Jodelet's 1991 study. The narratives also indicate some of the DSM-V diagnostic criteria for mental illness, namely the criteria of schizophrenic spectrum where the symptom of catatonic excitement is noted as 'wandering', avolition and asociality – these being the lack of interest in participating in activities which are self-initiated i.e. self-care or lack of interest in social interaction. In the instance of the bipolar and related disorders the symptoms of a manic episode or a hypomanic episode, observable in the mentally ill talking to themselves, wandering, being violent, and/or hoarding, are evident. This is the scientific knowledge

which the community has anchored in their pre-existing dialogue and has noted as eccentric behaviours of the mentally ill.

What is *'ukuhlanya'?*

In order to begin to understand and to be given a sense of how the participants thought and viewed mental illness, the theme of '*what is it'* emerged through the interview process. The sub-themes which emerged were the *description of 'ukuhlanya', causes of mental illness, different types (names)*, and the *personal understanding* of the participant's.

The sub-theme of the *description of 'ukuhlanya'* provided the participants an opportunity to express their individualised descriptions which they would place on an individual; this provided the opportunity for the researcher to identify where the knowledge of mental illness was placed in the particular age group and community context. Literature had shown that throughout the centuries mental illness has been given many names and definitions, and it has in many instances been a misunderstood concept (Narter, 2006). Madness has been at points considered evil or considered to be part of moral issues (Narter, 2006). In each of these understandings the social practices are noted as having influenced the variations imposed on mental illness (Narter, 2006). Thus, the social construct of the description of mental illness by the youth was noted through their narratives *"'ukuhlanya' umuntu okhubazekile ngokomuqondo owenza izinto ezihlukile njegalo engimudwebile. Izinto azenzayo izinto ezingajwayele ukwenziwa abantu so yena wenza izinto ezihlukile kodwa ngendlela thina esithi iyabheda ngokuthi manje izingubo azigqokile zidabukile kwase kuthiwa uyahlanya" (Participant 8)*

"Mental illness is a person whose brain is disabled, thus, they do things that are different, like the person I have drawn here. He does things that are not done by other people, the different things he does, are seen as not good. Since he wears torn clothes, thus he is called mentally ill"

"'ukuhlanya' ngingathini. Kunezindlela ezihlukene. 'ukuhlanya' isifo esike sihlasele ingqondo yomuntu. Agcine enze into engahlelekile kodwa yena usuke engazi ukuthi

wenza into engalungile konke kusuke kukuhle kuyena engazi ukuthi wenza into engalungile" (Participant 1)

"I would say mental illness, has different ways. It is an illness that attacks someone's brain, leading him to have disorganized behaviour; he is unaware whether he is doing a good or bad thing. It all appears good to him"

"'ukuhlanya' singakubona in different way njengo kuthi nje umbone umuntu obelungile umbone umuntu kuhambe kuhambe lomuntu usecosha amaphepha engesenahoe. Esehamba edlalisa noma ubani ngendlela engajwayelekile, esehamba edla izinja ezifile edla yonke into le esnaaks, ubona ngomuntu esengena emugqomeni edla emugqomeni and futhi abanye basuke bethakathiweke njengoba sengishilo" (Participant 10)

"We can see mental illness in different ways such as seeing someone doing well in life, as life continues you eventually see them picking up garbage, being oddly playful with anyone, eating dead dogs, eating out of dust bins. Others have been bewitched, like I said"

The participants indicated a similar way of describing a mentally ill person. The participants all described the person through the means of behaviour, they also included the medical construct with regards to the individual having some kind of difficulty within the brain, and they all noted a sense of senselessness which is exhibited by mentally ill persons. The participants have anchored and objectified the concept of mental illness into behaviours and into an understanding of the possible medical components which are part of mental illness. Through this sub-theme it was noted that the youth in rural KwaZulu-Natal have a general understanding and knowledge of mental illness.

A sub-theme of the *causes of mental illness* emerged in the narratives of the participants in that the participants were noting genetic disposition, substance abuse, thinking too much, bewitchment and having a difficult childhood as causations of mental illness. The literature indicated that in Africa specifically, in a study conducted in Nigeria (Gureje, Lasebikan, Oluwanuga, Olley and Kola, 2005), that community members in the study believed that drug abuse was the cause of mental illness. Other studies in African communities indicated causation to be due to God's will, a divine wrath, spiritual or magic possession, genetic dispositions, familial conflicts, trauma and

poverty (Kaber, Iliyasu, Abubakar, Muktar, Aliyu, 2004). The participants noted causations were similar to those found in previous studies *"phela ukugula ngekhanda sikuthatha ngo… Vele ukugula ngekhanda kuchaza ukuthi uyahlanya angithi, ngiku-understand kanjalo. Ukuthi nje once wagula ngekhanda uyahlanya. Noma yinto vele ebikhona emqondweni wakhe ebikhona kancane yagcina iya ngokukhula ngokukhula. Yagcina imaffecta wagcina ehlanya. Ngicabanga ukuthi usuke enenkinga vele engqondweni. Usuke enenkinga engqondweni eya ngokukhula ngokukhula" (Participant 1)*

"We see having something wrong with your mind as being mentally ill, that is how I understand it. Once there is something that happens in your mind then you become mentally ill. It is something that has been in your mind, which has escalated and has led to mental illness"

"Ngicabanga ukuthi ukucabanga kakhulu, kuyamenza umuntu ahlanye. Ukucabanga nezinto eziningi nengqondo yakhe, angazi ngzothi iyasindelwa noma injani" (Participant 2)

"I think, thinking too much makes someone mentally ill, thinking about a lot of things becomes too heavy for their mind"

"Bebandakanye namadrugs hlampe abanye bawasebenzise ngokweqile. Umuntu agcine engasakwazi ukucabangisisa kahle, abanye mengabe bezanyelwa usizo hlampe beyiswa kuma rehab bazibuyele mese baphinde bazosebenzisa amadrugs mese imizimba yabo ingasakwazi ukwenza ngendlela ejwayelekile mese ingqondo nayo iyadamejeka ngenye indlela nje. Ngoba amadrugs anezinto ezingadingeki emzimbeni" (Participant 3)

"They were using substances, and may have been abusing them until they were unable to think straight. Others are placed in rehab and they abscond and return to abusing substances until their bodies are unable to function and their minds become damaged because drugs contain elements which should not be in the body"

"Mina istory esengisizwile abantu bengichazela why lo esenje I think okuningi benziwa abantu. But okunye bathi kwenziwa hlampe ukuthanda into kuze kweqe ugcine usuhlezi wenza leyonto, kuze kudlule kube sengathi awusathathi kahle ekhanda" (Participant 4)

