Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg.

---

by

Amanda Mwelase

BSocSc (Hons) (Psychology)

Student number: 211509297

Research thesis submitted in partial fulfilment of the requirements for the degree Master of Social Science (Research Psychology), School of Applied Human Sciences, College of Humanities University of KwaZulu-Natal.

Supervisor: Professor Douglas Wassenaar

29 July 2019

Plagiarism declaration

I Amanda Mwelase declare that:

1. The research reported in this thesis, except where otherwise indicated, is my original research.

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

3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.

4. This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
    a. Their words have been re-written, but the general information attributed to them has been referenced
    b. Where their exact words have been used, then their writing has been placed in italics and inside quotation marks and referenced.

5. This thesis does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the thesis and in the Reference section.

Signed:

Prof D R Wassenaar

// Abstract

Mental health literacy refers to people's beliefs and knowledge about mental illnesses. How people conceptualise mental illness shapes their beliefs and attitudes towards such illness and the mentally ill. As mental illness is increasing in most parts of Africa, mental health literacy may play a vital role in greater adherence to treatment, greater ability to engage in self-care and in improved mental health status. A qualitative approach was used, using a focus group and individual interviews to investigate people's mental health literacy from a local context to contribute to the body of literature on mental health issues. Thematic analysis was used to identify factors affecting mental health literacy. The findings suggest that mental health literacy is more contextual than individualistic. Therefore, there is a need to have a contextual understanding of mental illness as beliefs about the causes of mental illnesses appear to influence people's attitudes and their perception of appropriate places to seek help.

Acknowledgement

I would like to acknowledge the important role played by my supervisor Professor Douglas Wassenaar. Your professional guidance, teaching and advice were very important to this project. I am truly grateful for your academic support, I have truly learnt a lot from you.

I would also like to thank the participants of the Sobantu community who volunteered to be part of my research project and the members that assisted me in the completion of this thesis. Thank you so much to the community of Sobantu, Ward 35.

Dedication

"GOD IS GOOD, ALL THE TIME. AND ALL THE TIME, GOD IS GOOD!!!".

Thank you, my heavenly father, for my mental capacity to cope and for the strength to push. There were times where I thought I did not belong, but because you are God, here I am.

"Give thanks to the Lord for he has done nothing but great things".

This thesis is dedicated to my late granny Thembisile Mkhwanazi, my daughter Zenazi Mwelase and my mother Zanele Mwelase. Gogo I know you are in a better place, but I still feel the need to apologise for not being able to mourn for you as much as I should have due to being too occupied with my school work. I loved you, I love you and I admire your strength and courage. I thank God for you and for all you have done for me. Zenazi my child, thank you for understanding that sometimes mummy must work, I love you a lot. You are my God-given angel. Mawami thank you for being you, for your love and for being with my daughter when I had to do varsity work. Thank you for listening and for advising me, you are my rock.

Table of contents

Plagiarism declaration i

Abstract ii

Acknowledgement iii

Dedication iv

Table of contents v

List of Acronyms ix

Definitions of isiZulu terms ix

List of tables ix

List of figures ix

CHAPTER ONE 1

Introduction 1

1.1 Mental illness 1

1.2 Mental health literacy 2

1.3 Aim and objectives 3

1.4 Project overview 4

CHAPTER TWO 5

Literature Review 5

2.1 Introduction 5

2.2 A brief history of mental illness 5

2.3 Modern psychology 7

2.4 Humans as Cultural-Beings 8

2.5 Contextualisation of mental illness 9

2.6 The prevalence of mental illness 11

2.7 Recognition of mental disorders 12
2.8 Help-seeking and mental illness 13
2.8.1 Inadequate resources as a negative factor towards help-seeking 13
2.8.2 Stigma as a negative factor towards help-seeking 14
2.9 Demographic factors associated with mental health literacy 15
2.10 Theoretical framework 16
2.10.1 Health Belief Model (HBM) 16
The seven elements of the health belief model: 16
2.10.2 Explanatory model 20
2.11 Summary 20

CHAPTER THREE 22
Methodology 22
3.1 Aims and Objective 22
3.2 Introduction 22
3.3 Research design 23
3.4 Sampling 23
3.5 Data collection 24
3.6 Ethical Considerations 28
3.6.1 Collaborative Partnership 28
3.6.2 Social Value 28
3.6.3 Scientific Validity 28
3.6.4 Fair Selection of Participants 29
3.6.5 Favourable risks and benefits ratio 29
3.6.6 Independent Ethics Review 29
3.6.7 Informed Consent 29
3.6.8 Ongoing Respect for the dignity of participants 29

3.7 Data Analysis 30

3.8 Validity, Reliability and Rigour 31

3.9 Summary 32

CHAPTER FOUR 33

Results 33

4.1. Introduction 33

4.2 Knowledge about mental illness 34

4.2.1. Source of knowledge 36

4.3 Knowledge about the causes of mental illness 37

4.4 Help-seeking and mental illness 41

4.5 Attitudes associated with mental illness 46

4.5.1 Stigma and mental illness 46

4.5.2 Labelling the mentally ill as a stigma 47

4.6 Demographic factors associated with mental health literacy 48

4.7 Summary 50

CHAPTER FIVE 51

DISCUSSION 51

5.1 Introduction 51

5.2 Awareness and perceptions of mental illness 51

5.3 Beliefs about the cause of mental illness 52

5.4 Help-seeking and mental illness 53

5.5 Attitudes associated with mental illness 55

5.6 Demographic factors 55

5.7 Summary 56

CHAPTER SIX **57**

CONCLUSION **57**

6.2 Limitations and recommendations 58

7 References **60**

Appendices: **70**

Appendix 1: Letter to the Community Councillor 70

Appendix 2: Individual interview Information Sheet and Consent 71

Appendix 3: Focus group Information Sheet and Consent 75

Appendix 4: Consent to be recorded 79

Appendix 5: Demographic Questionnaire 80

Appendix 6: Advertisement 81

Appendix 7: Individual Interview Schedule 82

Appendix 8: Focus Group Interview Schedule 83

Appendix 9: Letter to the child and family centre 84

Appendix 10: Letter from the child and family center 85

Appendix 11: Proposal approval letter from the HSS ethics committee 86

Appendix 12: Letter from the Sobantu community councillor 89

IsiZulu APPENDICES **88**

Appendix 13: Iphepha elinolwazi kanye nemvumo yokuba inxenye yaloncwaningo 88

Appendix 14: Iphepha elinolwazi kanye nemvumo yokuba inxenye ye-focus group 92

Appendix 15: Imvumo yokuqoshwa 97

Appendix 17: Isikhangiso 99

Appendix 18: iSchedule ye-individual interview 102

Appendix 19: iSchedule ye-focus group 101

List of Acronyms

DSM	Diagnostic and Statistical Manual of Mental Disorders
HBM	Health Belief Model
UKZN HSSREC	University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee

Definitions of isiZulu terms

Amadlozi	African spiritual figures of the Nguni people known as ancestors
Amafufunyana	Mental illness presumed to be caused by being possessed with the spirits of the dead
Isangoma	Traditional healer that relies primarily on divination for healing
Izangoma	same as a sangoma but izangoma for plural
Inyanga	Traditional healer that relies on herbs and animal medicine
Izinyanga	Same as inyanga but izinyanga for plural
iChibi	Holy water church
Mipfhukwa	Mental illness which is presumed to be caused by the anger of the spirits of the dead
Ukuthwasa	The process the chosen one goes through to become a sangoma

List of Tables

Table 1 Participants' demographic table---25

List of figures

Figure 1 The structure of the HBM---19

Figure 2 Simplified Jeffersonian conventions---------------------------------------33

CHAPTER ONE

Introduction

This chapter introduces this research project. This is done by problematising people's lack of mental health awareness and establishing the importance of mental health literacy. The chapter then discusses mental health literacy as a concept and what the concept entails, which moves to why this research is conducted. The chapter will discuss the research aims and objectives. The chapter will also present an overview of the entire research project.

1.1 Mental illness

Lack of mental health literacy and care is one of the major crises the world is facing (Bourget & Chenier, 2007) as mental illness is overwhelmingly among the most widespread conditions affecting people's health both in developed and developing countries (Jorm, 2012). Mental illnesses are common diseases affecting people's health (Angermeyer & Matschinger, 2003; Jorm, 2012). According to Charlson, van Ommeren, Flaxman, Cornett, Whiteford, and Saxena (2019) it is anticipated that 1 in 10 people in the world is living with moderate or severe mental illness. It is therefore likely that during a lifetime almost everyone will have direct contact with someone who suffers from mental illness. Only a third of the people who suffer from mental illness are treated, and many of those who remain untreated suffer deep consequences throughout their lives (Bourget & Chenier, 2007).

One of the major reasons why people fail to get treated is due to lack of knowledge. Corrigan and Watson (2002) established that people do not have sufficient or accurate knowledge of mental illness. Awareness of mental disorders is vital as it may be a significant determinant of help-seeking behaviour (Bourget & Chenier, 2007). According to Rüsch, Evans-Lacko, Henderson, Flach and Thornicroft (2011) there is a need for enhanced knowledge of mental health and mental disorders, which will improve people's awareness of where to go for help-seeking and treatment. Enhanced knowledge will also help in reducing stigma at individual, public and institutional level, this will help with early recognition of mental disorders, developed mental health results and improves use of mental health facilities (Rüsch et al., 2011).

1.2 Mental health literacy

The concept of mental health literacy was derived from health literacy, "which is originally defined as a functional capacity related to basic literacy skills and how these affect the ability of people to access and use health information" (Jorm, 2012, p. 1). "The term mental health literacy was first introduced by Jorm and his colleagues in Australia" (Jorm, 2000, p. 1). "The term 'mental health literacy' has been defined as people's knowledge and beliefs about mental disorders that aid the recognition, management or prevention of mental illness" (Jorm, Korten, Jacomb, Christensen, Rodgers & Pollitt, 1997, p. 143). "Mental health literacy has many components, including (a) knowledge of how to prevent mental disorders, (b) recognition of when a disorder is developing, (c) knowledge of help-seeking options and treatments available, (d) knowledge of effective self-help strategies for milder problems, and (e) first aid skills to support others who are developing a mental disorder or are in a mental health crisis" (Jorm, 2000, p. 1). Therefore "the concept of mental health literacy implies that it is critical to increase public knowledge about mental health and mental illness since it is a precondition for early recognition and intervention in mental disorders" (Jorm et al., 1997, p. 184).

Since the introduction of the mental health literacy concept, studies have been conducted globally and within South Africa on mental health literacy such as;

- "Mental health literacy: Public knowledge and beliefs about mental disorders" (Jorm, 2000)
- "Mental health services in South Africa: scaling up and future directions" (Sorsdahl, Stein, & Lund, 2012)
- "An African view of psychopathology: A blueprint" (Hadebe, 1986).
- "Community attitudes toward and knowledge of mental illness in South Africa" (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003)

However, only a few of these studies have been conducted on the African continent (Angermeyer & Dietrich, 2006). This study investigated people's mental health literacy from a South African context to contribute to the body of literature on mental health issues. The research study investigated how African people from Sobantu, Pietermaritzburg, conceptualised mental illness.

1.3 Aim and objectives

Mental illness affects people, families, and population with severe consequences for society. However, there have been limited studies on mental illness and the public, and fewer studies conducted in the South African context. Therefore, this study aimed at understanding how people from Sobantu conceptualise mental illness with the aim of contributing to the body of literature. One-third of all South Africans have mental illnesses and seventy five percent of all South African's who suffer from mental illness do not receive any kind of specialised help (Tromp, Dolley, Laganparsad, & Goveneder, 2014). Thus, the aim of this research was to assess people's mental health literacy from a South African context. Therefore, this study aimed to investigate how people from Pietermaritzburg (Sobantu) conceptualise mental illness with the aim of describing and understanding their perspectives on and awareness of mental illness.

It also aimed to examine whether spiritual and cultural influences affect how people conceptualise mental illness. The study also aimed to understand people's knowledge about the cause of mental illness, attitude and demographic factors associated with mental illness.

This research aimed to answer the following questions:

1. What are participants' perceptions of mental illness?
2. What do the participants think are the predominant causes of mental illness?
3. What is the interaction between spiritual and cultural beliefs and participants' beliefs about mental illness?
4. What attitudes do the participants have towards mental illness or towards the mentally ill?
5. What demographic factors are associated with mental health literacy?

The objectives of the study were to:

1. To explore participants' perception of mental illness.
2. To investigate participants' knowledge of the causes of mental illness.
3. To investigate participants' beliefs about spiritual and cultural influences on mental illness.
4. To explore attitudes associated with mental illness.
5. To explore demographic factors associated with mental health literacy.

1.4 Project overview

The research project consists of six chapters. The first chapter is the current introduction, which offers an overview of mental health literacy, which therefore leads to the research aims and objects, and an outline of the entire thesis. The second chapter, chapter two, is a literature review chapter, which is a body of literature and theory which helped guide this research project. Then chapter three describes the methodology of the study and details the research methods taken from the design to the analysis of the study. Chapter three also details the ethical considerations applicable to this study. Chapter four presents the results of the study. Then chapter five, which is the discussion chapter, attempts to link the literature and theory with the results of the study. Chapter six is a summary of the overall study, including the limitations and recommendations arising from the study.

CHAPTER TWO

Literature Review

2.1 Introduction

Approximately one in six South Africans is said to experience a common mental disorder a year. Seventy five percent of people who suffer from mental disorders in South Africa do not get the needed care (Lund, Petersen, Kleintjes, Bhana, 2012). "Strategy to improve health literacy in mental health and addictions is a capacity building initiative to support the implementation of a best practice framework to improve the public's understanding and reduce stigma related to mental health and substance use issues" (BHC Mental health & Health addiction service, 2010, p. 3). Hence this literature review seeks to explore how people have conceptualised mental disorders and their attitudes towards the mentally ill. The literature review hopes to understand what is known concerning the studied topic. This chapter commences with a brief European antiquity of mental illness as indication that mental illness has existed over the years and how the construction of mental illness has advanced over these years. The literature then discusses modern psychology with the aim of defining mental illness as a concept. However, because the history neglects a South African perspective of mental illness and the psychological understanding of mental illness differs from the cultural understanding, this chapter then moves to discussing humans as cultural beings, this is followed by contextualising mental illness. It then presents the prevalence of mental disorders, followed by the recognition of mental illness. Furthermore, the literature discusses the help-seeking behaviours of mental illness and the negative attitudes associated with mental illness. The review finally discusses the Health Belief Model (HBM) and the Explanatory model, as theoretical frameworks that informed this study.

2.2 A brief history of mental illness

Evidence from Davidson, Chinman, Sells and Rowe (2006) and Swartz, De la Rey, Duncan, Townsend and O'Neil (2008) report that people historically thought that mental illness resulted from mystical and ghostly wonders such as demonic possessions, witchery or punishment from god and responded with equally supernatural, and sometimes ruthless, treatments (Davidson et al., 2006). Problems with mental illness or insanity have always been part of the human

condition as it dates back from a long history which went through many developments and changes (Swartz et al., 2008). “The dominant understanding of mental illness during this period was informed by the belief that individuals who became psychologically disturbed were possessed by evil and supernatural forces” (Swartz et al., 2008, p. 494). For instance, trephination, which was an initial supernatural procedure in which a ‘patient’ was treated by drilling a hole through the patient’s cranium to allow the trapped wicked spirits inside the skull to be freed, allowing for the patient to be healed (Butcher, 2007).

The Greek physicians changed the way mental illness was viewed by rejecting mystical interpretations of mental disorders. During the 400 BC Hippocrates endeavoured to separate fallacies and religious beliefs from medicine and argued that mental illness occurred due to the body imbalances (Swartz et al., 2008). “Hippocrates classified mental illness into one of four categories epilepsy, mania, melancholia, and brain fever” (Farreras, 2005, p. 155). He argued that the mentally ill should not be held responsible for their actions (Swartz et al., 2008). Between the 11th and 15th century, spiritual conceptions of mental illness reconquered Europe in which fallacy, astrology, and alchemy were embrace, and other treatments such as; prayer cremations, relic touching, confessions, and atonement (Swartz et al., 2008).

During this period people who suffered from mental illness began to be treated more humanely (Farreras, 2005). “Johann Weyer and Reginald Scot tried to convince people in the mid to late 15th century that individuals were not possessed by the devil but were mentally unstable and could not be held accountable for their behaviour” (Swartz et al., 2008, p. 494). During the 16th century, patients were housed in asylums which in turn, became well known for their inhuman treatment of mental health patients (Davidson et al., 2006). During the 18th century, protests started due to the inhumane environments in which the mentally ill lived, which resulted in people identifying the mentally ill people as patients requiring care. This resulted in the treatment and recovery of some people who suffered from mental illness and the progressive training of mental health professionals (Farreras, 2005).

Toward the end of the 19th century, scientific discovery related to mental illness accelerated. Many developments occurred during this era in endeavouring to identify, understand and treat different forms of mental illness. This resulted in the development of several psychological theories of mental illness and treatments (Davidson et al., 2006). “Psychoanalysis was the

prevailing treatment for mental illness throughout the first half of the 20th century, providing the launching pad for more than 400 different schools of psychotherapy established today" (Swartz et al., 2008, p. 496). These psychology schools focus on behavioural, cognitive, cognitive-behavioural, psychodynamic, and client-centred approaches to psychotherapy applied in individual, families, or group formats (Davidson et al., 2006). Differences have been recognised among all these psychotherapy tactics. Yet; their success in treating mental illness may be due to aspects shared among the approaches (Swartz et al., 2008). At present, the status of applied psychology appears to be changing as it is now believed that our understanding of psychopathology is always context dependent (Davidson et al., 2006).

2.3 Modern psychology

The term psychopathology is a term used by the Western, Eurocentric perspective when referring to mental illness (Nwoye, 2015). According to Swartz et al. (2008) psychopathology refers to psychological disorders. Statistical deviance, maladaptation and personal distress are three commonly used criteria in psychology for distinguishing mental illness from what is deemed as normal behaviour (Swartz et al., 2008). Statistical deviance is a measure of abnormality in which a person's behaviour is said to be abnormal if it is statistically uncommon, this helps to address what is meant by normal within a context (Barlow & Durand, 2005). The problem is that it does not differentiate between what is desirable or undesirable behaviour. Maladaptation is another measure of abnormality which refers to behaviour that is dysfunctional for the individual or others, it refers to behaviour that prevents adaptation or adjustment (Barlow & Durand, 2005). This is problematic because abnormality is accessed outside the individuals and outsides one's cultural experience. Behaviour is also said to be abnormal when it causes personal distress. Personal distress is when an individual fails to cope with everyday life, suffering often accompanies psychological disorders (Swartz et al., 2008). The major issue within psychology is the quality of diagnoses, which argues for reliability and validity of diagnoses. This is achieved by using the "Diagnostic and Statistical Manual (DSM) published by the American Psychiatric Association, and by using the International Classification of Disease System (ICD) published by the World Health Organization" (Andrews, Slade & Peters, 1999, p. 1). These classifications are used by mental health specialised to classify abnormal behaviour.

However, what is deemed as abnormal behaviour brings up a complex problem as it raises the question on ‘what exactly is normal?’ For instance, with anorexia nervosa “how much is the desire for a thin body normal and how much of the same is abnormal, and who decides anyway?” (Njenga, 2007, p. 167). Nwoye (2015) argues that the notion of abnormality becomes hard to explain as it is culturally defined. Mkhize (2004) argues that these modern psychology conceptions were essential to western products which were brought to South Africa as a general transformation of knowledge. Nevertheless, it is significant to acknowledge that the western conceptions of mental illness are not to be considered wrong but limited in explaining some of the aspects of the African conceptions of mental illness (Nyowe, 2015). The western perspective, therefore, fails to give an in-depth insight into how culture may donate to the conceptions and experience of mental health issues, by doing so neglects South African perspectives of mental illness (Swartz et al., 2008). It is important to note that there is a wide difference between the conception of mental illness within the Western perspective and the African perspective (Nyowe, 2015). It is likewise significant to acknowledge that the above history of mental illnesses is told from a western perspective and the psychology conceptions of abnormality differ from the African cultural perspectives and conceptions of mental illness. The key to understanding mental illness according to the worldview and philosophical assumptions of Black people, which lies in understanding the cultural conception of mental illness (Sam & Moreira, 2012).

2.4 Humans as Cultural-Beings

The assumption in African communities is to view abnormal behaviour as a problem caused by hidden meanings that must be culturally interpreted to reach a solution (Mkhize, 2004). It is therefore important to define the term culture. According to Geertz (1973) culture refers to the way members of the community collectively share knowledge, beliefs and values which bind the community together (Geertz, 1973). These ways of thinking, feeling and believing are associated to the shared knowledge of culture, allowing people of that culture to gain meaning from the ideas and objects around them (Geertz, 2008). Geertz (1973), defines culture as a historically conveyed pattern of meanings. Therefore “what man is maybe so entangled with where he is, who he is and what he believes, that it is inseparable from them” (Geertz, 1973, p. 35). A culture is, therefore, an object that people create and use, hence culture is found in people’s cultural context, as becoming human is social and does not exist in isolation but in one’s cultural context (Doyal & Harris, 1986).

A Culture context is a community or society in which a group of people live which provides a set of rules and regulations that people live by (Sam & Moreira, 2012). However, these rules and regulations that make up culture are made up by the same people it represents. Therefore, the relationship between people's knowledge and one's cultural context are inter-related so that one cannot be analysed without the other (Geertz, 1973). Schweder (1991) argues that human beings and the social-cultural environment interpenetrate each other's identity and cannot be analysed into independent and dependant variables. They therefore cannot be defined without borrowing from the other. Hence, behaviour is best understood in the context in which it occurs. Rosenberg (1998), argues that for one to understand human action, one needs to understand the rules in which it arises, as these rules provide meaning. Therefore, to understand how people conceptualise mental illness, it significant to firstly understand how the cultural context influences how people conceptualise mental illness (Sam & Moreira, 2012).

2.5 Contextualisation of mental illness

Knowledge about mental illness differs between people, relatives, societies, beliefs, and countries. Understanding people's cultural beliefs about mental illness is important for the application of active methods to mental health care (Nieuwsma, Pepper, Maack & Birgenheir, 2011). Therefore, understanding people's cultural and individual conceptions about mental illness is important for the application of effective strategies to mental health care. People's views about mental illness affect their willingness and where to go for treatment (Nieuwsma et al., 2011). African communities view mental illness as a problem caused by hidden cultural meanings that need interpretation to free the tormented mentally ill individual. There are diverse ways of understanding mental illness as people living in "Mozambique and Angola believe that mental illness is directly related to the anger of the spirits of the dead and in southern Mozambique, these spirits are called *Mipfhukwa*" (Honwana, 1998, p. 105). These spirits are thought to belong to people that have been killed irrationally, and they did not have a proper funeral. Thus, their souls are said to not be in peace and are spirits of unpleasantness. It is presumed that the spirits can cause trouble and cause mental illness (Honwana, 1998). Hence, a ritual is carried out to remove the spirts which is performed to place the spirits in their rightful position, in the world of the ancestors (Honwana, 1998). "A study conducted in Uganda revealed that the phrase depression is not culturally appropriate among the population, while an alternative study conducted in Nigeria found that people answered with fear, avoidance and

anger to those who were observed to have a mental illness” (Amuyunzu-Nyamongo, 2013, p. 59). A third and above of Nigerian respondents to drug abuse as the most common cause of mental illness, “while divine wrath and the will of God were the second most prevalent reasons, followed by witchcraft or spirit possession” (Amuyunzu-Nyamongo, 2013, p. 59).

According to some African interpretations, some mental illnesses are due to being possessed, such of that of *Amafufunyana*, which is defined as a soul possession that results from witchcraft (Ngubane, 1977). According to the Zulu and the Xhosa cultures in South Africa, spirit possession is a result of a mixture of soil and ants taken from a cemetery, allegedly having fed from a dead corpse; the mixture is said to be positioned in the pathway of the targeted person (Ngubane, 1977). After walking on this mixture, the person will have symptoms like those of hysteria, throwing themselves on the floor, tearing off their clothes, speak in a strangely muffled voice which cannot be understood and may harm themselves due to acting violently and may also try to commit suicide (Hadebe, 1986). A person with *amafufunyana* in modern psychology “was originally described as a hysterical condition characterized by people speaking in a strangely muffled voice in a language that cannot be understood, and strange and unpredictable behaviour” (Niehaus, Oosthuizen, Lochner, Emsley, Jordaan, Mbanga, & Stein, 2004, p. 60).

Another example is *Indiki* which happens because of being possessed with amadlozi (ancestors). Ancestors are family members who have passed on and are assumed to live in the spiritual world (Nyowe, 2015) but are still active members of the family that protect and give guidance to the family. Nyowe (2015) argues that African epistemology assumes interconnection between the visible and invisible world that influence each other. The bizarre behaviours of an individual with `*Indiki’* are the initial signs that the ancestors have chosen that individual. An individual with *Indiki* starts by having certain dreams at night, and due to emotional conflict, he or she loses appetite and becomes thin. Thus, the within the Western perspective the person is manifesting some form of anorexia nervosa (Hadebe, 1986). In the African culture, the individual with *Indiki* accepts their calling, he or she becomes treated through traditional ceremonies called *Ukuthwasa* to become a sangoma (Manyike & Evans, 1998). Ukuthwasa is a process or a practice that an individual goes through to learn to become a sangoma. In modern psychology, *Ukuthwasa* is referred to “psychoses which in the mainstream psychiatry implies diseases of the unknown aetiology” (Booi, 2004, p. 3).

A sangoma talks to his or her ancestors to help heal their clients and sees things that other people don't see. In psychological terms, the sangoma hallucinates and is delusional because the sangoma talks and sees things that other people cannot see and also believes that he or she is the chosen prestige individual; this person may be said to be suffering from schizophrenia within the western perspective. The response is different within the African culture. Instead, such individuals are treated with respect because they can communicate with the ancestors (Manyike & Evans, 1998). Anorexia nervosa, for example, is also a psychological disorder which mostly affects Western adolescent women (Njenga, 2007). This is because most African cultures do not hold the same social construct of a search for thinness as required of females in Western societies which leads to dissatisfaction beliefs about body weight (Njenga, 2007). This demonstrates that African cultural perceptions of mental illness differ from the Western perspectives of mental illness.

2.6 The prevalence of mental illness

Studies conducted in America show that one in every four adults, approximately 61.5 million people, experience mental illness in a year, and one in 17 lives with a severe mental illness such as schizophrenia, bipolar disorder or major depression (Reavley & Jorm, 2011). In Australia, one in five Australians suffers from a mental or substance use disorder in any 12-month period, and this prevalence rate rises to one in four young Australians between the ages of 16 and 24 (Reavley & Jorm, 2011). According to research conducted in Africa, about 5% of the total population demonstrate definite psychiatric syndromes and approximately 20% demonstrate evidence of psychiatric distress (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003). In Tanzania, a study of mental disorders among those attending Primary Health Clinics (PHC) and Traditional Healer Centres (THC) found that the prevalence of common mental disorders among THC patients was 48% and this was double that of PHC patients at 24% (Ngoma, Prince & Mann, 2003). In Nigeria, of the 4984 people that were interviewed in a prevalence estimate survey, 12.1% had a lifetime rate of at least one DSM disorder and 5.8% had a 12-month rate of mental disorders (Gureje, Lasebikan, Kola & Makanjula, 2006).

In South Africa, the Department of Health issued a statement of concern in the year 2000 about the increasing rate of neglected people suffering from mental illness (WHO, 2001). The results from the South African Stress and Health Study (SASH), the first nationally representative

study of psychiatric morbidity in South Africa, indicate that roughly 30% of adults have had a mental illness in their lifetime, and that most of them remain untreated (Sorsdahl, Stein, & Lund, 2012). According to Tromp (2014), one-third of all South Africans have mental illnesses and 75% of them do not get any kind of professional help. Tromp et al. (2014) also state that there are more than 17 million people in South Africa dealing with depression, substance abuse, anxiety, bipolar disorder and schizophrenia. A study conducted in the Western Cape reported the overall prevalence rate of mental disorders to be 25.0% for adults and 17.0% for children and adolescents (Kleintjes, Flisher, Fick, Railoun, Lund, Molteno & Robertson, 2006). Another South African study reported a high prevalence of depression (47%), with over half of the depressed participants being women (67%) reporting episode duration greater than two months (Rochat, Tomlinson, Barnighausen, Newell & Stein, 2011). Trump and Hugo (2006), reported that about 1% of the South African general population suffers from schizophrenia, and this figure amounts to approximately 500 000 people suffering from this mental disorder at any given time. A study conducted in Durban reported a high prevalence of 55.4% of Axis 1 disorders. Among these disorders, psychotic disorders were diagnosed in 4.7% with a slightly higher lifetime prevalence of 7.3% (Naidoo & Mkhize, 2012).

2.7 Recognition of mental disorders

Past evidence supports the notion that mental illness is a world-wide phenomenon that has consistently happened throughout the olden times and continues to afflict humanity and should be easily recognised by the public (Agbayani-Siewert, Takeuchi & Pangan, 1999). However, many members of the public cannot recognise mental disorders and do not understand the meaning of psychological terms. For instance, according to a survey conducted in Australia on depression and schizophrenia found that there is poor recognition of mental disorders (Reavley & Jorm, 2011). A study conducted by Bourget and Chenier (2007) states that community surveys of mental health literacy in Australia, Canada, India, Japan, Sweden, the United Kingdom, and the United States show that many people are unable to accurately identify mental disorders. A study conducted by Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999), confirms that the symptoms of mental disorders are not correctly recognised by the public as mental illness. Studies conducted by Goldney, Fisher and Wilson (2001); Jorm et al. (1997), and Bourget and Chenier (2007) found that the public historically displayed poor mental health literacy towards various aspects of mental illness. The study also showed that people could not recognise the mentally ill and have inaccurate recognition of mental illness and therefore the

treatment interventions associated with the mental illness (Bourget & Chenier, 2007). The burden of mental illness in South Africa is also extensive and is said to largely increase, as some people fail to identify the mentally ill and have no knowledge of the psychological terms associated with mental illness (Lund et al., 2012). Therefore, there is appropriate mental health services and interventions that can easily teach people how to identify and recognise the symptoms associated with mental illness (Lund et al., 2012; Wynaden, Chapman, Orb, McGowan, Zeeman, & Yeak, 2005).

2.8 Help-seeking and mental illness

Psychological researchers generally see mental illness as having multifaceted aetiology involving psychological, social and biological factors (Jorm, 2000). Hence, society's views about the causes are normally less complex, such as the view of religion and culture (Amuyunzu-Nyamongo, 2013). Angermeyer and Matschinger (2003), argue that the causes of mental disorders are complex and vary depending on the disorder and factors within the individual. "It is important to investigate the public's beliefs regarding the aetiology of mental illness because they influence help-seeking behaviour and adherence to treatment" (Jorm, 2000, p. 1). For instance, if individuals believe that supernatural phenomena such as witchcraft and possession by evil spirits are the cause of mental disorders, such individuals are likely to seek help from a traditional healer or a church pastor (Amuyunzu-Nyamongo, 2013). Therefore, health behaviours of the mentally ill individuals and actions are understood in the context of the culture with respect to the causation and treatment of various mental disorders (Kate, Grover, Kulhara & Nehra, 2012).

2.8.1 Inadequate resources as a negative factor towards help-seeking

Attitudes towards seeking help include concerns about the cost of the treatment, transportation reasons such as affordability and not having access, confidentiality and the belief that the treatment will not help or that it may make the problem worse (Bourget & Chenier, 2007). Some people fail to trust health professionals. An individual's community such as friends and family are often said to be the idyllic source of help rather than health practitioners (Rickwood & Braithwaite, 1994). Rickwood and Braithwaite (1994) also argued that a high reliance on self to solve problems, a lack of emotional competence, and negative attitudes about seeking professional help are barriers to seeking help (Rickwood & Braithwaite, 1994). Rickwood, Deane and Wilson (2007, p. 37) "found that approximately 18% to 34% of young people with elevated levels of depression or anxiety symptoms seek professional help". For instance, a

school-based study of 12 to 17-year-old German adolescents reported that only 18.2% of those with diagnosable anxiety disorders, and 23% of those with depressive disorders had ever used mental health services (Rickwood, Deane & Wilson, 2007).