"The stories I have been told indicate that mental illness is inflicted by others on an individual. Other stories indicate that mental illness occurs due to an individual being obsessed with something until they do that one thing over and over again until it becomes a habit then you seem as if you are mentally ill"

"Kuyenzeka ukuthi uzalwe nakho. Kuwufuzo or ngesikhathi ekwiprocess ezalwa kwabakhona into eyenzeka, yaaffectha ingqondo yakhe. Noma umawakhe hlampe esaseswini khona izinto azidla or something. Kodwa uzalwa nakho" (Participant 6)

"One can be born with a mental illness, it can be genetically inherited or during childbirth there may be a complication or whilst the mother was pregnant she may have eaten something which lead to the child being born mentally ill"

"Kokunye umuntu ugcina hlampe esehlanya isimo esisuke sisekhaya hlampe uyahlukumezeka, nayo futhi indlala" (Participant 8)

"Due to a person's home circumstances and hunger they may develop a mental illness"

The narratives of the participants indicate cognitive polyphasia in that the participants have coexisting knowledge within them; they appear to acknowledge genetic, substance-induced, pre or post-natal complications, poverty, thinking too much and the concept of bewitchment. These coexisting sets of knowledge of the scientific causations as well as, the culturally constructed understanding of causation exists within these participants – this may be due to high literacy levels whilst also being embedded within their own culture. It may be a process of acculturation which has occurred through the education system which is internationally adopted, therefore, the participants are able to identify a more 'Western' explanatory model. However, they have not lost their own cultural explanatory model and it still plays a part in their construction of their understanding.

The *different types (names)* and sub-themes emerged from the participants who, when asked about mental illness using the word *'ukuhlanya'* began using different words to describe mental illness. The participants elaborated on the words used in order for the researcher to gain a better understanding. The participants began to describe different behaviours and attributing a 'diagnosis' to each of the behaviours they were describing *"Abanye omunye uthole ukuthi akalona loluhlanya oluthwalayo. But uloluhlanya*

olungcolayo. Ngicabanga ukuthi indlela yena agula ngayo, ayifani nale yabanye. Ngicabanga ukuthi bagula ngezindlela ezingafani" (Participant 1)

"You find that others are mentally ill but they do not hoard, they instead are just unhygienic. I think it has to do with the nature of their illness; it is not the same as the others. They have different mental illnesses"

"Umuntu omentally disabled. Ngokucabanga kwami igama leli gama leli ayi ukuthi umuntu ongacabangi kahle kodwa indlela enza izinto ngayo ihlukile kunabanye abantu. Umuntu ohlukile kunabanye abantu. Akafani ngendlela esicabanga ngayo thina abantu nje. Mmm ngathi umuntu ya umuntu owenza izinto ngendlela yakhe nje" (Participant 2)

"I think that a mentally disabled person this is a name which doesn't mean a person cannot think clearly but rather it means he behaves differently to other people and is different to other people. He is not the same as us; he doesn't think like us and does things his own way"

"Lona umentally disturbed. Aphazamiseka khona ngokwenqondo. Ukusangana. Lichaza 'ukuhlanya'. Osanganayo, uthanda ukuthetha, naye futhi uthanda ukushaya, uthanda ukublamer abantu ngisho ingekho into embi oyenzile kodwa nje efune ukulokhe exabana nawe" (Participant 3)

"This person is mentally disturbed. His mind is disturbed. He is mad and has hallucinations. A hallucinating person shouts a lot, he is physically aggressive, he is paranoid and blames others and wants to cause arguments"

"Mehluko walaba abanodlame nalaba abaright? I think owalaba abanenkinga it because mhlampe back then umuntu esaright hlampe khona lento eyamhurtha angakwazanag ukuthi ayikhulume yagcina isimuphendula ukuthi engabe esaba ilomuntu ayewuyena. And leyonto iyona emucontrollayo ukuthi agcine esebona abantu sengathi abantu ekumele alwe nabo. Nabantu njengeylwane" (Participant 4)

"The difference between physically aggressive ones and those that are okay? I believe that the aggressive ones have gone through some traumatic or hurtful experiences whilst they were okay and they were unable to speak about it until he became someone else. That experience controls him to see others as enemies and animals"

The participants began to use words like mentally disturbed or mentally disabled as opposed to *'ukuhlanya'.* In using these words the participants also began to name behaviours such as hoarding, being unkempt, physical aggression, and hallucinations, and the participants appeared to be attempting to differentiate between disorders. The participants appeared aware of the fact that there are different disorders, however, were unclear on what they were or what this meant. Furthermore, the factor of causation was viewed in the sense of differentiating between behaviours and naming as well as outcomes of different names for example participant 2 states: *"I think that a mentally disabled person this is a name which doesn't mean a person cannot think clearly but rather it means he behaves differently to other people…"* There is an understanding of differences which is present, however, there is not enough knowledge for the participants to be able to definitively differentiate. Furthermore, the use of different words i.e. "mentally disabled, and mentally disturbed" appears to not mean the same as the Zulu equivalent of *'ukuhlanya'*. The use of the Zulu word appeared to be difficult for the participants to say and they opted to use English equivalents, this could be the fact that the Zulu word of *'ukuhlanya'* in the most direct translation means madness and it has over time become seen as a derogatory word, at times used to belittle or insult someone. This move could be due to the education system and the higher literacy levels of the participants.

The final sub-theme which appeared was that of *personal understanding.* In this sub-theme the participants identified how they personally understood mental illness. The majority of the participants simply stated the noted behaviours of the mentally ill and how that is what they understood of mental illness. The three chosen narratives were of a different nature and the participants exhibited a difference in their understanding. Participant 10 and Participant 4 speak of mental illness being self-inflicted which was found in the literature to be an accepted understanding within the African context. Literature observed that an individual seen as being mentally ill is then viewed as having self-inflicted the mental illness upon themselves through the elicit use of substances which caused the wrath of God to fall upon the individual (Gureje, Lasebikan, Oluwanuga, Olley and Kola, 2005). There is a premise amongst African culture that one can cause disease to be placed upon themselves through the ancestors or through God's wrath. Participant 4 further stated that it's a choice one makes to be mentally ill.