In South Africa, the Mental Health and Poverty Project (MHaPP), based at the Department of Psychiatry and Mental Health at UCT, established that there is a connection among poverty and mental disorders (Campbell-Hall, Petersen, Bhana, Mjadu, Hosegood, Flisher, & MHaPP Research Programme Consortium, 2010). Sadly, this implies that resources are most constrained where they are most needed, therefore even if people seek help they will not find it. "The inadequacy of accessible resources, injustices in their distribution, and inefficacies in their use causes the main difficulties to treat mental health, particularly in low-income and middle-income countries" (Saxena, Thornicroft, Knapp & Whiteford, 2007, p. 879). The overwhelming worldwide insufficiency of human resources for mental health, predominantly in low-income and middle-income countries cause central difficulties to improve mental health (Kakuma, Minas, van Ginneken, DalPoz, Desiraju, Morris & Scheffler, 2011). "Government spending on mental health in most low-income provinces is far lower than is needed, based on the proportionate burden of mental disorders and the accessibility of cost-effective and affordable interventions" (Saxena et al., 2007, p. 833).

2.8.2 Stigma as a negative factor towards help-seeking

"There is a high level of stigma associated with mental illness which may hinder help-seeking. Stigma is a reality for many people with a mental illness, and they report that judgement by others is one of their greatest barriers to a complete and satisfying life" (Mohamad, Zabidah, Fauziah, & Sarnon, 2012, p. 74). People who suffer from mental illness are often afflicted by negative attitudes (Corrigan, & Watson, 2003). "Due to negative attitudes associated with mental illness, people who suspect that they might have a mental health condition are unwilling to seek help for fear of what others may think" (Reavley & Jorm, 2011, p. 1087). A study conducted in the USA showed that people refused to seek help for depression as they feared undesirable effect on their employment state, and in the UK some individuals fear that the health professional may see them as unbalanced or neurotic (Jorm, 2012). Studies examining people's attitudes towards mental illness have found that there is a personal stigma associated with mental illness which leads to lower help-seeking among both adults and adolescents (Cooper, Corrigan, & Watson, 2003).

The media play a role in implanting negative public perceptions of mental illness (Bourget & Chenier, 2007). "Many studies have found that the media and the entertainment industry play a key role in shaping the public's opinions about mental health and illness" (Bourget & Chenier, 2007, p. 9). People with mental health conditions are often depicted as dangerous, violent and unpredictable (Corrigan, Green, Lundin, Kubiak & Penn, 2001). "News stories that sensationalise violent acts by a person with a mental health condition are typically featured as headline news; while there are fewer articles that feature stories of recovery or positive news, concerning similar individuals" (Bourget & Chenier, 2007, p. 12). Entertainment frequently features negative images and stereotypes about mental health conditions, and these portrayals have been strongly linked to the development of fears and misunderstanding (Corrigan et al., 2005). Bourget and Chenier (2007) argue that "these negative images are of concern because they increase psychological distress and fear of stigma for individuals with mental disorders and reduce help-seeking" (Bourget & Chenier, 2007, p. 9).

2.9 Demographic factors associated with mental health literacy

Demographic factors also play a role in determining the use of mental health services. A study conducted by Park, Jeon, Kim, Kim and Roh (2014) showed that participants who had a lower education level were less likely to use mental health services compared to those with a higher education level. The study also highlighted a significant effect of gender, showing that fewer men were likely to use mental health services compared to females (Park et al., 2014). According to Parslow and Jorm (2000) living in an isolated area is allied with lesser use of professional services as opposed to living in town.

2.10 Theoretical framework

A theoretical approach is essential because it helps to explain, predict and recognise certain phenomena under investigation (William & Healy, 2001). Therefore, the Health Belief Model and the explanatory model are theoretical frameworks used to guide this study.

2.10.1 Health Belief Model (HBM)

The health belief model (HBM) is a psychological health behaviour change model established to explain and predict health-related behaviours, particularly concerning the use of health services (Champion & Skinner, 2008). The model was established as a systematic method to explain and predict precautionary health behaviour (Glanz, Barbara, Rimer & Viswanath, 2008). The model was developed by social psychologists at the U.S. Public Health Service during the 1950s and was said to be one of the top acknowledged and extensively used theories in health behaviour research at the time (Hochbaum, 1958, as cited in Champion & Skinner, 2008). The health belief model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action, and self-efficacy explain engagement in health-promoting behaviour (Brannon, Feist & Updegraff, 2013). The HBM, therefore, embraces that health-seeking behaviours such as going to see a doctor for treatment affect a result of the interaction of a set of core beliefs (Brannon et al., 2013). It is, therefore, an intrapersonal theory which focuses on phenomena inside the person, such as a person’s knowledge and beliefs about the health problem (Norman & Conner, 2005), in this case, mental illness. Hence, in this study, the HBM is used to understand whether participants’ opinions about mental illness are related to their attitudes and help-seeking behaviour.

The seven elements of the health belief model:

The following elements of the HBM are suggested to differ between individuals and are said to predict health-related behaviours (Janz & Becker, 1984).

Perceived severity: Perceived severity refers to the personal evaluation of the seriousness of a health problem and its latent consequences (Norman & Conner, 2005). The HBM suggests that people who identify a given health problem as serious are more likely to engage in behaviours to avoid the health problem from occurring (Brannon at el., 2013). "Perceived seriousness incorporates beliefs about the disease itself" (Janz & Becker, 1984, p. 2). For instance, an individual may perceive that depression is not medically serious, but if he or she perceives that there would be serious financial loss because of being absent from work for several days because of depression, then he or she may perceive depression to be a serious health problem (Janz & Becker, 1984). Hence, the HBM is appropriate for this study because it argues for the individual's subjective beliefs about the illness. In the case of perceived severity, the more the risk is perceived, the greater the chances of a person engaging in behaviours to decrease that risk.

Perceived susceptibility: Perceived susceptibility refers to one's evaluation of the threat of developing a health problem. The HBM predicts that individuals who perceive that they are susceptible to a health problem will engage in behaviours to reduce their risk of developing the health problem (Norman & Conner, 2005). Individuals with low perceived susceptibility may think that they are not at risk for contracting a specific illness. Such individuals are more likely to engage in unhealthy or risky behaviours (Rosenstock, Strecher & Becker 1988). For instance, an individual whose parent suffered from depression might think that he or she is likely to suffer from depression and might seek help to reduce the risk of suffering from depression

Perceived benefits: Health behaviours are also influenced by the perceived benefits of acting. Perceived benefits refer to an individual's valuation of the importance of engaging in health-promoting behaviour to reduce the risk of getting the disorder (Janz & Becker, 1984). "If an individual believes that action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behaviour regardless of objective facts regarding the effectiveness of the action" (Janz & Becker, 1984, p. 2). For example, individuals who believe that seeing a psychologist about their problem will prevent depression are more likely to go and see a psychologist and talk about his or her problems. Another example is if the individual is called to be a sangoma and refuses to accept the calling and doesn't do the rituals required for him or her to do then the individual is likely to be seen as vulnerable to suffering from a mental illness which may result in the individual seeking for help.

Perceived barriers: Health-related behaviours are also a function of perceived barriers to acting. These supposed barriers denote to a person evaluation to the difficulties to behaviour alteration (Stretcher, Victor, Irwin & Rosenstock , 1997). For instance, even when a person sees a health disorder as a threat and believes that going to see a doctor will lessen the risk, perceived barriers could prevent engagement in the health-promoting behaviour (Brannan et al., 2013). Thus, the perceived benefits must be greater than the perceived barriers to behaviour change to happen. Perceived barriers refer to individual subjective evaluations of the obstacle that might stand in the way of help-seeking. For instance, the side effects of a medical process and anxiety involved in engaging in the behaviour, therefore, lack access to affordable health care and the perception that pills for depression or schizophrenia may cause withdrawal from reality and pain may act as barriers to receiving medication (Rosenstock et al., 1988). And, the time needed to for kuthwasa (the process of being a sangoma which is said to be a month or months (Booi, 2004) may also be a barrier for the called individual to accept the calling.

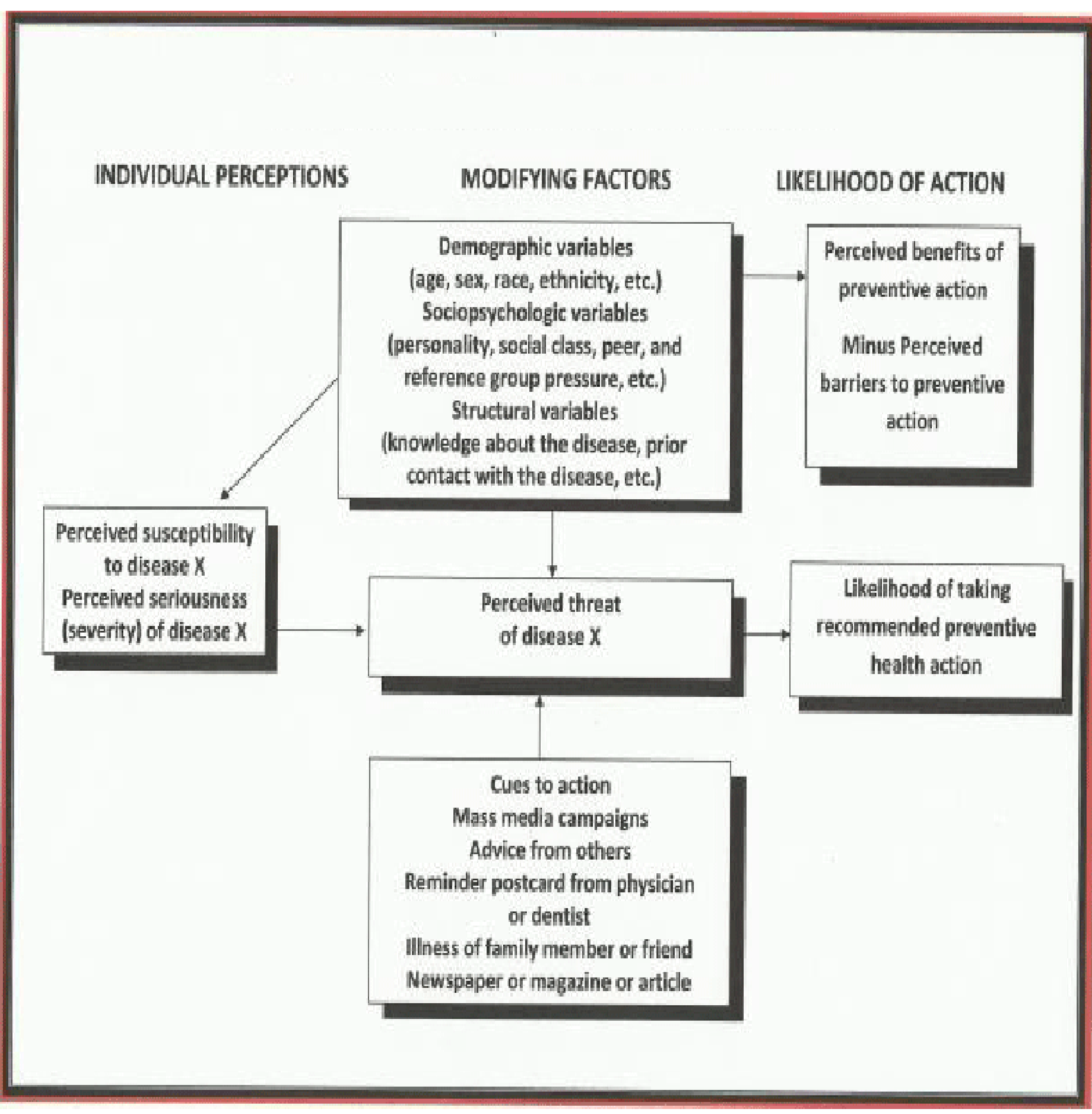
Modifying variables: This health belief element suggests that modifying variables such as demographical, psychosocial, and structural variables affect health-related behaviours indirectly by affecting perceived seriousness, susceptibility, benefits, and barriers (Norman & Conner, 2005; Stretcher et al., 1997). Therefore, an individual's social context may influence how they see mental illness.

Cues to action: The cues to action element posit that a cue, or trigger, is necessary for promoting engagement in health-promoting behaviours (Glanz et al., 2008). Cues to action can be internal (physiological: pain and symptoms) or external (source of information) cues (Glanz et al., 2008). The intensity of cues needed to promote action differs among individuals by supposed susceptibility, seriousness, benefits, and barriers (Stretcher et al., 1997). For instance, health-related behaviours presented on television might be a prompt to trigger an individual to act on health behaviour.

Self-efficacy: Self-efficacy refers to an individual's observation of his or her ability to effectively perform the behaviour (Brannon et al., 2013). If an individual believes that he or she can do a behaviour, chances are that he or she will do it. If he or she believes that he or she is not capable then the chances are that he or she will not do it. Figure 1 below illustrates the HBM:

Figure 1: The structure of the HBM:

The following structure illustrates how the HBM functions.



Source: Ebomoyi (2017, p. 7)

2.10.2 Explanatory model

Studies conducted by Anthropologists have shown that psychological phenomena are understood in diverse ways across cultures and those individuals are treated differently (William & Healy, 2001). For instance, “social withdrawal, feeling sad and lack of energy is frequently categorised as depression within western societies while in Sri Lanka such understanding receives little attention or treatment” (William & Healy, 2001, p. 467). Hence, people explain their distress in a multitude of ways, often blaming social situations, affiliation problems, witchcraft and broken taboo (Apte, Damerau, & Weiss, 1998).

Explanatory models are ideas and beliefs about an illness that assist an individual to make sense of the illness within a cultural context (Kelinman, 1980). Cultural context is a community or society in which an individual lives, which provide a set of rules and regulations that people in that community live by (Geertz, 2008). Therefore, Kleinman (1980), recommended that a patient's explanatory models of illness should be elicited using a mini-ethnographic approach that explored their concerns such as ‘why me?’, ‘why now?’, ‘what is wrong?’, ‘who can intervene or treat the condition?’ With patients’ exploration of these questions, according to Bhui and Bhugra (2002), the specialist can get collaborative outcomes to assist the patient. Arguing that the health beliefs of people suffering from mental health problems are essential.

2.11 Summary

In summary, this review has outlined how mental health has been conceptualised over the years which led to a discussion of modern psychology. However, it is important to note that the history of mental illness and the modern psychological conceptions of mental illness are different from the African perspective because they neglect the views of culture and religion. The literature then moved to defining humans as cultural-beings which therefore moved to contextualising mental illness in the views of culture and religion. The literature also highlighted the prevalence of mental disorders in South Africa in contrast with other countries throughout the world, followed by the recognition of mental disorders. Furthermore, the review discussed help-seeking and mental illness. The review also highlighted demographic factors associated with mental illness. This review outlined and discussed the HBM and Explanatory Model as an essential theoretical approach because both approaches help to give explanation, predict and recognize the phenomena under investigation. The evaluation of the available literature helped inform the following methodology chapter. The methodology chapter is

outlined in detail below, followed by the ethical considerations that helped guide the research methods.

CHAPTER THREE

Methodology

3.1 Aims and Objective

This research aimed to answer the following questions:

1. What are the participants' perceptions of mental illness?
2. What do the participants think are the predominant causes of mental illness?
3. What is the interaction between spiritual and cultural beliefs and participants' beliefs about mental illness?
4. What attitudes do the participants have towards mental illness or towards the mentally ill?
5. What demographic factors are associated with mental health literacy?

The objectives of the study were to:

1. To explore participants' perception of mental illness.
2. To investigate participants' knowledge of the causes of mental illness.
3. To investigate participants' beliefs about spiritual and cultural influences on mental illness.
4. To explore attitudes associated with mental illness.
5. To explore demographic factors associated with mental health literacy.

3.2 Introduction

This chapter presents the research steps taken to achieve the above research aims and objectives. It will firstly discuss the research design selected which guided the research process. It will, secondly, discuss the sample used and the sampling procedure followed. This chapter will then explain the data collection process. The chapter then explains the ethical considerations taken to ensure the welfare of its participants. This is followed by an explanation of the data analysis process used to analyse the collected data. Finally, the chapter discusses the reliability, validity and rigour of the study which hopefully ensures credibility, transferability, dependability and confirmability of the study.

3.3 Research design

The objectives of this research were achieved by employing a qualitative approach which allowed for individual interviews and a focus group discussion (Terre Blanche, Kelly & Durrheim, 2006). The reason for adopting this research approach was that the study sought to understand people's constructions that were achieved in talk. Therefore, adopting qualitative research helped in capturing how people construct meaning and understanding from the individual experience or personal perception of mental illness (Welman, Kruger & Mitchell, 2005). Another reason is that it helped the researcher analyse information that is conveyed through language (Kealey & Protheroe, 1996).

However, there are some disadvantages to using a qualitative research method. According to Cumming (2001), qualitative research focuses on the participant's knowledge and experience and therefore fails to look at other objects in the context that may influence behaviour. Silverman (2001) argues that qualitative research focuses more on meaning and experience, therefore leaves out contextual sensitivities. For instance, it does not look at other objects in the environment that may influence people's behaviour. A qualitative research design uses a smaller sample size than a quantitative research design, which raises issues of generalizability (Welman et al., 2005). Nonetheless, a qualitative design was appropriate for this study as it helped capture expressive information not transferred in quantitative design about beliefs, values and motivations associated with the phenomenon under study (Terre Blanche et al., 2006).

3.4 Sampling

"In order to make claims about a population based on a sample from the population, researchers need to select their sample so that people in it are represented in the sample" (Swartz et al., 2008, p. 30). This research used convenience sampling, which allowed for the recruitment of available and willing participants (Terre Blanche et al., 2006). Convenience sampling is rejected by some researchers as it results in the inability to generalize research findings and could also result in research bias (Terre Blanche et al., 2006). However, convenience sampling was appropriate for this study, as it allowed the researcher to enrol participants that were available and willing to participate.

The study only focused on African participants living in Sobantu, Pietermaritzburg. Participants were 18 years and above. The sample size of the study was four participants for the individual interview and five participants for the focus group. This study, therefore, sampled nine participants in total. The reason for sampling adult participants that are 18 years and above is because it was easier to get consent from the participants as sampling below the age of 18 would necessitate consent from their parent or legal guardian which would be time-consuming. The reason for focusing on African participants is because the research question is focused on African communities. The community councillor was notified about the research (see Appendix 1 and 12), as the researcher is African and understands that in an African community it is respectful for a leader to know about what is happening in his or her community. To recruit the participants, posters inviting people to participant in the study were put up around the community and the posters were both in English (see Appendix 6) and isiZulu (see Appendix 17).

3.5 Data collection

To collect data the study had a focus group discussion and four individual interviews. Participants were labelled differently. Focus group participants were given numbers (participant 1 to participant 5). The individual interviews were given alphabet (participant A to participant D) this was done to ensure that the participants remained anonymous throughout the study write up. This is presented in the demographic table below:

Table 1

Participants' demographic table

Participant	Age	Participated in a focus group	Participated in individual interviews	Gender	Race
Participant 1	41	✓		Female	Black
Participant 2	25	✓		Female	Black
Participant 3	18	✓		Female	Black
Participant 4	20	✓		Female	Black
Participant 5	21	✓		Male	Black
Participant A	27		✓	Female	Black
Participant B	25		✓	Female	Black
Participant C	25		✓	Female	Black
Participant D	27		✓	Female	Black
Total		5	4		

a) Focus group:

According to Terre Blanche et al. (2006) a focus group is a discussion conducted in a form of interview as group. Hence focus groups are characterised by a collection of people with shared comparable experiences (Terre Blanche et al., 2006). This study involved one focus group. This was conducted to elicit the group's understanding of mental illness, allowing the researcher to co-construct meaning from participants (Babbie & Mouton, 2005). The focus group was also conducted to allow for the observation of participants as they communicated, which may trigger a 'real-world' response from other participants. It was hard to find time for all the participants to meet for the focus group, this was because some were studying, and some were working. The focus group was conducted in a private place in Sobantu where there was

privacy and no interruptions. The focus group discussion was recorded and everyone participating in the focus group gave consent to be recorded. The schedule was semi-structured and asked broad questions about what people in the community think about mental illness, what their peers say about mental illness and what are the participants' perceptions of mental illness. The focus group schedule was designed to fit the aim of this study and the schedule was in both English (see Appendix 8) and isiZulu (see Appendix 19).

When the focus group discussion started, participants were firstly given informed consent forms which could have been English (see Appendix 3) or isiZulu (see Appendix 14) depending on the participant preference. The informed consent form informed the participants about their role in the study and asked the participants to give consent if they would like to participate. It also outlined the rights and responsibilities that they hold in relation to the research (see Appendix 3 and 14). The researcher also gave a verbal explanation of the study. When participants signed the consent form, this reflected that the participants understood their rights, responsibilities and they participated knowing the nature of the research. The consent form also included a section which participants must sign to give permission to be recorded (see Appendix 4 for English and 15 for the isiZulu). Wassenaar (2006) argues that it is hard to maintain confidentiality in focus group interviews because of the presence of multiple participants. Therefore, it was important to inform participants about how confidentiality is compromised in focus groups (Wassenaar, 2006). As a result, participants were asked to sign the confidentiality pledge which requested that all discussions in the focus group remain confidential and the issues discussed in the group not to be discussed outside (see appendix 3 and 14). To maintain privacy participants were asked to use a pseudonym instead of their own names and were advised not to discuss personal and sensitive issues in the focus group because confidentiality cannot be guaranteed. The participants were also assured that only the researchers and the supervisor would have access to the recordings and transcripts of the focus group and that this will be entered into files and findings will be recorded and saved in a password protected computer.

b) Individual interviews:

Semi-structured interviews were carried out to collect data, which consisted of four individual interviews. An interview schedule which was in English (see Appendix 7) and isiZulu (see Appendix 18) guided the interview allowing participants to talk without restriction about their

knowledge and attitudes on mental illness (Terre Blanche et al., 2006). Participants were selected based on, being from Sobantu Pietermaritzburg and were available and willing to participate. Therefore, the first four available and willing participants were selected, thus removing researcher bias. The interviews were informal and carried out in a conversational style, during which all interviews were recorded with consent.

Participants were given informed consent forms in English (See Appendix 2) or in isiZulu (see Appendix 13) which ensured confidentiality in individual interviews. In individual interviews, confidentiality is not compromised as in focus group interviews. However, it was still important to ensure that the participant understands that what was discussed in the interview is confidential and cannot be discussed with any other individual outside the interview. The participants were assured that a pseudonym would be used when transcribing their interview and that only the researcher would know they participated in the interview. The participants were also assured that only the researchers and the supervisor would have access to the recordings and transcripts of the interview and that they would be entered into files and findings will be recorded and saved in a password protected computer.

Over ninety percent of the South African population is reported to have a home language other than English, even though English is used as the language of instruction in most schools, tertiary institutions, the workplace, and in healthcare settings (Posel & Zeller, 2016). Therefore, the interview schedules were translated into isiZulu (see translated Appendices 12 to 19). The reason for adding isiZulu is for those that do not understand English and because the study focused on Africans living in Pietermaritzburg who are mainly isiZulu speakers (Posel & Zeller, 2016). The translation was carried out by the researcher and checked by another isiZulu speaking student, therefore employing back-translation. Back translation is the translation of a foreign language back to the original by a person different from the one who made the first translation (Chen & Boore, 2010). The reason for using this approach is because the researcher wants to identify language and interpretation errors (Chen & Boore, 2010) by comparing the back-translation to the original.

3.6 Ethical Considerations

"The essential purpose of research ethics is to protect the welfare of research participants" (Wassenaar & Mamotte, 2012, p. 1). There are eight elements of ethical research discussed below:

3.6.1 Collaborative Partnership

According to the collaborative partnership ethical consideration researchers must co-operate with the community which they seek to research (Wassenaar, 2006). The aim of this research was to gain the community's knowledge of mental illness. Gatekeeper's permission was sought before recruiting any participants, to show respect for community leadership. Feedback will also be given to the community once the data have been analysed.

3.6.2 Social Value

Research ethics argues that "research should address questions that are of value to society or particular communities in society" (Wassenaar & Mamotte, 2012, p. 14). This study will permit the researcher to do a debriefing report of the study findings with the community, with the aim of doing a future intervention that may be of value to the community and improve community literacy about mental illness.

3.6.3 Scientific Validity

"Unreliable research methods are unethical as they waste resources, yield invalid and generalizable results, which may expose participants to risk and inconvenience for no purpose" (Wassenaar & Mamotte, 2012, p. 15). This study aimed to ensure scientific validity by ensuring that the research methods are rigorous, valid and reliable. The research aimed to obtain participants' understanding of mental illness and their own personal views of mental illness. Therefore, a qualitative research design was appropriate for this study as it allowed for an in-depth understanding of the individual experience or personal perception of mental illness. To achieve scientific validity the study used triangulation; therefore, two methods of data collection were conducted, which were: individual interviews and a focus group discussion. The study also used convenience sampling which helped in eliminating researcher bias, as it allowed for available and willing participants to take part in the study. The use of thematic analysis helped in identifying, analysing and reporting patterns 'within data' therefore removed researcher bias (Silverman, 2001).

3.6.4 Fair Selection of Participants

The researched population chosen by the researcher must be the population in which the researched question applies (Wassenaar, 2006). This research used convenience sampling to ensure the fair selection of participants. Convenience sampling allowed for the recruitment of available and willing participants to participant in the research (Terre Blanche et al., 2006). No individual was unethically removed from participating in study.

3.6.5 Favourable risks and benefits ratio

A favourable risk/benefit ratio necessitates a just explanation of the study risks and benefits (Wassenaar & Mamotte, 2012). Although there were no direct benefits, there were no foreseeable possible harms or threats associated with participating in the study. However, if there would be any need arising after the study, arrangements were made with the UKZN Child and Family Centre for any psychological support (letter of support attached as Appendix 10).

3.6.6 Independent Ethics Review

"An independent and competent REC should subject all proposals to independent ethics review prior to commencement of data collection" (Wassenaar & Mamotte, 2012, p. 18). This study was ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (Approval no. HSS/1227/018M) (see Appendix 11).

3.6.7 Informed Consent

To ensure that participants are protected and know their rights as participants, informed consent was sought from all participants (see Appendix 2 and 3, and the isiZulu Appendix 13 and 14). The informed consent briefly described the study by stating that only willing participants will take part in a research study on 'mental health literacy' and detailed clearly what the research was about to maximise participants' understanding. The informed consent also included factual details about the research; the risks and benefits and contact details of the researcher and the HSSREC for participants who wished to know more about the research.

3.6.8 Ongoing Respect for the dignity of participants

This principle requires that participants be treated with respect during and after a study (Bell & Bryman, 2007). Participants were provided with any additional information or changes required during the research process. If a participant wished to withdraw from the study, the researcher would respect that right to withdraw as it is the participants right to withdraw. Lastly, participants' participation in the study was confidential to ensure the protection of the participants' identity.

The study employed a focus group to collect data, which according to Wassenaar and Mamotte (2012, p. 20) "is of concern regarding confidentiality because the researcher cannot guarantee that all participants will keep the information discussed by other participants confidential". Therefore, the researcher stressed the importance of confidentiality and advised participants not to disclose sensitive personal information in the group (Wassenaar, 2006). The professional integrity principle is concerned with the researcher's conduct and practice when carrying out their research (Wassenaar & Mamotte, 2012). This principle was achieved by ensuring that no data was falsified and/or modified by the researcher. Therefore, the researcher used the proposal guidance during the construction of data and during analysis. This ensured the integrity and dignity of the research and researcher.

3.7 Data Analysis

The process of data analysis requires inspecting, cleaning, transcribing, transforming, and modelling data with an aim of discovering information useful to the research questions, suggesting inferences and conclusions made (Terre Blanche et al., 2006). Data was reviewed by the researcher, during which the researcher made notes and began to sort data into categories.

The researcher then moved the analysis from the broad reading of the data towards discovering patterns and developing themes. Therefore, the study employed a thematic analysis to analyse data. "Thematic analysis is a qualitative analytic method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). The initial phase of analysis started during the data gathering stage as this was when the researcher developed ideas about the phenomena being studied (Terre Blanche et al., 2006). During the transcription process, the researcher started to induce themes that arise from the focus group and interviews. According to Silverman (2001), after transcription, the text is broken down for sentences which are said to be descriptive of the research question. Terre Blanche et al. (2006), refer to this as a phase of inducing themes.

Therefore, to analyse data the researcher carefully went through text, underlining and highlighting words and sentences relevant to the research questions (Silverman, 2001). Coding was then conducted in which the words, phrases and sentences were assigned under headings determined by content related to each research question. According to Silverman (2001) this

process of thematic identification should be then followed by elaboration. Hence the researcher moved to the elaboration stage which is associated with the final phase of interpretation (Terre Blanche et al., 2006)

3.8 Validity, Reliability and Rigour

Validity refers to the truth, it is the way in which the results of the study hold the truth (Babbie & Mouton, 2005). Reliability refers to the dependability of a measurement instrument, that is, the extent to which the instrument yields the same results on the repeated trials (Terre Blanche et al., 2006, p. 52). Generalisability is the extent to which it is possible to generalise from the data and context of the research study to broader populations and settings (Terre Blanche et al., 2006, p. 91). However, this research aimed for credibility, dependability and transferability and trustworthiness as it was a qualitative design (Babbie & Mouton, 2005).

To achieve credibility there was a need to get truth value; hence, capture the perspectives of the sampled participants. This was "achieved by the researcher spending enough time interviewing and discussing with the participants" (Shenton, 2003, p. 64). Credibility was also ensured by the notes that the researcher took during and after data collection. This research also aimed to ensure credibility through triangulation. Therefore, two methods of data collection were conducted, which were; individual interviews and a focus group. The study also ensured "credibility through the structural coherence of analysis and report, therefore ensuring that there is logic in the report and to ensure that the report is easily understood by other readers" (Shenton, 2003, p. 64).

Transferability refers to the applicability of the research findings to other people (Babbie & Mouton, 2005). Therefore, the study hopefully ensured transferability "by ensuring that no misleading questions were asked during data collection" (Shenton, 2013, p. 69). Transferability was hopefully ensured as the researcher sampled participants from the studied community, therefore hopefully ensuring transferability to other people in a similar community from similar community setting (Terre Blanche et al., 2006).

Dependability of a measurement instrument, "is the extent to which the instrument yields the same results on the repeated trials" (Terre Blanche et al., 2006, p. 52). "This was achieved by using overlapping methods of data collection" (Shenton, 2003, p. 71), hence the focus group

and individual interviews. Dependability was also achieved by the researcher "clearly detailing the study to ensure that it is understood by any researcher who seeks to repeat the study" (Shenton, 2003, p. 71).

In confirmability, "steps must be taken to help ensure as far as possible that the works' findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher" (Shenton, 2003, p. 72). Confirmability was achieved by using thematic analysis. "The method will help in identifying, analysing and reporting patterns within data" (Braun & Clarke, 2006, p. 79), therefore removed the researcher's subjectivity.

3.9 Summary

In summary, this chapter presented the methodological steps taken to conduct this study, including the research design, sampling process, data collection and analysis. It also presented the ethical considerations taken to ensure the rights and well-being of the sampled participants. This chapter also presented the credibility, transferability, dependability and confirmability of the research. This chapter described how data were collected and analysed. The outcome of the data analysis is described in the Results chapter that follows.

CHAPTER FOUR

Results

4.1. Introduction

This section presents the results of the data analysis of this study. It describes how participants from Sobantu identified and described mental illness. The data collection methods which are individual interviews and the focus group produced data around the following themes: Knowledge about mental illness, perceived causes of mental illness, recognition of mental illness and finally help-seeking and mental illness. The themes are discussed in detail below with short extracts to illustrate how participants conceptualised mental illness. Simplified Jeffersonian transcription conventions (Kasper & Wagner, 2014) were used to represent the subtleties of meaning in a speech in the data.

Figure 2: Simplified Jeffersonian conventions

The following structure illustrates the Simplified Jeffersonian convention.