“Sibu-understanda as in like sometimes umuntu ozenzile, owenza something engahambiselani nenye into. As in umuntu odlwengulayo amaphoyisa ajike futhi aphikelwe aphume masekuthi umzali waleyomuntu maseyahamba ayomhlanyisake. See understanda as in nje umuntu ozenzile noma umuntu owenziwe ukuthi mhlampe umuntu beyinto eright empilweni mase beyamhlanyisake ngoba befuna ukuthatha something yakhe mhlawumbe” (Participant 10)

“We understand it as in someone has brought it upon themselves by doing something wrong, such as raping someone and they are held unaccountable by the law then the victims’ family will take the law into their own hands and bewitches them. Or the person becomes bewitched due to jealousy or envy over something they have”

“KwiEnglish its specific mentally disturbed kushuthi kuyasho ukuthi uhlukumezeke ngokwengqondo. Kanti ngokwesiZulu uyahlanya it’s like uyazenza vele, it’s just a decision uvuke wayitshela ukuthi ngzohlanya. Ngzovele ngenze izinto ngalendlela abantu benza ngayo, ngzokwenza into ngendlela yami” (Participant 4)

“In English the word mentally disturbed is specific to being mentally impaired however in isiZulu mental illness is something you have done to yourself, it is a decision you woke up and took. That you would do things your own way and not like others”

“Ayimina ngicabanga ukuthi nje noma kuthiwa khona umuntu ohlanyayo kumele umphathise njengabanye abantu ngoba naye usawumuntu nje” (Participant 2)

“I believe that even if there is a mentally ill person you should treat them the same as anyone else because they are human too”

Participant 2, brought forth the spirit of *Ubuntu* which is one that has underpinned African culture, the “umuntu, umuntu ngabantu” (I am because you are) cultural belief system which could be explained by the fact that participant 2 is a female and literature showed that females exhibit more sympathy for the mentally ill than males do, or, it is possibly the influence of her cultural background, and the way she has thus constructed her representations of the world around her as not being a threat to her identity but rather as part of her journey as a human being. The participants appeared aware that there are different types of mental disorders, however they lack clarity regarding symptom criteria and their subsequent effects.

Community perceptions

There appeared to be quite a lot of beliefs and views on mental illness which emerged and appeared to be embedded within the structure of the community itself, thus, sub-themes of the *treatment by community members, bewitchment* and *the 'other'* emerged from the narratives shared by the participants.

The sub-theme of *treatment by community members* came through in the participants' narratives rather strongly and it is also a factor that needs attention when looking at research regarding perceptions of the mentally ill, as the community as a whole are the custodians of mentally ill persons found in their area. This is in line with Social Representations Theory with ideas of the object being a threat to the identity or social cohesion of the society (O'Conner, 2012). Flament and Rouqette also added some contributions to the understanding of social representation in commenting on conditions that would be considered, such as that the object must be something that the society has comments about, and that there must be some association with the practices of the society (O'Conner, 2012). It can be seen that mental illness is something that the participant's communities have comments about and that mental illness appears to be a threat to the community's identity, thus, the narratives of the participants indicate physical violence being exerted upon the mentally ill and inhumane types of treatment where individuals are denied a basic need such as water *"Ubdlelwane wabantu abasemphakathini nabantu abahlanyayo, abubuhle ngoba angisho ukuthi bonke, abubuhle ngoba mawuzohlala nomuntu ohlanyayo abanye hlampe bake bamshaye" (Participant 8)*

"The relationship between the community and the mentally ill is not good, because if you go and engage with one of them some community members would go and physically assault him"

"Ababatreathi ngendlela mabebona umuntu ohlanyayo nje ngathi babona istranger abanye bayamhleka. Bemhleka, nje. Abathathiswa nje kwabantu" (Participate 1)

"They do not treat them right, it's as if they see strangers when they see the mentally ill and they laugh at them and don't treat them like human beings"

"Babasebenzisa ukuthi bona bathole imali. Like ukuthi bayabathatha bahlale nabo babalungisele yonke into nempesheni but uthole ukuthi lomuntu lo ulala emnyango,

isikhathi esingingi endlini akanakwa kodwa labantu bayahola. Abathengelwa ingubo, bahlezi begqoke ingubo ezizodwa kodwa labantu bayahola, bahlala nomuntu ophilile ekhanda" (Participant 4)

"They use them to get money, they take them to apply for a disability grant, however, when at home the mentally ill individual sleeps outside, nobody takes care of him, they don't buy him clothing or anything yet their carer gets the disability grant and they are sane"

"Bayahlukunyezwa bayashawa. Noma ethi uyafika ekhaya uzocela amanzi uyancishwa" (Participant 7)

"They are ill-treated and beaten, even when they come ask for water at someone's house they do not give them any to drink"

The above chosen quotes reflect the relationships with the mentally ill as observed by the participants within their communities. All the participants narrated negative community attitudes towards the mentally ill. This type of relationship with the mentally ill has been noted in literature and could be due to the lack of resources which are directed at educating and addressing negative belief systems, the fear and suspicion of the mentally ill within communities plays a huge role in the social rejection, isolation and abuse of people who suffer from psychiatric disorders (Hugo et al, 2003). Furthermore, the impact of culture and African traditions on the community and its understandings is great. African communities, particularly in rural areas, are still very much shaped and informed by traditional healers (Sorsdahl, Flisher, Wilson and Stein, 2010). These factors would explain the ill treatment of mentally ill individuals, there is a scarcity in studies and health promotion packages aimed at communities at a level that they are able to understand and identify with in South Africa, thus, the ability to interact with mentally ill persons more humanely is one which is difficult in this particular rural area.

The sub-theme of *bewitchment* came up quite often and throughout each of the participant's narratives, the traditional belief systems appear to still be quite embedded within the participants and governed some of their understanding: *"'ukuhlanya' ukugula. Kodwa sometimes because siphila in the rural areas kuyenzeka ukuthi*

umuntu wayethakathiwe then wahlanya. Wayephile eright engenalutho. Maybe wantshontsha then bese bamthakatha mese wahlanya ingqondo yakhe yangabe isasebenza completely" (Participant 6)

"Mental illness is a sickness but because we live in the rural areas it does happen that a person is bewitched. They may have stolen something and been bewitched and then their mind was never the same again"

"Abantu abaningi basuke benziwe abanye abantu ngoba basuke benomona ngento anayo, abanye hlampe usuke ekhule nakho from abazali bakhe" (Participant 7)

"A lot of mentally ill people have been exposed to witchcraft due to jealousy and envy from others whilst some have grown up with, they genetically inherited it from their parents"

"Omunye usuke enziwa, so uzwe kuthiwa, hawu yazi lo weright, unezitifiketi, unamaqualifcation kodwa mbuke lesenjalo .abanye njengeyigebengu, uyafika emzini womuntu agqekeze antshontshe then beseke bayahambe ke abantu abakholwelwa enyangeni, bese bayahambe bayobaloya then bahlanye" (Participant 1)

"Others have been made by someone else to be mentally ill, you often hear people saying that the person was alright previously, they had some kind of qualifications or they were involved in criminal activities and they go to someone's home and steal and the home owners go to a witch doctor and use witchcraft against them"

The concept of witchcraft and the dependence on traditional healers for understanding mental illness is still very much present within the African understanding and social representation construction. The literature showed that traditional healers explanatory models of mental illness were separated into psychotic and non-psychotic: the psychotic disorders were viewed as the main example of mental illness and the non-psychotic disorders were explained by respondents as "thinking too much" (Sorsdahl, Flisher, Wilson and Stein, 2010). This particular study raises awareness on the impact of culture and African traditions on the community and its understandings. African communities, particularly in rural areas, are still very much shaped and informed by traditional healers (Sorsdahl, Flisher, Wilson and Stein, 2010). Thus, the existence of this understanding is still present in the youth within this community.

The "other" sub-theme became very evident in the participants' narratives. The stigma and separation of the community from the mentally ill members of the community was very much evident. There was a sense of the community seeing mentally ill persons as 'the other' rather than an extension or part of themselves, this further indicated the communiy's identity protection as the presence of the mentally ill provides a threat to the constructed identity of 'normality' vs 'non-normality'. The literature indicates that this phenomena is present in all spheres when it comes to mental illness – the evolution of the human being needs to be looked at in that modernity has instituted the definition of the human being as a rational object. The ability of society to intellectualize reason has played a part in the redefinition of mental illness over the decades to where it presently stands (Narter, 2006). So, in looking at oneself in relation to the mentally ill, one sees self as rational and the other as not and this becomes a threat to identity and the beginning of socially separating from that which seems irrational, as in the instance of this study and the participants' narratives.

"Noma bafele amathe ukutshengisa ukuthi abafuni nje into ezobahlanganisa naye" (Participant 8)

"They are spat on; this is to show that the community doesn't want them there"

"Abanakiwe, abanakekelwa nje. Bayaziphilela nje emugwaqweni" (Participant 9)

"They are not cared for and no one cares about them, they just live on the streets"

"Nje abantu abahlala nje emphakathini wabo bodwa" (Participant 1)

"They are people who live in their own separate world"

"Mengabe ngibona umuntu osanganayo nomuntu ohlanyayo angiphatheki kahle ngiphatheka kabuhlungu ngoba ngike ngicabange sekuthiwa umuntu ohlanyayo hlampe ukhona hlampe nasemndenini wami noma umngani wami ashintshe naye asangane. Nje angiphatheki kahle kodwa ngisuke ngingazi ukuthi ngingamusiza kanjani lomuntu" (Participant 3)

"When I see someone mentally disturbed and someone mentally ill, it makes me sad because I always think that they could be in my family or a friend. I am saddened by their circumstance but I never know how to help"

The otherness concept could be as a result of the history of mental illness and the social representations of mental illness in South Africa where mentally ill individuals were left in communities and as times changed, mentally ill individuals were institutionalized. The levels of overcrowding were a constant feature of South African institutionalisation, the lack of effective treatments, the chronicity of mental illness and the lack of resources within South Africa were factors that contributed to the overcrowding of the institutions (Gillis, 2012). Community service and effective treatments have provided relief to the psychiatric hospitals overcrowding status (Gillis, 2012).Thus, more mentally ill individuals are being found within their communities due to the South African issues which transcend the past. The 'revolving door' effects on mental health and the decentralization of care which is taking place around South Africa plays a role in the situation of finding the mentally ill within their communities, having defaulted from medication, due to there not being enough beds within the hospital system, due to individuals feeling dehumanized, gaps in referral systems and so much more at the various levels of care (Lund, Petersen, Kleintjies & Bhana, 2012). Once the mentally ill are within their communities, the community members establish and maintain mental and social distances from the mentally ill individuals within the community. According to Jodelet's (1991) study madness always depicts itself to be a threat to the constancy of daily living. This is being seen through the participant's narratives where the mentally ill have been separated from the community. A study by Morant indicates themes of otherness and sameness in how mental illness is socially represented. Morant's research indicated that the mentally ill possess varied experiences which cannot be understood by the "normal" people, thus, the mentally ill are the "Others" Morant (1995). It is also important to note that in Africa stigma and ignorance still frame mental health in a negative light (Hugo et al, 2003). The community's attitudes and their perceptions of people with psychiatric disorders are majorly influential in the successful treatment and social reintegration of the mentally ill into their communities (Hugo et al, 2003). The otherness sub-theme speaks to the still present difficulties of society to integrate the mentally ill into their identity.

Influences

The final theme which emerged was that of influences which have had an impact on the views and opinions of the participants. The *cultural and traditional influences and practices* was noted as a sub-theme due to the fact that culture and tradition is not something that one can separate themselves from – it has its impact and influence on the way we see ourselves and the world around us. The sub-theme of *other influences* was also apparent due to the fact that some of the participants cited having other things that influence their opinions, views and social construction regarding mental illness.

The sub-theme of *cultural and traditional influences* indicated a social construct of the participants being shaped by that which they have learnt whilst growing up in their respective communities. Their belief systems appear to be heavily embedded in the idea of 'Ubuntu' like participant 4 expressed – treating one like you would want to be treated – whilst the rest of the participants cited the manner in which one develops a mental illness or the causation of a mental illness as being from witchcraft due to jealousy or envy. This appears to be the consistent model used within African communities in order to explain illness and the participants appear to still abide by this model.

"My culture and my tradition makes me believe ukuthi we all the same ukuthi umuntu ukuthi akumele wena umthathe ngenye indlela just because ubona engezi into, ubona engazenzi lezinto ozenzayo, cha naye unjengawe. Wena mawuzwa ubuhlungu naye uyabuzwa, wena mawufuna ukujabula naye uyafuna ukujabula. Wena ngoba ufuna ukwamukelwa ngendlela oyiyona naye uyakufuna lokho. So iyangifundisa ukuthi akumele ngitreathe wonke umuntu differently just because ngimubona ngendlela ehlukile" (Participant 4)

"My culture and traditions make me believe that we are all the same, we shouldn't treat people differently because they are not doing the same things as you are. They feel pain just like us, they want to be happy just like us, and they also want to be accepted as they are. My culture and traditions have taught me not to treat others differently just because they are not like me"

Participant 3 speaks of seeing mentally ill patients being taken to traditional healers, this speaks to the fact that traditional healers still hold a large amount of weight

regarding illness within rural communities, and their understanding or explanation of illness is still very much a part of the development of social representations. Participant 10 speaks of bewitchment and this also shows the predominant socially accepted understanding of illness and the power which traditional healers still hold.