[brackets]	overlapped speech.
(0.5)	pause in tenths of a second.
(.)	micropause of less than two tenths of a second
=	contiguity between the speech of one speaker or of two different speakers.
.	intonation descent.
?	intonation ascent.
,	continuous intonation.
? ,	intonation ascent, stronger than a comma and less strong than the question mark.
:	sound elongation.
-	self-interruption.
underlined	accent or emphasis of volume.
CAPITALS	strong emphasis.
°	low voice speech immediately after the signal.
°words°	low voice excerpt.
word:	uninflected intonation descent.
word:	uninflected intonation ascent.
↑	sharp ascent in intonation, stronger than the underlined colon.
↓	sharp descent in intonation, stronger than the colon preceded by underline.
>words<	compressed or accelerated speech.
<words>	slowing of speech.
<words	accelerated beginning.
Hhh	audible aspirations.
(h)	aspirations during the speech.
.hhh	audible inspiration.
(( ))	analyst's comments.
(words)	doubtful transcription.
( )	impossible transcription.
...	non-measured pause
"word"	reported speech, reconstruction of a dialogue

Conventions developed by Gail Jefferson and published in Sacks, Schegloff and Jefferson (1974), the last two symbols were suggested by Schifrin (1987) and Tannen (1989).

Source: Oliveira and Oliveira (2014, p. 141)

4.2 Knowledge about mental illness

Participants displayed some form of knowledge about mental illness but could not pinpoint the different types of mental illness and the different terms used for each mental illness. As the extract below illustrates, the participant knew about mental illness as a sickness but did not know the different terms attributed to each illness.

Extract 1, Individual interview, Participant D

4	Interviewer	oh okay and eem are you aware of mental illnesses?
5	Participant	eem the word is not foreign to me like the name mental illness is not
6		foreign
7	Interviewer	mmha
8	Participant	I:: do know that there are mental illnesses even though I don't I can't
9		really pinpoint or name them individually but I do know there's a
10		sickness called mental illness

Participants also had some form of knowledge of mental illness as 'participant A' stated in the following extract that it's a disturbance in the brain which affects how people with this illness think which makes them behave abnormally.

Extract 2, Individual interview, Participant A

15	Interviewer	Are you aware of mental illness?
16	Participant	↑↑yah eem I am aware of it
17	Interviewer	okay (.) and what is your understanding of mental illness?
18	Participant	I:: I think its probabl::y sort of disturbance in one's brain its affect how
19		they think and ultimately how they behaviour and they start behaving
20		abnormally (.) yah

The participant in the extract below explains that mental illness is conceptualised as being crazy, slow in different ways and on certain things. Basically, a mentally ill individual is someone who acts in a different way compared to others.

Extract 3, Individual interview, Participant B

9	Interviewer	okay ha are you aware of mental illness?
10	Participant	yes I am
11	Interviewer	and what is your understanding of mental illness
12	Participant	in my own understanding is one person that eem some term as being
13		crazy some term as being slow in different ways it can be in talking the
14		way they they act or the way they learn oo::n on how to do certain things
15		a::nd its it ↑↑mostly it's basically eem being slow at at being able to:: to
16		to ◦what can I say◦ ↑↑ to learn a certain behaviour because mentally ill
17		person ↑↑people usually act in different ways

The next extract highlights the idea that some people are mentally ill or are pretending to be mentally ill because they want to be cool especially being at a young age. Others are mentally ill to move away from things that are happening around them and do not want to take responsibility for it.

Extract 4, Individual interview, Participant C

29	Interviewer	so these views and opinions what are they about mental illness?
30	Participant	↑↑I:: can't really go in-depth but others would obviously think (.) aarh
31		but others are just doing it for the sake of wanting to be cool you think
32		around our age, others it's like shying away from basic things that are
33		happening around us or they just shying away from responsibility, others
34		I don't know there's quite a few

4.2.1. Source of knowledge

The findings suggest that respondents from the Sobantu community were not aware of psychological perspectives of mental illness. The extract below illustrates that the community is the fundamental source of information when it comes to conceptualising mental illness. When the researcher asked where the participants from the focus group get their information from they all replied from the street. Participant 2 noted that they hear from people talking about it, therefore from the streets and society.

Extract 5, focus group, Participant 2

107	Interviewer	okay, uhh your knowledge or the community as a whole where do you
108		get it from?
109	All	[in the streets]
110	Participant 2	we usually hear from people talking about it and then we take what they
111		say but I think that ehh its less likely that we get it from the people that
112		know better or the people that graduated for this and the people that can
113		tell us directly what it's is in most cases its usually in the streets in the
114		society

Extract 6 below illustrates another major source of information, which is the media. The media appear to have an influence on how people conceptualised mental illness.

Extract 6, individual interview, Participant A

63	Interviewer	em:: where do you get your information from about mental illness?
64	Participant	ee::m (.) well after after after that guy (.) I sort of did my research
65		cause there where many things that were being said like he was
66		bewitched and yah everything I think the media also plays a huge role
67		eem we watch these things on TV read about them on on on news
68		papers and ↑↑watch movies I have seen about of movies about about
69		people with characters who are mentally ill

It was also found that people were only becoming aware of mental illness when it affected someone they know or live with. The extract below shows that the participant was aware of mental illness and the issues surrounding the mental illness because she has a family member who suffered from the illness.

Extract 7, individual interview, Participant B

47	Interviewer	◦oh okay◦ and where do you get your information from about mental
48		illness?
49	Participant	↑↑FROM THE INTERNET, BOOKS and there's a workshop he attends
50		a mental illness school and that usually has classes to teach the parents
51		and family members about mental illness and how to treat them and not
52		to discriminate or exclude them in anyway ◦so yah◦
53	Interviewer	oh so you you attend those workshops?
54	Participant	no my grandfather attends has and he brings back notes and (.)
55		information's from those workshops and then informs us

4.3 Knowledge about the causes of mental illness

Different views were expressed about the causes of mental illnesses. The responses here seemed to be clustered around tradition and taboo.

Participant 2 in the focus group stated that mental illness could be caused by the way an individual think to a point where they cannot control their thoughts. Participant 2 also stated that society also has an influence. The problem within the community is seeking help from someone who is not fit to help you as they conclude to say that 'you are crazy' which hinders the prevention step.

Extract 5, Focus group, participant 2

33	Interviewer	mhhm so when you think about mental illness what causes it?
34	Participant 2	mm thinking that just as I said that the way you think, for some you
35		allow your thoughts to control till the point that you can no longer

36 control it that’s when you turn to someone you were not cause for some

37 you find that there were not born like that the society also does have a

38 lot of influence because some can be prevented but if you going to see a

39 person who supposed to be helping you by stating that no it’s not the

40 way you should be thinking but instead, a person just concludes by

41 saying that you are crazy, so I’m thinking it’s something like that.

Another participant in the focus group stated that wishing for high things in life which cannot be attained may result in depression.

Extract 6, Focus group, participant 1

42 Interviewer [okay

43 Participant 1 in some] in some it’s wishing for high things that you will not achieve

44 wishing for high things results in being crazy having your brain mixed

45 up [the brain

46 Participant 2 yah] yah [depression

Another cause of mental illness identified by participants is a rejection of the ‘calling’. The participants identified that when a person refuses a calling to be a sangoma (traditional healer), the person who refuses is likely to suffer from a mental illness as she disobeyed the ancestors by refusing, which results to him or her being punished by the ancestors as they make the person ‘crazy’.

The following extract below is a conversation which took place in the focus group between participants 1 and 5. The extract shows how media are seen to play a role in shaping how people conceptualise mental illness. The extract illustrates how people with mental illness are portrayed by social media which influence how people conceptualise mental illness. There is also a belief that to be mentally ill there is a need for something to enter you, in this instance line 414, the cause for mental illness was due to Nosipho (the TV character) to be entered by a woman. And in line 421, mental illness is identified by abnormal behaviour.

Extract 7, Focus group, participant 1 and 5

410	Interviewer	Uzalo what is that?
411	Participant 1	uZalo is a series we watch on SABC 1 that plays at half past 8
412	Interviewer	okay
413	Participant 1	yes like Nosipho from uZalo Nosipho was normal right working and
414		alright was entered by this thing see this woman that people did not see
415	Participant 5	oh thank you what you are saying then it's the craziness [her behaviour
416	Participant 1	wait participant 5 wait participant 5] when she saw this person she kept
417		on doing funny things that we members of the community like in Mashu,
418		she was starting to be crazy because she was doing these things what she
419		never did before talking to herself taking of her shoes and goes around
420		but she knew where she was going
421	Participant 5	it what I am saying that a crazy person you see by their behaviour

The following extract 8, participant 1 highlights the view that that a person with a calling is well but what makes a person mentally ill is the rejection of the calling.

Extract 8, Focus group, participant 1

100	Participant 1	↑↑NO you are well when you have a calling, but it ends up being the
101		same things if let's say I am going to have a calling, then I disagree with
102		that I don't have a calling and I don't become a sangoma ((traditional
104		healer)) I won't as time goes on because it's the ancestor but this
105		ancestor, it could happen that it makes you crazy when it makes you
106		crazy then you also became part of the mentally ill you see

Extract 9, Focus group, participant 4

Participant 4 in the focus group stated that some mental illnesses are caused by the ancestors. The illness is caused by having an ancestral calling but the called individual does not want to accept the calling which results in the ancestors making the individual crazy.

47 Participant 4 for some] you may somehow have a calling like in terms of
48 the ancestors and stuff, things like that maybe you don't want to follow
49 the thing that that they tell you to do then u-end up having confusions in
50 the brain going to traditional healers a lot
51 Participant 1 [maybe till the ancestors make you crazy
52 Participant 4 till the ancestors make you crazy] because you not doing the thing they
53 say you must do

Extract 10, Focus group, participant 3

Other factors that were identified by the participants as the cause of mental illness were, as said by participant 3 in the extract below, that the way one is raised may also be a cause of mental illness. Other participants noted drugs and stress as causal factors for mental illness.

54 Participant 3 for some it's caused by the way they were raised ehh maybe they were
55 abused than when they grow up end having an effect in the brain
56 Interviewer mmha
57 Participant 5 ehh for others what makes them crazy is different it's a lot; alcohol,
58 drugs, stress also ends up making you crazy

The extract below shows that participant D stated that members in the community saw another cause of mental illness as bewitchment, believing that witchcraft may also be a cause of mental illness.

Extract 11, Individual interview, Participant D

31 Participant If I can put it like that because there's an assumption that it's either
32 witchcrafts or

33	Interviewer	mmha
34	Participant	the assumption that you know it's because you studied to hard you
35		study too much people don't like that, so they make you crazy so with
36		my understanding mental illness is just be crazy well that's what
37		culturally that's what they say

4.4 Help-seeking and mental illness

The results of both the individual interviews and the focus group discussion indicated that although the community had some knowledge about mental health practitioners, they could not go to them for help because they were identified as expensive.

The extract below illustrates participant 5's views on why they will never seek professional help. One of the reasons was that as a Black person, it does not make sense to talk to a stranger about your problems. Another reason was that it's expensive and cannot be afforded by people.

Extract 12, Individual interview, Participant D

125	Interviewer	What difficulties do you see in seeking for help from health
126		professionals? ◦like psychologists◦ [psychologists
127	Participant	=eeem] the very first thing (.) I think we:: (.) ↑↑don't really know
130		much about these thing men especially us Black people ah ah and we::
131		we don't think to us its really doesn't make sense to go there and to see
132		a stranger about your problems and secondly it it doesn't make sense to
133		talk to strangers about your problems we don't know the important of
134		these things eeem (.) ↑↑money its its its quite costly so very expensive
135		not many people can't afford that so I think those are the barriers

The participant in extract 13 highlights that the problem is money. She pointed out that seeing a health professional like a psychologist costs money that they do not have. The participant

also shows a lack of knowledge about the fact that the government offers free mental health services.

Extract 13, Focus group, Participant B

120	Interviewer	◦oh okay◦ aarh what do you see as difficulties to seeing a health
121		professional (.) so what are the challenges that you foresee like seeking
122		help from a health professional such as a psychologist a psychiatrist
123	Participant	aaarhmm::: (.) ↑↑money wise like aarh seeing a professional like a
124		psychologist eem cost money a::nd that money that we don't have so::
125		I think that's one of the challenges a person might come across but if if
126		eem if assessing a psychologist was free I don't think it would be
128		something as difficult as it is because most psychologists that are well
129		know and are qualified needs to be paid and
130	Interviewer	mmha
140		(.)
141	Participant	and also eem most people from the township are not educated about
142		psychologist only a few people know them because as something happen
143		to a person they rush to traditional healers to ask for answers or seek for
144		help

In contrast to the above, the extract below shows that some people in the community were aware of relevant different health professionals. The extract also shows that some people were aware that they could get help from government clinics without paying. Participant 5 noted that the problem with government health professionals was that they do not offer help like the private health professional (line 253 – 255).

Extract 14, Focus group, Participant 5

250	Interviewer	okay so as we were speaking that there are health professionals such as

251		psychologists and psychiatrists and others, what is the hard thing for
252		people, to go and see them ehhe the difficulties?
253	Participant 5	eyy these places are expensive and even the government places you do
254		get help but you don't get it as you were going to get it there in where
255		you must pay

Extract 15 below suggested that people's help-seeking is motivated or associated with what they identify as the cause of the mental illness.

Extract 15, Focus group, participant 4 and participant 5

Participants identified several places to seek help. Participants identified health professionals (lines 73-74), the church (lines 76-77) and the traditional healers.

71	Interviewer	are there places where people can go to get this help?
73	Participant 5	ehh there are Government places as participant 2 was saying in hospital
74		and Forth Napier
75	Interviewer	and then [others?
76	Participant 4	others] can go to church others that are drinking can try to prevent things
77		that can make them crazy

Participants in the focus group discussion identified a place called the throne which is in a church called eChibini, which is said to be a church for holy water, this holy water helps remove the mental illness.

Extract 16, Focus group, participant 1 and 4

81	Participant 1	but some they forget, if you forget it's that going to church like echibini
82		((church for holy water)) the Nazaretha ((church)) there is something
83		they call a throne where they take them, a person who is problematic

84		you take them there for maybe three months where he gets healing from
85		just like this person
86	Participant 4	like-Mayo
87	Participant 1	yes him but not really that he was sick, but he had signs when he was
88		drunk

Participant 1 goes on to say that a doctor will not see that the person has a calling but will treat the patient like everybody else who is said to be crazy. The created sickness (the bewitched or ancestral sickness), the doctor will see that the person has a certain sickness but will not see that the sickness is created by someone else. For instance, the doctor will see that you had a stroke but will not see that someone sent it to you. The doctor will, therefore, treat you the same way as the person who has an illness. Whereas if the person is taken to a traditional healer it will take one or two days for the person to be healed. Participant 1 emphasised that it's important for black people to always remember that they are Black and must remember to go back to their customs and seek for a traditional healer as the hospital may be unable to help.

Extract 17, Focus group, participant 1

422	Participant 1	I am thinking that the doctor does not see if it's a calling he just takes it
423		as this person needs to be treated like everybody else who is crazy where
424		as he should not like a stroke that people create with it maybe it's
425		thinking a lot till it ends up hitting you right the created one the person
426		is taken to hospital the doctor will see that it's a stroke
427	Participant 5	but know a stroke is a stroke the brain changes physically when you are
428		hit by a stroke
429	Participant 1	I am saying that participant 5 the doctor will see that it's a stroke just
430		like everyone else's who is sick but maybe you were sent a bird ((some
431		form of witchcraft)) maybe the mouth was touched you end up not being
432		able to talk and treats you the way he treats people who have a stroke

433		until I take my family member to be healed by a traditionalist one to
434		two days given those herbs the person becomes okay and back to normal
435		now she can walk I am saying that even with a calling you won't see if
436		it's a Zulu thing the doctor will take it as if you are crazy maybe you
437		have depression like everyone else but you must remember that we
438		are black people maybe we must go back to our customs and take that
439		persons to a traditional healer maybe it will heal much quicker whereas
440		take him to the hospital maybe he won't heal a person will keep on
441		seeing that woman just like Nosipho until they did the ritual

The participant in the following extract had a granny who is a sangoma who people in the community consult for help. When asked if the granny speaks to the ancestors, she noted that she does and that people have been going to her for help and, she has received testimonies for her work.