"Ya kodwa kuyadephenda ukuthi lomuntu loyo osuke uyomhlanyisa usuke nje ufuna ukumenza something bad uya kumuntu onjani. Kodwa kwesinye isikhathi thina maZulu engbaziyo into enje abayenze hlambe nje bayamshaya umuntu kuphele kanjalo noma aboshwe. Kodwa imost yabo bayasho ukuthi yabona lo njengoba engeze into eyukuthi ngizohamba ngyomenza ukuthi ahlanye. Uyoze alikhiphe mhlamoe iqiniso lokuthi leyonto uyenzile, uma kukuthi akayenzanga ngike ngingazi ukuthi kwenzekalani" (Participant 10)

"It depends on what you want to do to the person you're a bewitching. However, the Zulu people I know normally hit the person or have them arrested, but most of them say that since that person has done something bad to them they will go and make them mentally ill until they confess. If the person really hasn't done anything I'm not sure what happens to them"

"Ngike ngibone abantu abahlanayo behanjiswa eynangeni hlampe behlala 3 months babuye sebengcono. Abanye babuya baberight hlampe isikhashana babuyele. Abanye babuye seberight sebengase nalutho" (Participant 3)

"I often see mentally ill people being taken to the medicine man where they remain for three months and return better. Others are better for a little while and have to go back and others are never going back because they are okay"

In looking at *other influences* it was noted that participants have undergone some acculturation. For example, in the instance of participant 2 who has been influenced by a religious belief system hence believing that mental illness occurs because God allows it to be so for a particular individual. This belief system is one encountered in literature in Nigeria where there is the belief that God's wrath falls upon an individual *"ukuthi vele ngijwayele ukuba bona ngoba bakhona la emphakathini. ngikholelwa ekutheni uNkulunkulu osuke evumile vele ukuthi ayi kungcono ahlanye ngoba sonke vele sidlawe uyena. Konke kwenzeka yena masevumile" (Participant 2)*

“I normally see them because we have them in the community. I believe it is God who has allowed them to be mentally ill, because he has created us all, all things happen as per his permission”

Whilst other participants attributed their social representations to what they have observed in the community so the language used, the treatment of mentally ill individuals and the general response of society to mentally ill persons has influenced the participants’ views. Furthermore, I believe that the education system and the present health promotion dialogues have helped to shape these representations.

“Ngaba indawo engikhulele kuyona nabantu engikhule bengisurroundile nangendlela ebengikhula ngizwa ngayo mekuchazwa umuntu ohlanyayo” (Participant 6)

“It can be the area in which I was raised and the people I grew up surrounded by and the stories I grew up hearing about mentally ill people”

“Imicabango yami iqhamuko ezintweni engizibona zenzeka khona lempakathini” (Participant 8)

In looking at the influences one needs to stop and consider the literature which speaks to the possible way of understanding the present attitudes. In Nigerian communities mental illness is viewed as a supernatural infliction, as a divine punishment for bad behaviour, thus, mentally ill individuals deserve the lot they are served. This supernatural view of mental illness implies that the use of western medicine would be futile in dealing with the mental illness, thus, traditionalists would be engaged in the healing process (Gureje, Lasebikan, Oluwanuga, Olley and Kola, 2005). In Africa, mental illness is viewed in relation to having to do with satisfying the ancestors, and witchcraft is ascribed to jealousy or pay back, the majority of the time. This speaks to the social representation of mental illness within Africa as such that the society does not approach this new phenomenon of mental illness having a blank slate, but rather observes it through the pre-existing sets of worldviews and representations that are held by the society. This provides a broader range of concerns than those encountered in expert evaluations (O’Conner, 2012) which in this case are those of culture and tradition, religion, and daily observations.

CHAPTER SIX

CONCLUSION

The social representation of mental illness as a scientific knowledge in its diagnostic patterns, and varying degrees is one which has been disseminated and found root in the rural community. It has been anchored in already present understandings of mental illness mainly brought about through culture and tradition and the presence of traditional healers who hold a pivotal role in such communities. Mental illness has been socially represented as a threat to the identity of the community and thus identity protection has taken place in the context of separating the community from the mentally ill, thus viewing them as the 'other'. Traditional healers still hold an important role within communities and it can be seen that the youth are still influenced by their teachings. Furthermore, there appears to be acculturation through the education system which has enabled the youth to hold two world views, a Western understanding of mental illness causation and the present cultural understanding of causation. Consequently, the youth appears more sympathetic towards the mentally ill, unlike the communities they find themselves in. It was noted during this study that there are also language difficulties experienced in providing an adequately descriptive Zulu word for the mentally ill. Participants were using English words which appeared to better describe what they observed rather than substitute Zulu words. This study showed that the youth from rural KwaZulu-Natal have developed social representations that are informed by their exposure to education, the communities they have grown up in and the belief systems that the community is rooted in. The social representations of the youth showed through the pictorial representation that the youths understanding of mental illness is still of eccentric, and bizarre behaviour. The youth has the understanding of differing causations and manifestations, however, they do not possess enough knowledge to differentiate and name varying disorders according to their diagnostic criteria. The assumed social representations were through this study found to be accurate and surprisingly different in that the youth had a greater amount of sympathy and willingness to understand than older individuals in rural communities. This is an area of research that can be expanded upon, through looking at larger numbers of participants and varying areas within South Africa. In this area there can be strides towards beginning to consider interventions at school going level in addition to the promotion of mental health, which would be aimed at a generation of growing

young people in the hopes of having a greater impact on the understanding, and presence of the mentally ill within communities.

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Appendix 1 A
Informed Consent Participant Form

My name is Sinqobile Elevia Nyalungu, and I am doing my Masters of Psychology (Clinical) through University of KwaZulu Natal, Howard College, under the supervision of Prof. Steven Collings (collings@ukzn.ac.za). We seek individuals who are willing to participate in a study about mental illness commonly known as ukuhlanya. The larger research interest is how young individuals from rural areas view, perceive and think about mental illness commonly known as ukuhlanya.

We would like to invite you to take part in our study. Participation will involve:
1) Taking part in a focus group with people from in and around your community (1 hour)
2) I, the researcher, would like to audio-tape the interviews, so we can pay attention to what each person says.

As a participant, you will have certain rights:
1) Voluntary – you have the right to choose to take part in this study. This means you are free to decide whether to take part or not, and furthermore, you have the right to withdraw at any stage, without fear of penalties or consequences. In the interview setting, you can choose to skip a particular question if you would prefer.
2) Confidentiality – By participating in this study, you have the right for your identity to be protected. You will be asked to choose a pseudonym, so that no one in the study will know your real name. This pseudonym will be used in the focus group discussion, and will be used in the transcription and final research project. Because you are in a group setting, you will be asked to sign a confidentiality pledge stating that everything said in the focus group will be kept confidential. By promising to keep what is discussed in the focus group confidential you are agreeing not to reveal the identity of anyone in the group or what was said by them to anyone outside the group. This will also encourage other participants to respect and protect personal information given by you during the focus group. Any personal information that is revealed during your participation will be concealed or made anonymous by the researcher in the report to protect your identity. However, please be advised that we cannot guarantee confidentiality even if a pledge is signed, as the researcher cannot guarantee that the other participants will adhere to the conditions of the confidentiality pledge. For this reason, it is recommended that you do not disclose any sensitive information about yourself when taking part in this focus group discussion. While your answers to these would be very helpful, it is up to you to choose whether or not to answer these questions, and to decide what level of detail you feel comfortable providing.

Your data will be used as part of my Research Project; your identity will always be hidden by the researcher.

Participant Agreement

I have read and understood the information sheet. I have been given the opportunity to ask questions, and agree to take part in this research project, knowing that my participation is voluntary and I can withdraw at any time.

_____	_____
PARITICPANT SIGNATURE	RESEARCHER SIGNATURE
_____	_____
DATE	DATE

Participant Agreement for use of tape recorder
I agree that my interview may be tape recorded, on the understanding that my identity will remain anonymous.

_____	_____
PARTICIPANT SIGNATURE	RESEARCHER SIGNATURE
_____	_____
DATE	DATE

Appendix 1B

Informed Consent Parent Form

My name is Sinqobile Elevia Nyalungu, and I am doing my Masters of Psychology (Clinical) through University of KwaZulu Natal, Howard College, under the supervision of Prof. Steven Collings (collings@ukzn.ac.za). We seek individuals who are willing to participate in a study about mental illness commonly known as ukuhlanya. The larger research interest is how young individuals from rural areas view, perceive and think about mental illness commonly known as ukuhlanya.

We would like to invite your child to take part in our study. Participation will involve:
1) Taking part in a focus group with people from in and around his/her community (1 hour)
2) I, the researcher, would like to audio-tape the interviews, so we can pay attention to what each person says.

Your child's rights as a participant:
1) Voluntary – your child has the right to choose to take part in this study. This means your child is free to decide whether to take part or not, and furthermore, he/she has the right to withdraw at any stage, without fear of penalties or consequences. In the interview setting, your child can choose to skip a particular question if he/she would prefer.
2) Confidentiality – By participating in this study, your child has the right for his/her identity to be protected. He/She will be asked to choose a pseudonym, so that no one in the study will know his/ her real name. This pseudonym will be used in the focus group discussion, and will be used in the transcription and final research project. Because he/she is in a group setting, he/she will be asked to sign a confidentiality pledge stating that everything said in the focus group will be kept confidential. By promising to keep what is discussed in the focus group confidential he/she is agreeing not to reveal the identity of anyone in the group or what was said by them to anyone outside the group. This will also encourage other participants to respect and protect personal information given by your child during the focus group. Any personal information that is revealed during your child's participation will be concealed or made anonymous by the researcher in the report to protect your child's identity. However, please be advised that we cannot guarantee confidentiality even if a pledge is signed, as the researcher cannot guarantee that the other participants will adhere to the conditions of the confidentiality pledge. For this reason, it is recommended that your child does not disclose any sensitive information about themself when taking part in this focus group discussion.

Your data will be used as part of my Research Project; your identity will always be hidden by the researcher.

Parent/Guardian Agreement
I,_____ (parent/guardian) have read and understood the information sheet. I have thus give consent for my child _____ (child's name) to partake in this research project.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Parent/Guardian Agreement for use of tape recorder

I,_____ (parent/guardian) agree that my child _____ (child's name) interview may be tape recorded, on the understanding that my identity will remain anonymous.

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Informed Consent Parent Form-IsiZulu

Igama lami ngingu Sinqobile Elevia Nyalungu, ngingumfundi waseUniversity of KwaZulu Natal, eHoward College, ngenza iMasters of Psychology. uSupervisor wami nguProf. Steven Collings (collings@ukzn.ac.za). Sibheka abantu abangathanda ukuzibandakanya ngocwaningo olumayelana nokuhlukumezeka ngokomqondo okubuye kubizwe ngokuhlanya. Lolucwaningo lubheka imicabango yabantu abasha ukuthi bacabangani ngabantu abahlukumezeke ngokwengqondo.

Sicela umtwana wakho athathe inxenxeba kulolucwaningo. Lolucwaningo luzothatha ihora elilodwa. Endaweni yaseHillcrest AIDS Centre Trust. Lolucwaningo luzoqoshwa.

Umntwana wakho akaphoqelekile ukuba ingxenye yalolucwangingo futhi imininingwane yakhe izofihlwa ngaso sonke isikhathi.

Isivumelwano somuzali

Mina,_____ **(**umzali) ngifundile futhi ngiyazwisisa ngalolucwaningo. Ngiyayinika imvumo yokuba umtwana wami _____ (igama lomuntwana) abe ingxenye yalolucwaningo.

_____ _____

ISIGNATURE YOMZALI USUKU

Isivumelwano somuzali

Mina,_____ (umzali) ngiyavuma ukuba umtwana wami_____ (igama lomuntwana) aqoshwe, ngiyazwisisa ukuthi imininingwane yakhe izofihlwa.

_____ _____

ISIGNATURE YOMZALI USUKU

Appendix 2
Participant Take-away Information Form

My name is Sinqobile Elevia Nyalungu, and I'm doing my Masters in Psychology (Clinical), through University of KwaZulu Natal, Howard College, under the supervision of Prof. Steven Collings. Thank you for taking part in our study about mental illness commonly known as ukuhlanya.

We really value your participation. As a reminder of your rights as a participant:
1. Your participation is voluntary. So even though your role is now completed, if you decide at a later stage that you do not wish to be included in the study, it is your right to be able to do withdraw. If you have any concerns around this, please feel free to contact us using the information listed below.
2. Your participation is also confidential. The researcher will only refer to you in all the research output using a pseudonym. Any identifying information you may mention will be made anonymous. Anything that bears your signature on it will be stored separately to your interview data, so they cannot be linked in any way. Once this study is completed, this information will be destroyed. These rules around confidentiality will be applied in whatever type of output results from your participation, so that your identity as a participant will always remain hidden.