Extract 18, individual interview, participant D

162	Interviewer	so she speaks to
163	Participant	=yes
164	Interviewer	=the ancestors?
165	Participant	she speaks to the ancestors or for them and yeah that's how it is ( )
166	Interviewer	and people actually go to her for help and
167	Participant	=yes people do go and consult and they do come with testimonies
168		saying that you know it worked that and that worked for me and
169		↓↓things like that

4.5 Attitudes associated with mental illness

4.5.1 Stigma and mental illness

Stigma refers to how mentally ill patients are prejudiced by society. Mentally ill individuals are associated with the stigma of being aggressive and violent. In the extract below the participant highlighted that she could be stressed by 'those people' that are mentally ill. The participant stated that she has only seen only a few that are aggressive and violent. She believed that mental illness or being close to the mentally ill could rub on off you (line 144).

Extract 19, individual interview, participant A

136	Interviewer	Okay so em are there any risks of being ↑↑do you foresee any risks of
137		being around people that suffer from mental illness?
138	Participant	.hhhh yah for sure for sure for sure eem
139	Interviewer	mha
140	Participant	I've seen quite a few who:: are aggressive and violent in a way those are
141		the those are the only risks basically and arh maybe even those who are
142		not aa::rhm aggressive in a way I think you could be stressed yourself
143		from being around those people always trying to help them and
144		everything I think it could rub on you in a certain way

The extract below also highlights that mentally ill people are stigmatised as dangerous to the community (line 26).

Extract 20, Focus group, participant 1

20	Interviewer	oh I was saying what are people in the community saying about the
21		people with mental illness?
22	Participant 2	[people from the community
23	Interviewer	are they] seeing it the same way as you all?
24	Participant 1	they don't see it the same way ((clear throats))
25	Interviewer	yes

26 Participant 1 some take it as a person is crazy and a danger to the community

4.5.2 Labelling the mentally ill as a stigma

Stigma refers to the way that people roughly use the word 'crazy' when talking about or to a mentally ill person as if having a mental illness is not suffering or a sensitive matter like any other health problem.

The extract below shows how participants stigmatise people who suffer from mental illness by using the word 'crazy'. The participant in this extract mentioned that they always say people with mental illness are crazy and they are not given a space in the community. They are therefore seen as nothing or fewer humans. They are called names because they are 'not well in their head'. They don't have to do or say anything but because the community knows that they are mentally ill they are disrespected and not given a chance or even recognised by the community. They are also disrespected by children in the community.

Extract 21, Focus group, Participant 2

212 Participant 2 ehh you see if we come to the community we will not hide that we
213 always say they are crazy nje we don't give them their place even when
214 they don't do anything they just by showing up if it's an older person
215 the kids run away from him or her, if it's a younger person kid's will be
216 rude to him and call him names saying that his a crazy and his not well
217 in his head even when he did not do anything to these kids you see so
218 something like this so I'm thinking that the way we treat them is not nice
219 it has no joy it's no has happiness

Participant 4 in the following extract agreed with the extract above (extract 21). Participant 4 mentions that at home they have a mentally ill person who picks up papers. She mentioned that the person is crazy because the person does not take a bath. The participant mentioned that the

mentally ill person is mistreated by the community because he picked up papers and cleaned the community.

Extract 22, Focus group, participant 4

220	Participant 4	but there are some that are not that crazy like saying at home we have
221		one who picks up papers like he is crazy because he doesn't not bath and
222		he is not doing the things he is supposed to be doing but he got nothing
223		to say his mistreated by community because he cleans you see he picks
224		up papers you see he likes the place to be clean every single time

4.6 Demographic factors associated with mental health literacy

Table 1

Participants' demographic table

Participant	Age	Participated in a focus group	Participated in individual interviews	Gender	Race
Participant 1	41	✓		Female	Black
Participant 2	25	✓		Female	Black
Participant 3	18	✓		Female	Black
Participant 4	20	✓		Female	Black
Participant 5	21	✓		Male	Black
Participant A	27		✓	Female	Black
Participant B	25		✓	Female	Black
Participant C	25		✓	Female	Black
Participant D	27		✓	Female	Black
Total		5	4		

The participants' ages were between 18 to 41. All had completed their matric. Four participants had completed their tertiary education, one was at the honours level and one was doing a masters. Three were still in tertiary doing their undergraduate studies. One dropped out of tertiary and one was unemployed and had never entered tertiary education. None of them had suffered from mental illness. They all knew someone who was said to suffer or had suffered from mental illness. None of them had been educated about mental illness but were aware of and had different definitions and understandings of mental illness.

Participants did not seem to highlight different understandings of mental illness based on their age, education level and gender. They all had a cultural perspective and limited understanding of the psychological perspective of mental illness. Six of the nine participants shared that they had family members who suffered from mental illness. They shared that because they had someone who suffers from the illness, this changed the way they conceptualised mental illness, as shown in extract 22 (line 30 – 32)

Extract 22, individual interview, participant B

29	Interviewer	so do you see them differently than how people around you see them?
30	Participant	yah I would say that because eem I have I I I actual have an uncle whose
31		mentally ill so I have learnt to understand that there is nothing wrong
32		with them and there is nothing they can do to harm you so::

Two participants noted that they had family members who are traditional healers (izangoma), which also shaped their knowledge.

Extract 23, individual interview, participant D

157	Interviewer	oh okay and the notion of isangoma having callings do you believe that
158		your granny had a calling
159	Participant	I believe she does I believe she still does I believe she does I don't
160		want to go in that too deeply about it being a calling to be a sangoma
161		but she does have a gift

Therefore, the main demographic factor of the study was the community, the context. Sobantu is a community with a supernatural understanding of mental illness which is inherited from generation to generation. The psychological perspective remains neglected. However, due to some having family members that suffered from mental illness allowed some participants to get some of the psychological understanding of mental illness but the dominant being the contextual understanding of mental illness. Participants also acknowledged that the Sobantu community had several traditional healers who are respected and helped the community by healing them or communicating them with their ancestors which in this case heal the mental illness.

4.7 Summary

In summary, the results showed that participants had their own cultural and religious conceptions of mental illness which were different from the western psychological perspective. The type of help-seeking was influenced by what participants believed to be the cause of mental illness and what participants believed to be the cause of mental illness was influenced by how they conceptualised mental illness. The findings also showed that there was a high level of stigma associated with mental illness which leads to discriminating and labelling the mentally ill. The main sources of these conceptions were the context and television. However, participants' conceptions of mental illness were contextual rather than individual. These results are discussed in detail in the chapter that follows.

CHAPTER FIVE

Discussion

5.1 Introduction

The aim of this research was to assess the sample's mental health literacy from a South African context. By understanding how local people conceptualise mental illness with the aim of describing and understanding their perspectives and awareness of mental illness it also aimed to examine whether spiritual and cultural influences affect how people conceptualised mental illness. The study also aimed to understand the sample's knowledge about the cause of mental illness, attitude and the demographic factors associated with mental illness. The motive behind the study was that the history of mental illness is generally taken from a western perspective, which fails to comprehend insights into how culture may contribute to the perception of mental illness (Swartz et al., 2008). There are limited studies on mental illness and the public, and fewer studies conducted in the South African context. This causes a challenge in addressing the issues of mental illness and mental health literacy, as the participants showed that they are aware of mental illness but conceptualise mental illness differently from the western perspective. This chapter will discuss the findings of the study. It will firstly discuss the sample's awareness and perspective of mental illness, the contextual understanding of mental illness, help-seeking and mental illness, and the attitudes associated with mental illness.

5.2 Awareness and perceptions of mental illness

The literature review illustrated that historically and currently, many people cannot accurately identify people who suffer from mental illness (Link et al., 1999; Reavley & Jorm, 2011). The results of the study showed that participants in this study were aware of mental illness as being a disturbance in the brain which causes an individual to behave differently than what is deemed as normal. All participants noted that they cannot pinpoint the different types of mental illnesses. Six of the nine participants in the study mentioned that they had a family member who suffers from mental illness. However, none from them could identify the type of mental illness. Reavley and Jorm (2011) argued that people cannot recognise or identify mental disorders and do not understand the psychological concepts attached to the illness.

The findings illustrated the sample's conceptions of mental illness, which highlighted the explanatory model. Participants' understanding and beliefs about mental were based within

their cultural context (Bhui & Bhugra, 2002). The results of the study illustrated that how participants conceptualised or explained mental illness was due to knowledge from the community members. As participants noted that they were told by the elders and other community members about mental illness. According to Rickwood and Braithwaite (1982) an individual's context, community members such as friends, family and neighbours are said to be a relevant source of information. The problem with having people from the community as a source of information is that people are not well informed about mental illness as they give information that they heard from others and are not certain of, which leads to a generalisation of misconceptions about mental illness (Rickwood & Braithwaite, 1982).

The results of the study also highlighted television as another source of knowledge about mental illness. The problem with the media being the source of knowledge is that the media portrays individuals with mental disorders as dangerous and harmful (Bourget & Chenier, 2007). According to Bourget and Chenier (2007) negative media images are of concern because they increase psychological distress, fear of and stigma for individuals with mental disorders. The media, therefore, may play a major role in the public perceptions of fear and dangerousness interrelated with mental illness.

5.3 Beliefs about the cause of mental illness

The sample's conceptions about the cause of mental illness fluctuated between contexts, therefore there is a need for a contextual understanding of mental illness. According to Nieuwsma et al. (2011) people's cultural beliefs about the cause of mental illness is dynamically significant, therefore understanding these cultural beliefs will help in the application of active methods to mental health care (Nieuwsma et al., 2011). The literature highlighted that there are diverse ways of understanding mental illness which are different from a Western perspective. The results of the study highlighted how participants conceptualised mental illness was based on their beliefs about the cause of mental illness. The findings highlighted conceptions of culture and religion in understanding the cause of mental illness. Mental illness was strongly seen as a result of being bewitched and suffering the consequences of saying 'no' to their ancestors.

The results illustrated that some mental illnesses were perceived as caused by their ancestors. This is caused by having a calling to be a sangoma and because the individual that is called does not want to accept the calling, the ancestors punish that person by making them 'crazy'. Once the person has come to terms and is ready to accept the calling a ritual is carried out to

apologise to the ancestors and if the ancestors accept the apology and the ritual is performed well, the person is believed to become healed (Honwana, 1998). Only then can a person start preparing to be a sangoma. Hence healing is a traditional process.

The results also highlighted that it is believed that a sangoma's talks to their ancestors and helps people communicate with their ancestors for help. This is evidenced in the literature. According to Manyike and Evan (1998) a sangoma talks to his or her ancestors to help heal their clients and see things that other people don't see. In the isiZulu culture being a sangoma is glorified because they help people communicate with their ancestors. However, in the western perspective, the Sangoma may be seen as hallucinating as sangoma talks to the unseen (Swartz et al., 2008). According to the results of the study, the participants from Sobantu had cultural and religious understandings about how they conceptualised mental illness. However, even though participants did not have deep insight into other mentioned causes of mental illness, they did mention psychosocial causes of mental illness. Some participants argued that mental illness could also be caused by drug abuse. Depression and stress were also mentioned. Depression and stress, according to participants, are caused by wishing for high things that are later not attained by the individual and also not having the right person to talk to about your problems.

The problem with both the Western and the contextual understanding is that they contradict each other which can make it impossible for the two perspectives to co-exist. The results also highlighted that participants' beliefs about the causes of mental illness reflect where the participant would go for help-seeking.

5.4 Help-seeking and mental illness

The results of the study indicated that participants had knowledge of mental health practitioners but did not go to them for help because they were identified as too expensive. It was also highlighted that the free health practitioners provided by the government are perceived as not at the same high standard as health practitioners that people pay privately. The trouble in South Africa is that although its mental healthcare policies are progressive, these are not filtering down. For instance, the Department of Health has reported that 53% of hospitals have been listed to provide 72-hour assessments of psychiatric emergencies, in keeping with the provisions of the Mental Health Care Act (Lund et al., 2011). However, the hospitals frequently don't have enough staff or resources to provide the care required (Bowers, Van Der Merwe,

Paterson, & Stewart, 2012). Patients end up being admitted to general wards, in which suicidal patients are sometimes turned away due to a lack of space in hospitals (Bowers et al., 2012).

The HBM is about a belief that a phenomenon or object is true or real to them. Therefore, people are more likely to seek help if the sickness is real to them (Brannon et al., 2013). The results highlighted that people do not go for professional help as the psychological sickness is not real to them. Therefore, individuals perceived beliefs about an illness leads to action. Hence, the HBM associate's individuals' beliefs about illness and treatment with health actions. The model highlights that health-seeking behaviours such as going to see a doctor for treatment are the result of the interaction of a set of core beliefs (Brannon et al., 2013). Thus, if the person doesn't believe that he or she is likely to get the help she needs from the health professional then the person will seek help from the health professional. When participants were asked about the chances of them becoming mentally ill they all noted that it's not likely. According to the perceived susceptibility perspective in the HBM people who think that they are prone to a health problem will engage in behaviours to reduce their risk of developing the health problem. And those that do not, will not even go for a psychological check-up (Glanz et al., 2008). The results suggested that participants got to know and went to a health professional when they were already mentally ill or only when a family member was already mentally ill.

The results also highlighted that participants views about mental illness affects where to go for treatment (Nieuwsma et al., 2011). Therefore, people who believed that they are bewitched, participants noted that they are likely to go to izinyanga (traditional healers) for help. Whereas those that believed that people in their families suffered from mental illness due to being possessed by the demons or their ancestors, they are taken them to church and a sangoma (traditional healer) for help. And if they believed that someone is possessed by an evil spirit then they take them to church. For instance, participants in this study spoke about a place called the throne which is in a church called eChibini, which is said to be a church of holy water, where people are cleansed and healed with holy water. These notions about the different causes and treatments of mental illness support the explanatory theory which states that psychological phenomena (in this case mental illness) are understood and explained differently in different cultures and ethnicities. Hence, the causes of mental illness are complex and differ depending on the illness and factors within the individual. Therefore, it is important to investigate the public's beliefs regarding the aetiology of mental illness because they influence help-seeking behaviour and adherence to treatment (Jorm, 2000). Psychological phenomena are understood

in diverse ways across cultures and those individuals are treated differently (William & Healy, 2001). Hence, this is in support of the explanatory model which argues that people explain their distress in a multitude of ways and that ideas and beliefs about an illness assist an individual to make sense of the illness within a cultural context (Kleinman, 1980).

5.5 Attitudes associated with mental illness

The results of the study highlighted that there is a high level of stigma associated with mental illness. Mentally ill individuals are associated with the stigma of being aggressive, violent and dangerous. People with mental illness and their families are often stigmatised and discriminated against by the public (Reavley & Jorm, 2011). Some individuals have been denied adequate housing, health insurance and jobs due to their history of mental illness (Mohamad et al., 2012). The results also highlighted that the mentally ill are labelled as 'crazy' within the community. The problem with labelling is that it may also hinder help-seeking as people do not want to be called 'crazy'.

According to the results, people who from suffer mental illness within the community may be mistreated, not because they are harmful but because they are mentally ill. The results highlight that they are called names due to being unwell. They are disrespected and are not recognised by the community. Due to these negative attitudes associated with mental illness, people that may think they have mental problems, and people that are already suffering from mental illness are unlikely to seek for help due to the fear of being stigmatised (Reavley & Jorm, 2011). The results also reflected that mentally ill individuals within the community are also disrespected by the children in the community, which reflects that even children in their early age are already taught to not associate with and possibly also to be cruel towards the mentally ill.

5.6 Demographic factors

Demographic factors appear to influence the sample's perceptions and conceptions about mental illness (Park et al., 2014). The findings of the study suggested there was one main demographic factor associated with this study and that this factor was the context (Sobantu). The differences in age and gender did not appear to play a role in how participants conceptualised mental illness. How participants conceptualise, believed about the cause of mental illness, where to seek help and their attitude about mental illness appeared to be strongly influenced by the community they lived in.

5.7 Summary

In summary, this chapter discussed the results of the study. These results were presented as stated in the aims of the study. The sample's awareness and perspectives of mental illness were discussed, suggesting that participants could not identify people who suffered from mental illness and were not aware of the psychological concepts of mental illness. The findings also suggested that mental health literacy was more contextual than individual. The results suggested that participants were aware of mental illness but conceptualised mental illness differently from the western perspective. The findings also highlighted that spiritual and cultural influences affect how people conceptualise mental illness.