If you have any questions, or would like to contact us regarding the study, please feel free to do so.

Our contact information is:

Sinqobile Elevia Nyalungu (M. Psychology Student Researcher)
sinqobile.nyalungu@gmail.com 031 260 7425

Prof. Steve Collings (Research Supervisor)
collings@ukzn.ac.za 031 260 2414

Appendix 3
Confidentiality Contract

I have consented to take part in a focus group regarding face book evangelism. I acknowledge that the narratives told by myself and the other participants are to be used for research purposes, and will be treated with confidentiality by the researcher. I understand that every member of this focus group has the right to respect and privacy. As part of my commitment to participate, and in a spirit of mutual respect, I understand that the viewpoints and narratives told by the participants should also be protected by me, in order to encourage trust and a spirit of openness in the focus group. I understand that while the researcher has no control over my actions, if I break my promise of confidentiality this could harm my fellow participants. I understand that it is important for the research that we, as participants, feel comfortable in expressing our views and experiences, without fear of negative consequences. Therefore, I promise to keep the personal details of these narratives and the identities of the other participants confidential, and by the same token, acknowledge my right to expect the same from the other participants.

_____ _____
PARITICPANT SIGNATURE DATE

Appendix 4
Interview Schedule

1. What is *ukuhlanya* (mental illness)?

    - What is your definition
    - What is your understanding of *ukuhlanya* (mental illness)

2. How is *ukuhlanya* (mental illness) understood by you and your peers?

    - How does your community interact with the mentally ill

3. What are some of the things that influence how you see the mentally ill?

4. What do you believe makes someone mentally ill?

5. What role has culture or tradition played in your understanding of *ukuhlanya* (mental illness)?

    - Do your cultural or traditional belief systems have an impact on your views?

TRANSCRIPTS

Participant Two Interview

Interviewer: So uhm, ngicela ungixoxele ngesithombe sakho

Participant: Okay, isithombe sami ngidwebe umuntu omentally disabled. Okay into eyenza futhi ngimudwebe esandleni sakhe kukhona inyoka ukuthi vele umuntu ongacabangi kahle. Yabo izinto eziningi akazicabangi kahle. Njengoba kade ngisho futhi ukuthi akekho right nase khanda. Uggoke nebhulukwe elide komunye umlenze omunye mufishane. Uyakhala, okungenzeka nokuthi akazi ukhalelani. Nezilwane zimenza noma yini ngoba umuntu ongacabangi. Uphethe nenduku, siyazi ukuthi ezinye inhlanya ziyashayana, ngisho ungezanga lutho. Ehh nezinwele zakhe ziyabonakala nje ukuthi umuntu ongekho right. Akekho umuntu oright ongaba nezinwele ezingahlelekile. Futhi njengoba ngidwebe nomuzi la ngadweba nomgwaqo, kukhombisa ukhona usemphakathini ngeke aze avele ahlale yedwa nje.

Interviewer: Okay uhm, khona igama olisebenzisile, uthe mentally disturbed, disabled. Yini umehluko phakathi kwa… angithi ngesiZulu kuthiwa ukuhlanya?

Participant: Yebo

Interviewer: Iliphe elinye igama elisetshenziswa ngesiZulu? Likhonaelinye?

Participant: Angicabangi ukuthi umuntu ongaphilile kahle

Interviewer: So uhm ngicela ungichazela more about mentally disabled. What do you mean?

Participant: Ngokucabanga kwami igama leli gama leli ayi ukuthi umuntu ongacabangi kahle kodwa indlela enza izinto ngayo ihlukile kunabanye abantu. Umuntu ohlukile kunabanye abantu. Akafani ngendlela esicabanga ngayo thina abantu nje. Mmm ngathi umuntu ya umuntu owenza izinto ngendlela yakhe nje.

Interviewer: Okay. And then yini ukuhlanya, idefinition yakho yokuhlanya yini?

Participant: Mmmmm. Mina ngicabanga ukuthi ukwenza izinto abantu abangakaze bacabange ukuthi umuntu angazenza. Ukwenza izinto nje ezihlukile izinto nje ziqale ngawe. Kodwa ayi ukuthi bonke abantu abaqala izinto bayahlanya. Kodwa phela izinto ezingahlelekile.

Interviewer: Wena uku-understanda kanjani ukuhlanya? Iunderstanding yakho kwako?

Participant: Uhm ukuhlanya. Ayimina ngicabanga ukuthi nje noma kuthiwa khona umuntu ohlanyayo kumele umphathise njengabanye abantu ngoba naye usawumuntu nje.

Interviewer: Uhm umphakathi wakho, uinteractha kanjani nabantu abahlanyano makukuthi bakhona

Participant: Umphakathi ubabuka njengabantu abangasile. Abantu nje ongasho ukuthi umadakeni. Babathume, most of the time bajwayele ukubenza nje hlampe ngingasho ukuthi igqila zabo. Babathume, hlame babnieze imali encane. Ababphathi nje kahle.

Interviewer: Iziphi izinto hlampe ezikuinfluncile ngendlela obona ngayo abantu abahlanyayo?

Part: Mmmm ukuthi vele ngijwayele ukuba bona ngoba bakhona la emphakathini

Int: So iunderstanding yakho nendlela obabona ngayo iinfluencwe ukuthi ukuba bone vele?

Part: Yebo

Inte: Mawucabanga wena yini eyenza umuntu ahlanye?

Part: Ngicabanga ukuthi ukucabanga kakhulu, kuyamenza umuntu ahlanye. Ukucabanga nezinto eziningi nengqondo yakhe, angazi ngzothi iyasindelwa noma injani

Int: And then amatraditions akho neculture yakho ikhonaindima eyidlalile in your understanding of umuntu ohlanyayo?

Part: Yebo ukuthi kwesinye isikhathi bake basho ukuth hlampe umuntu uhlanyiswe omunye. Hlampe ukuthi bamsebenzisele imithi yabo hlampe izinto ezinjalo

Int: Wena ukholelwa ini?

Part: Mina ngikholelwa ekutheni uNkulunkulu osuke evumile vele ukuthi ayi kungcono ahlanye ngoba sonke vele sidlawe uyena. Konke kwenzeka yena masevumile.