Beliefs about the cause of mental illness were strongly associated with how participants conceptualised mental illness. Help-seeking behaviour was strongly associated with what participants believed to be the causes of mental illness. The findings also suggested that there was a high-level of stigma, which results in labelling, discrimination and ill-treatment of the mentally ill in the community of Sobantu, and this stigma begins to be taught at an early age.

The results of the study reflected that there is a need to have a contextual understanding of mental illness as the perceived conceptions, aetiological beliefs, help-seeking behaviour and attitudes associated with mental illness varied from current psychological conceptualisations. Thus, there is a need to understand the individual's cultural context in order to understand their beliefs about mental illness, as this probably influences attitudes and the perception of appropriate places to seek help. The findings of the study appeared to support international studies on attitudes and recognition of mental illness, with differences pertaining to culture and beliefs about mental illness.

CHAPTER SIX

Conclusion

6.1 Conclusion

This study aimed to answer the following questions; firstly, what are participants' perceptions of mental illness? Secondly, what do the participants think are the predominant causes of mental illness? Thirdly, what is the interaction between spiritual and cultural beliefs and participants' beliefs about mental illness? The fourth question was, what attitudes do the participants have towards mental illness or towards the mentally ill? The fifth question the study aimed to answer was, what demographic factors are associated with mental health literacy? These questions were answered as follows:

Participants expressed different perceptions of mental illness. Some participants perceived mental illness as being a disturbance in the brain, as people with mental illness act differently from what participants deemed as normal. Other participants perceived mental illness as a scapegoat that people use to be cool or move away from reality. The mentally ill were also conceptualised as slow and crazy. The results of the study highlighted that people were aware of mental illness but could not such illnesses with psychological labels or concepts. Participants conceptualised mental illness differently from a western perceptive.

Participants expressed that there could be multiple causes of mental illness, with a cultural view being the dominant view. Some participants argued that mental illness was caused by unattainable goals or not having the right person to talk too. Drug abuse was another factor that was mentioned as a cause of mental illness. However, the study findings reflected that participants saw the cultural and religious context as vital when studying beliefs about the causes of mental illness, as mental illness was considered a complex cultural phenomenon. Participants highlighted that mental illness was caused by ancestral spirits that possess a person. This believed to be caused by saying 'no' to the ancestors. For instance, a person might have a calling to be a sangoma but refuses. The ancestors might get angry and punish that person by making them mentally ill. Witchcraft was another mentioned cause of mental illness which is is seen as being caused by a jealous person.

The findings also suggested that there is an interaction between spiritual and cultural beliefs and the participants' beliefs about mental illness. Participants' conceptions of mental illness appeared to be related to what participants thought the causes of mental illness were. These

cultural conceptions and beliefs about the assumed causes of mental illness seemed to influence where participants were likely to go for help-seeking. The findings revealed multiple spiritual and cultural help-seeking behaviours. Participants were likely to go to a sangoma or inyanga (traditional healers) for help. The participants spoke about going to church for help which may help cleanse the mental illness with the holy water. They also highlighted that members of the community go to a sangoma to get help to communicate with their ancestors in order to perform a ritual to stop the mental illness. Another help-seeking pattern was going to inyanga for help to heal the created (bewitched) sickness. The findings also suggested that participants were unlikely to seek help from private health professionals as they were seen as expensive. The findings also suggested that participants are also unlikely to seek help from public health professionals as they were seen as less effective as private health professionals.

Participants expressed a high level of stigma associated with mental illness. They associated people who suffered from mental illness with violence. The participants also highlighted that people who suffer from mental illness are ill-treated and discriminated just because they are known to suffer from mental illness. They mentioned that people who suffer from mental illness are labelled as crazy within the community. Such a high level of stigma associated with mental illness is likely to inhibit help-seeking.

The findings suggest that no particular demographics seemed to be associated with these beliefs, and future studies could test these beliefs in other communities. The findings suggest that it is important to have a contextual understanding of mental illness, as the study revealed that the participant's conceptualisation of mental illness was contextual rather than individual. The findings also imply that it is important to increase the public’s mental health literacy, as it may help prevent misconceptions about mental illness that in turn might decrease stigma towards the mentally ill so that help-seeking is facilitated.

6.2 Limitations and recommendations

The first limitation of the study is that there was only one male participant in the study. For future research, the study should include an equal number of males and females to compare their mental health literacy. The second limitation of the study was, as mentioned in the methodology chapter, that the research was conducted in isiZulu or English. Thus, some participants emphasised that they want to be interviewed in English. This was a problem

because some of the participants wanted to share their knowledge but could not do so as they were not very fluent in English, making the interviews a bit challenging. For future research, all individual interviews and focus group discussions, if they are focusing on African participants, should be done using an indigenous/home language, as this could help remove communication barriers. This could help capture more nuanced information and allow participants to convey their knowledge in a language that they speak and understand very well which will assist in building rapport and collecting more accurate data.

Recommendations for further studies could be done on this topic with a larger number of participants, incorporating other Black communities which are similar to the studied community. To allow for generalisation of the research findings. It would also be valuable to get traditional healers' views about mental illness to gain deeper detailed insight from those who speak to the ancestors and to find out how they communicate with them. Therefore, further research could look at conceptualisation of mental illness by traditional healers in Sobantu and elsewhere.

7 References

Agbayani-Siewert, P., Takeuchi, D. T., & Pangan, R. W. (1999). Mental illness in a multicultural context. *In Handbook of the sociology of mental health*. Boston: Springer.

Amuyunzu-Nyamongo, M. (2013). The social and cultural aspects of mental health in African societies. *Commonwealth Health Partnerships*, *1*, 59-63. Retrieved from www.commonwealthhealth.org.

Andrews, G., Slade, T., & Peters, L. (1999). Classification in psychiatry: ICD–10 versus DSM–IV. *The British Journal of Psychiatry*, *174*(1), 3-5. doi: 10.1192/bjp.174.1.3.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163-179. doi: 10.1111/j.1600-0447.2005.00699.x.

Angermeyer, M. C., & Matschinger, H. (2003). The stigma of mental illness: Effects of labelling on public attitudes towards people with mental disorder. *Acta Psychiatrica Scandinavica*, *108*(4), 304-309. Retrieved from http://www.brown.uk.com.

Angermeyer, M. C., & Matschinger, H. (2005). Causal beliefs and attitudes to people with schizophrenia: Trend analysis based on data from two population surveys in Germany. *British Journal of Psychiatry*, *186*(4), 331-334. Retrieved from http://www.brown.uk.com.

Apte, C., Damerau, F., & Weiss, S. (1998). *Text mining with decision rules and decision trees*. IBM Thomas J. Watson Research Division.

Babbie E., & Mouton J. (2005). Qualitative studies. In E. Babbie & J. Mouton (Eds.), *The practice of social research* (pp. 269-311). Cape Town: Oxford University Press.

Barlow, D. H., & Durand, V. M. (2005). *Abnormal psychology: An integrative approach* (4th ed.). Pacific Grove, CA: Brooks/Cole.

Bell, E., & Bryman, A. (2007). The ethics of management research: an exploratory content analysis. *British journal of management*, *18*(1), 63-77. doi: 10.1111/j.1467-8551.2006.00487.x.

BHC Mental health & Health addiction service. (2010). *Youth and Young Adult Mental Health Literacy: Best practices and recommendations for promoting mental health literacy among*

BC's youth and young adults. An Agency of Provincial Health Services Authority. Retrieved from https://phabc.org/wp-content/uploads/2015/07/.

Bhui, K., & Bhugra, D. (2002). Explanatory models for mental distress: Implications for clinical practice and research. *British Journal of Psychiatry*, *181*, 6–7. Retrieved from https://www.cambridge.org.

Booi, B. N. (2004). *Three perspectives on ukuthwasa: The view from traditional beliefs, Western psychiatry and transpersonal psychology* (Doctoral dissertation, Rhodes University).

Bourget, B., & Chenier, R. (2007). Mental health literacy in Canada: Phase one report. *Mental health literacy project. Ottawa: Canadian Alliance on Mental Illness and Mental Health*. Retrieved from https://camimh.ca/wp-content/uploads/.

Bowers, L., Van Der Merwe, M., Paterson, B., & Stewart, D. (2012). Manual restraint and shows of force: The City-128 study. *International Journal of Mental Health Nursing, 21*(1), 30-40. Retrieved from https://doi.org/10.1111/j.1447-0349.2011.00756.x.

Brannon, L., Feist, J., & Updegraff, J. A. (2013). *Health psychology: An introduction to behaviour and health*. Belmont: Thomson-Worth.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. doi: 77-101. ISSN 1478-0887.

Butcher, J. (2007). Controversial mental health bill reaches the finishing line. *The Lancet*, *370*(9582), 117-118. doi: https://doi.org/10.1016/S0140-6736(07)61067-8.

Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., Flisher, A. J., & MHaPP Research Programme Consortium. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Transcultural Psychiatry, 47*(4), 610-628. doi: 10.1177/1363461510383459.

Champion, V. L., & Skinner, C. S. (2008). The health belief model. *Health behaviour and health education: Theory, research, and practice*, *4*, 45-65. Retrieved from http://iums.ac.ir/files/hshe.

Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *The Lancet. 6*(19) 1-9. Retrieved from https://reader.elsevier.com/.

Chen, H. Y., & Boore, J. R. (2010). Translation and back-translation in qualitative nursing research: methodological review. *Journal of Clinical Nursing*, *19*(1-2), 234-239. doi: 10.1111/j.1365-2702.2009.02896.x.

Cooper, A. E., Corrigan, P. W., & Watson, A. C. (2003). Mental illness stigma and care seeking. The *Journal of Nervous and Mental Disease, 191*(5), 339-341. doi: 10.1097/01.NMD.0000066157.47101.22.

Corrigan, P. W., Green, A., Lundin, R., Kubiak, M. A., & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services*, *52*(7), 953-958. Retrieved from https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.52.7.953.

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, *9*(1), 35-53. doi: doi.org/10.1093/clipsy.9.1.35.

Cumming, A. (2001). ESL/EFL instructors' practices for writing assessment: Specific purposes or general purposes? *Language Testing, 18*(2), 207-224. Retrieved from http://dx.doi.org/10.1177/026553220101800206.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: a report from the field. *Schizophrenia Bulletin, 32*(3), 443-450. doi: https://doi.org/10.1093/schbul/sbj043.

Doyal, L. & Harris R. (1986). *Empiricism, explanation and rationality: an introduction to the philosophy of the social sciences.* London: Routledge and Kegan Paul.

Ebomoyi, W. (2013). Genomic Epidemiology of Cardiovascular Disease, Adoption of the Health Belief Model to Increase Screening for Known Risk Factors and Use of Natural Approaches to Enhance Heart Health. *Journal of Cardiovascular Diseases & Diagnosis, 1*(5), 1-7. Retrieved from https://doi.org/10.4172/2329-9517.1000127.

Evans-Lacko, S., Henderson, C., & Thornicroft, G. (2013). Public knowledge, attitudes and behaviour regarding people with mental illness in England. *British Journal of Psychiatry*, *202*(55), 51-57. doi: 10.1192/bjp.bp.112.112979.

Farreras, I. (2005). The historical context for National Institute of Mental Health support of American Psychological Association training and accreditation efforts. In W. E. Pickren & S. F. Schneider (Eds.), Psychology and the National Institute of Mental Health: A historical analysis of science, practice, and policy (pp. 153–179). Washington, DC: APA Books.

Geertz, C. (2008). Thick description: Toward an interpretive theory of culture. In *The Cultural Geography Reader* (pp. 41-51). New York: Routledge. Retrieved from https://philpapers.org.

Geertz, C. (1973). *The interpretation of cultures*. London: Hutchinson.

Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). (2008). Health behaviour and health education: Theory, research, and practice. Georgia: John Wiley & Sons. Grob, G. N. (2005). Public policy and mental illnesses: Jimmy Carter's presidential commission on mental health. *Milbank Quarterly*, *83*(3), 425-456. doi: 10.1111/j.1468-0009.2005.00408.x.

Goldney, R. D., Fisher, L. J., & Wilson, D. H. (2001). Mental health literacy: an impediment to the optimum treatment of major depression in the community. *Journal of affective disorders, 64*(2), 277-284. doi: https://doi.org/10.1016/S0165-0327(00)00227-5.

Gureje, O., Lasebikan, V. O., Kola, L., & Makanjuola, V. A. (2006). Lifetime and 12-month prevalence of mental disorders in the Nigerian Survey of Mental Health and Well-Being. *British Journal of Psychiatry, 188*(5), 465-471. Retrieved from https://www.ncbi.nlm.nih.gov.

Hadebe, J. M. B. (1986). An African view of psychopathology: A blueprint. *Journal of Psychology: University of Zululand, 2*(2), 1-26.

Hochbaum, G.M. (1958). *Public participation in medical screening programmes: A socio-psychological study*. Washington DC: Government Printing Office.

Hollingshead, A. B., & Redlich, F. C. (2007). Social class and mental illness: A community study. *American Journal of Public Health*, *97*(10), 1756-1757. doi: 10.2105/AJPH.97.10.1756.

Honwana, A. (1998). Sealing the past, facing the future: Trauma healing in rural Mozambique. *Accord: An international review of peace initiatives*. London: Conciliation Resources. Retrieved from https://www.c-r.org/accord.

Hugo, C. J., Boshoff, D. E., Traut, A., Zungu-Dirwayi, N., & Stein, D. J. (2003). Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry and Psychiatric Epidemiology*, *38*(12), 715-719. Retrieved from https://www.ncbi.nlm.nih.gov.

Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education Quarterly,11*(1), 1-47. doi: 10.1177/109019818401100101.

Jorm, A. F., Korten, A, E., Jacomb, P, A., Christensen, H., Rodgers. B., & Pollitt, P. (1997). Public beliefs about causes and risk factors for depression and schizophrenia. *Social Psychiatry and Psychiatric Epidemiology, 33*(3), 143-148. doi: 10.1186/1471-244X-5-33.

Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry, 177*(5), 396-401. Retrieved from https://www.ncbi.nlm.nih.gov.

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist, 67*(3), 231. doi: 10.1037/a0025957.

Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., & Scheffler, R. M. (2011). Human resources for mental health care: *Current situation and strategies for action. Lancet, 378*(9803), 1654-1663. doi: 10.1016/S0140-6736(11)61093-3.

Kasper, G., & Wagner, J. (2014). Conversation analysis in applied linguistics. *Annual Review of Applied Linguistics*, *34*, 171-212. doi: 10.1017/S0267190514000014.

Kate, N., Grover, S., Kulhara, P., & Nehra, R. (2013). Relationship of quality of life with coping and burden in primary caregivers of patients with schizophrenia. *International Journal of Social Psychiatry, 60*(2), 107-116. doi: 10.1177/0020764012467598.

Kealey, D. J., Protheroe, D. R., MacDonald, D., & Vulpe, T. (2003). Instituting a competency-based training design and evaluation system. *Performance Improvement*, *42*(5), 28-33. Retrieved from www.mentalhealthworkforce.org.

Kelly, E., & Lesh, R. (2002). Understanding and explicating the design experiment methodology. *Building Research Capacity*, *3,* 1-3. Retrieved from http://gse.gmu.edu/research.

Khalili-Damghani, K., & Tavana, M. (2013). A new fuzzy network data envelopment analysis model for measuring the performance of agility in supply chains. *International Journal of Advanced*

Manufacturing Technology, *69*(1-4), 291-318. Retrieved from https://doi.org/10.1007/s00170-013-5021-y.

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry* (3rd ed). Berkeley: University of California Press.

Kleintjes, S., Flisher, A. J., Fick, M., Railoun, A., Lund, C., Molteno, C., & Robertson, B. A. (2006). The prevalence of mental disorders among children, adolescents and adults in the Western Cape, South Africa. *South African Psychiatry Review, 9*(3), 157-160. Retrieved from http://dx.doi.org/10.4314/ajpsy.v9i3.30217.

Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A., & Pescosolido, B. A. (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American Journal of Public health, 89*(9), 1328-1333. Retrieved from https://ajph.aphapublications.