Int: Okay. Ngyabonga

Forward Translation-Participant Two

Interviewer: So uhm, ngicela ungixoxele ngesithombe sakho

Please tell me about the picture you have drawn

Participant: Okay, isithombe sami ngidwebe umuntu omentally disabled. Okay into eyenza futhi ngimudwebe esandleni sakhe kukhona inyoka ukuthi vele umuntu ongacabangi kahle. Yabo izinto eziningi akazicabangi kahle. Njengoba kade ngisho futhi ukuthi akekho right nase khanda. Ugqoke nebhulukwe elide komunye umlenze omunye mufishane. Uyakhala, okungenzeka nokuthi akazi ukhalelani. Nezilwane zimenza noma yini ngoba umuntu ongacabangi. Uphethe nenduku, siyazi ukuthi ezinye inhlanya ziyashayana, ngisho ungezanga lutho. Ehh nezinwele zakhe ziyabonakala nje ukuthi umuntu ongekho right. Akekho umuntu oright ongaba nezinwele ezingahlelekile. Futhi njengoba ngidwebe nomuzi la ngadweba nomgwaqo, kukhombisa ukhona usemphakathini ngeke aze avele ahlale yedwa nje.

Okay, in my picture I have drawn a mentally disabled person. The reason I have drawn him with a snake in his hand is because he doesn't think clearly. You see he doesn't think about a lot of things clearly. Like I have said he is not right on the head. He is wearing pants that do not have the same length legs, one leg is shorter than the other. He is crying and he doesn't know why he is crying. There are animals that are doing whatever they want to him this shows that he is a person that doesn't think straight. He is carrying a stick and as we know mentally ill people hit other people, even when others have done nothing wrong. You can see from his hair that he is not alright, his hair is dishevelled. A person that is alright would not have dishevelled hair. I have drawn a house and a road to indicate that he is in the community, he does not live alone.

Interviewer: Okay uhm, khona igama olisebenzisile, uthe mentally disturbed, disabled. Yini umehluko phakathi kwa… angithi ngesiZulu kuthiwa ukuhlanya?

Okay, there is a word you used, you said mentally disturbed, disabled. What is the difference between the two? In isiZulu is it not called madness?

Participant: Yebo

Yes

Interviewer: Iliphe elinye igama elisetshenziswa ngesiZulu? Likhonaelinye?

What other word is used in isiZulu? Is there another?

Participant: Angicabangi ukuthi umuntu ongaphilile kahle

I think it is someone who is not well

Interviewer: So uhm ngicela ungichazela more about mentally disabled. What do you mean?

Please tell me more about mentally disabled. What do you mean?

Participant: Ngokucabanga kwami igama leli gama leli ayi ukuthi umuntu ongacabangi kahle kodwa indlela enza izinto ngayo ihlukile kunabanye abantu. Umuntu ohlukile kunabanye abantu. Akafani ngendlela esicabanga ngayo thina abantu nje. Mmm ngathi umuntu ya umuntu owenza izinto ngendlela yakhe nje.

I think that a mentally disabled person this is a name which doesn't mean a person cannot think clearly but rather it means he behaves differently to other people and is different to other people. He is not the same as us, he doesn't think like us and does things his own way

Interviewer: Okay. And then yini ukuhlanya, idefinition yakho yokuhlanya yini?

Okay. And then what is the definition of ukuhlanya?

Participant: Mmmmm. Mina ngicabanga ukuthi ukwenza izinto abantu abangakaze bacabange ukuthi umuntu angazenza. Ukwenza izinto nje ezihlukile izinto nje ziqale ngawe. Kodwa ayi ukuthi bonke abantu abaqala izinto bayahlanya. Kodwa phela izinto ezingahlelekile.

I think that it is doing things that others would never think would be done. It is doing different things, with you being the first to do them, however not to say that everyone who initiates new things is mentally ill, but it is things that are disorganized

Interviewer: Wena uku-understanda kanjani ukuhlanya? Iunderstanding yakho kwako?

How do you understand ukuhlanya?

Participant: Uhm ukuhlanya. Ayimina ngicabanga ukuthi nje noma kuthiwa khona umuntu ohlanyayo kumele umphathise njengabanye abantu ngoba naye usawumuntu nje.

I believe that even if there is a mentally ill person you should treat them the same as anyone else because they are human to

Interviewer: Uhm umphakathi wakho, uinteractha kanjani nabantu abahlanyano makukuthi bakhona

What about the community, how does it interact with mentally disturbed people? If you have any in the community

Participant: Umphakathi ubabuka njengabantu abangasile. Abantu nje ongasho ukuthi umadakeni. Babathume, most of the time bajwayele ukubenza nje hlampe ngingasho ukuthi igqila zabo. Babathume, hlame babnieze imali encane. Ababphathi nje kahle.

The community sees them as people who are not in their right minds. People you can refer to as dirty. They send them to do small chores most of the time and treat them like slaves at times. They give them small amounts of money. They do not treat them well

Interviewer: Iziphi izinto hlampe ezikuinfluncile ngendlela obona ngayo abantu abahlanyayo?

Which things influence the way you see mentally disturbed people?

Participant: Mmmm ukuthi vele ngijwayele ukuba bona ngoba bakhona la emphakathini

I am used to seeing them in the community

Interviewer: So iunderstanding yakho nendlela obabona ngayo iinfluencwe ukuthi ukuba bone vele?

So your understanding, and the way you see things is influenced by you seeing mentally disturbed people?

Participant: Yebo

Yes

Interviewer: Mawucabanga wena yini eyenza umuntu ahlanye?

What do you think makes a person become mentally disturbed?

Participant: Ngicabanga ukuthi ukucabanga kakhulu, kuyamenza umuntu ahlanye. Ukucabanga nezinto eziningi nengqondo yakhe, angazi ngzothi iyasindelwa noma injani

I think, thinking too much makes someone mentally ill, thinking about a lot of things becomes too heavy for their mind

Interviewer: And then amatraditions akho neculture yakho ikhonaindima eyidlalile in your understanding of umuntu ohlanyayo?

And do your traditions or your culture play a role in your understanding of mental illness?

Participnat: Yebo ukuthi kwesinye isikhathi bake basho ukuth hlampe umuntu uhlanyiswe omunye. Hlampe ukuthi bamsebenzisele imithi yabo hlampe izinto ezinjalo

Yes, sometimes people say that maybe someone has bewitched the other.

Interviewer: Wena ukholelwa ini?

What do you believe?

Participant: Mina ngikholelwa ekutheni uNkulunkulu osuke evumile vele ukuthi ayi kungcono ahlanye ngoba sonke vele sidlawe uyena. Konke kwenzeka yena masevumile.

I believe that God is the one who holds the power to make someone mentally disturbed or not

Interviewer: Okay. Ngyabonga

Okay. Thank you