Lund, C., Petersen, I., Kleintjes, S., & Bhana, A. (2012). Mental health services in South Africa: Taking stock. *African Journal of Psychiatry, 15*(6), 402-405. Retrieved from http://hdl.handle.net/10520/EJC127141.

Manyike, R.W., & Evans, A.C. (1998). Attitudes of University of Venda students towards mental illness: western or African? In S.N. Madu, S.N., P. K. Baguma, & A. Pritz, *Quest for psychotherapy for modern Africa*. pp. 220-234. Pietersburg: UNIN Press.

Mkhize, N. (2004). Psychology: an African perspective. *Self, community and psychology*, 4-1.

Mohamad, M. S., Zabidah, P., Fauziah, I., & Sarnon, N. (2012). Mental health literacy among family caregivers of schizophrenia patients. *Asian Social Science*, *8*(9), 74-82. doi: http://dx.doi.org/10.5539/ass.v8n9p74.

Naidoo, S., & Mkhize, D. L. (2012). Prevalence of mental disorders in a prison population in Durban, South Africa. *African Journal of Psychiatry, 15*(1), 30-35. doi: http://dx.doi.org/10.4314/ajpsy.v15i1.4.

Ngoma, M. C., Prince, M., & Mann, A. (2003). Common mental disorders among those attending primary health clinics and traditional healers in urban Tanzania. *British Journal of Psychiatry, 183*(4), 349-355. Retrieved from https://www.ncbi.nlm.nih.gov.

Ngubane, H. (1977). *Body and mind in Zulu medicine. An ethnography of health and disease in Nyuswa-Zulu thought and practice.* New York: Academic Press Inc.

Niehaus, D. J. H., Oosthuizen, P., Lochner, C., Emsley, R. A., Jordaan, E., Mbanga, N. I., & Stein, D. J. (2004). A culture-bound syndrome 'amafufunyana'and a culture-specific event 'ukuthwasa': differentiated by a family history of schizophrenia and other psychiatric disorders. *Psychopathology*, *37*(2), 59-63. doi: 10.1159/000077579.

Nieuwsma, J. A., Pepper, C. M., Maack, D. J., & Birgenheir, D. G. (2011). Indigenous perspectives on depression in rural regions of India and the United States. *Transcultural Psychiatry*, *48*(5), 539-568. Retrieved from http://journals.sagepub.com.

Njenga, F. (2007). The concept of mental disorder: an African perspective. *World Psychiatry*, *6*(3), 166-167. Retrieved from https://www.ncbi.nlm.nih.gov.

Norman, P., & Conner, M. (2005). The theory of planned behaviour and exercise: Evidence for the mediating and moderating roles of planning on intention-behaviour relationships. *Journal of Sport and Exercise Psychology*, *27*(4), 488-504. Retrieved from https://doi.org/10.1123/jsep.27.4.488.

Nwoye, A. (2015). What is African psychology the psychology of? *Theory and Psychology*, *25*(1), 96-116. doi: 10.1177/0959354314565116.

Park, S. J., Jeon, H. J., Kim, J. Y., Kim, S., & Roh, S. (2014). Sociodemographic factors associated with the use of mental health services in depressed adults: results from the Korea National Health and Nutrition Examination Survey (KNHANES). *BMC Health Services Research*, *14*(1), 645-667. doi:10.1186/s12913-014-0645-7.

Parslow, R. A., & Jorm, A. F. (2000). Who uses mental health services in Australia? An analysis of data from the National Survey of Mental Health and Wellbeing. *Australian and New Zealand Journal of Psychiatry*, *34*(6), 997-1008.

Petticrew, M., & Roberts, H. (2006). Why do we need systematic reviews? *Systematic reviews in the social sciences: A practical guide*, 1-26. doi:10.1002/9780470754887.

Pescosolido, B. A., Gardner, C. B., & Lubell, K. M. (1998). How people get into mental health services: Stories of choice, coercion and "muddling through" from "first-timers". *Social*

Science & Medicine, 46(2), 275-286. Retrieved from http://dx.doi.org/10.1016/S0277-9536(97)00160.

Polit, D., & Hungler, B. (1997). *The essentials of nursing research*. 4th ed. Philadelphia: Lippincott-Raven.

Posel, D., & Zeller, J. (2016). Language shift or increased bilingualism in South Africa: Evidence from census data. *Journal of Multilingual and Multicultural Development, 37*(4), 357-370. doi: 10.1080/01434632.2015.1072206.

Reavley, N. J., & Jorm, A. F. (2011). Recognition of mental disorders and beliefs about treatment and outcome: findings from an Australian national survey of mental health literacy and stigma. *Australian & New Zealand Journal of Psychiatry*, *45*(11), 1086-1093. doi: 10.3109/00048674.2011.621060.

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems? *Medical Journal of Australia*, *187*(7), 35-39. Retrieved from https://works.bepress.com.

Rickwood, D. J., & Braithwaite, V. A. (1994). Social-psychological factors affecting help-seeking for emotional problems. *Social Science & Medicine*, *39*(4), 563-572. Retrieved from https://www.ncbi.nlm.nih.gov.

Rochat, T. J., Tomlinson, M., Bärnighausen, T., Newell, M. L., & Stein, A. (2011). The prevalence and clinical presentation of antenatal depression in rural South Africa. *Journal of Affective Disorders*, *135*(1), 362-373. doi: 10.1016/j.jad.2011.08.011.

Rosenberg, A. (1988). *Philosophy of social science*. Oxford: Oxford University Press.

Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. *Health Education Quarterly*, *15*(2), 175-183. Retrieved from https://www.ncbi.nlm.nih.gov.

Rüsch, N., Evans-Lacko, S. E., Henderson, C., Flach, C., & Thornicroft, G. (2011). Knowledge and attitudes as predictors of intentions to seek help for and disclose a mental illness. *Psychiatric Services*, *62*(6), 675-678. doi: 10.1176/ps.62.6.pss6206_0675.

Sam, D. L., & Moreira, V. (2012). Revisiting the mutual embeddedness of culture and mental illness. *Online Readings in Psychology and Culture*, *10*(2), 1. Retrieved from https://scholarworks.gvsu.edu.

Sawyer, M. G., Arney, F, M., Baghurst, P. A., Clark, J. J., Graetz, B.W., Kosky, R. J., Nurcombe, B., Patton, G. C., Prior, M. R., Raphael., B, Rey, J. M., Whaites, L. C., & Zubrick, S. R. (2001). The mental health of young people in Australia: Key findings from the child and adolescent component of the national survey of mental health and well-being. *Australian & New Zealand Journal of Psychiatry*, *35*(6), 806-814. doi: 10.1046/j.1440-1614.2001.00964.x.

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The lancet*, *370*(9590), 878-889. doi: 10.1016/S0140-6736(07)61239-2.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63-75. Retrieved from https://eric.ed.gov

Sorsdahl, K. R., Stein, D. J., & Lund, C. (2012). Mental health services in South Africa: Scaling up and future directions. *African Journal of Psychiatry, 15* (3), 168-171. doi: http://dx.doi.org/10.4314/ajpsy.v15i3.21.

Statistics, A. B. O. (2007). National survey of mental health and wellbeing: summary of results. *Canberra, Australian Bureau of Statistics*. Retrieved from www.abs.gov.au/.

Stretcher, Victor, J., Irwin M., & Rosenstock (1997). *The health belief model*. Cambridge, UK: Cambridge University Press.

Shweder, R. (1991). Cultural Psychology: What is it? In R. Shweder. *Thinking through culture: expeditions in cultural psychology*. (pp. 73-110). Cambridge, Mass: Harvard University Press.

Silverman, D. (2001). *Interpreting qualitative data: Methods for interpreting talk, text and interaction*. London: Sage.

Sorsdahl, K. R., Stein, D. J., & Lund, C. (2012). Mental health services in South Africa: Scaling up and future directions. *African Journal of Psychiatry, 15*(3), 168-71. doi: http://dx.doi.org/10.4314/ajpsy.

Sokal, R. R., & Rohlf, F. J. (1969*). The principles and practice of statistics in biological research* (pp. 399-400). San Francisco: W.H Freeman.

Swartz, L., de la Rey, C., Duncan, N., Townsend, L. & O'Neill, V. (2008). *Psychology: An introduction*. Cape Town: Oxford University Press.

Terre Blanche, M., Kelly, K. & Durrheim, K. (Eds.). (2006). *Research in practice: Applied methods for the social sciences*. Cape Town: UCT Press.

Tromp, B., Dolley, C., Laganparsad, M., & Goveneder, S. (2014). One in three South Africans suffer from mental illness-most won't get any help. *Times Live*. Retrieved from https://africacheck.org/.

Trump, L., & Hugo, C. (2006). The barriers preventing effective treatment of South African patients with mental health problems. *African Journal of Psychiatry*, *9*(4), 249-260. Retrieved from https://www.ajol.info/index.php/ajpsy/article/view/30224.

Wassenaar, D. R. (2006). Ethical issues in social science research. In M. Terre Blanche, K. Durrheim, & M. Painter (Eds.), *Research in practice* (2nd ed.). (pp. 60-79). Cape Town: Juta's.

Wassenaar, D. R., & Mamotte, N. (2012). Ethical Issues and ethics review in social science research. In M. M. Leach, M. J. Stevens, G. Lindsay, A. Ferrero & Y. Korkut (Eds.), *The Oxford handbook of international psychological ethics* (pp. 268-282). New York: Oxford University Press. DOI: 10.1093/oxfordhb/9780199739165.013.0019

Welman, C., Kruger, F., & Mitchell, B. (2005). *Research methodol*ogy. Cape Town: Oxford University Press.

Williams, B., & Healy, D. (2001). Perceptions of illness causation among new referrals to a community mental health team: "explanatory model" or "exploratory map". *Social Science & Medicine, 53*(4), 465-476. Retrieved from https://doi.org/10.1016/S0277-9536(00)00349-X.

Wynaden, D., Chapman, R., Orb, A., McGowan, S., Zeeman, Z., & Yeak, S. (2005). Factors that influence Asian communities' access to mental health care. I*nternational Journal of Mental Health Nursing, 14*(2), 88-95. Retrieved from https://doi.org/10.1111/j.1440-0979.2005.00364.x.

Appendices:

Appendix 1- Letter to the Community Councillor

Cllr Dlamini

My name is Amanda Mwelase I am a student from the University of KwaZulu-Natal (UKZN), Pietermaritzburg campus. I am currently a master's student in Research Psychology and I am registered in the Discipline of Psychology at UKZN. You can contact me via email: mwelaseamanda@gmail.com.

I write this letter to request permission to put posters and conduct a study in the community of Sobantu. The study will be about 'Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg'. The aim of this research is to explore how people conceptualisation mental illness. The study is expected to enrol nine participants in total, therefore five participants in the focus group and four for the individual interview.

Your support would be much appreciated.

If you have any problems or concerns/questions you may contact the researcher at mwelaseamanda@gmail.com or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Yours sincerely,

Ms SA Mwelase

APPENDIX 2: Individual interview Information Sheet and Consent

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

Information Sheet and Consent to Participate in Research

Date: 17 March 2018

Good day Sir/Madam

My name is Amanda Mwelase. I am a student from the University of KwaZulu-Natal (UKZN), Pietermaritzburg campus. I am currently a master's student in Research Psychology and I am registered in the Discipline of Psychology at UKZN. You can contact me via email: mwelaseamanda@gmail.com

You are being invited to consider participating in a study that involves research on 'Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg'. The aims and purpose of this research are to explore how people conceptualise mental illness. You are being invited to participate in an individual interview.

The study will involve the following procedures

- An introduction informing you about myself as the researcher and my contact details.
- Informing you about the study and informed consent from you as a participant.
- Facilitation of the interview will involve an interview between the researcher and the participant.

- The duration of your participation, if you choose to enrol, and remain in the study is expected to be 30 minutes.

There are no foreseeable risks to your participation in the interview. However, if there is any need arising after the study, arrangements have been made with the Child and Family Centre for any psychological support.

Your participation and the content of what you discuss will be kept confidential. In addition, your identity will not be requested nor revealed when the findings from the study are reported. For example, pseudonyms will be used in the reporting of the research, and any potentially identifying information about you will be anonymized.

The study will not provide direct benefits to you, but I hope that the study will enable the following benefits:

- To explore participants' perception of mental illness.
- To investigate participants' knowledge of the causes of mental illness.
- To investigate participants' beliefs about the religious and cultural influence on mental illness.
- To explore attitudes associated with mental illness.
- To explore demographic factors associated with mental health literacy.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number: HSS/1227/018M).

In the event of any problems or concerns/questions you may contact the researcher at mwelaseamanda@gmail.com and my supervisor Professor Douglas Wassenaar on wassenaar@ukzn.ac.za or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

CONSENT

I ………………………………. have been informed about the study on 'Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg' by Amanda Mwelase.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at mwelaseamanda@gmail.com

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

APPENDIX 3: Focus group Information Sheet and Consent

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

Information Sheet and Consent to Participate in Research

Date: 17 March 2018

Good day Sir/Madam

My name is Amanda Mwelase. I am a student from the University of KwaZulu-Natal (UKZN), Pietermaritzburg campus. I am currently a master's student in Research Psychology and I am registered in the Discipline of Psychology at UKZN. You can contact me via email: mwelaseamanda@gmail.com

You are being invited to consider participating in a study that involves a focus group discussion of 'Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg'. The aims and purpose of this research are to explore how people conceptualise mental illness. The study is expected to enrol five participants in a focus group. A focus group is a group of people gather to participate in a discussion about a topic of interest (in this case mental illness).

The study will involve the following procedures

- An introduction informing participants about myself as the researcher and my contact details.
- Informing the participants about the study and informed consent from the participants.
- Facilitation of a focus group which involves an interaction between the researcher and another participant

- The duration of the schedule which is expected to be 60 minutes if participants choose to enrol and remain in the study.

There are no foreseeable risks to your participation in the interview. However, if there is any need arising after the study, arrangements have been made with the Child and Family Centre for any psychological support.

Your participation and the content of what you discuss will be kept confidential by the researcher.

The researcher will also ask all members participating in the focus group to ensure that what is discussed is to remain in the discussion room and not to be shared with anyone. However, you are advised not to share personal sensitive information in the focus group as we cannot guarantee that other members will respect confidentiality. In addition, your identity will not be requested nor revealed when the findings from the study are reported. For example, pseudonyms will be used in the reporting of the research, and any potentially identifying information about you will be anonymized.

The study will not provide direct benefits to the participants, but I hope that the study will enable the following benefits:

- To explore participants' perception of mental illness.
- To investigate participants' knowledge of the causes of mental illness.
- To investigate participants' beliefs about the religious and cultural influence on mental illness.
- To explore attitudes associated with mental illness.
- To explore demographic factors associated with mental health literacy.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number: HSS/1227/018M).

In the event of any problems or concerns/questions you may contact the researcher at mwelaseamanda@gmail.com and my supervisor Professor Douglas Wassenaar on Wassenaar@ukzn.ac.za or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609Email: HSSREC@ukzn.ac.za

CONSENT

I ………………………………. have been informed about the study on 'Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg' by Amanda Mwelase.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at mwelaseamanda@gmail.com

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

I hereby provide consent to:

All information shared during this focus group discussion will remain in the discussion room and will not be shared anywhere or to anyone else.

______________________ ______________________

Signature of Participant **Date**

______________________ ______________________

Signature of Witness **Date**
(Where applicable)

Appendix 4 – Consent to be recorded

I hereby provide consent to:

Audio-record my interview / focus group discussion YES / NO

Signature:

Appendix 5 - Demographic Questionnaire

Name:

Age:

Race:

Sex/Gender:

Appendix 6 - Advertisement

LET'S TALK ABOUT MENTAL HEALTH LITERACY

Are you African and living in Pietermaritzburg in an African based community?

Would you be interested in participating in a focus group about mental disorders?

I am looking for African individuals living in an African community to be part of a research study that wishes to explore people's knowledge about mental disorders. I will conduct a focus group in which we will talk about mental illness.

If you are interested in participating in this study or need more information, **please contact me** by email, SMS or please call me.

Email: mhl21@gmail.com or Call: 074 326 6825

mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825

Appendix 7- Individual Interview Schedule

1. Are you aware of mental illness?
2. How do you describe mental illness?
3. Have you ever seen someone who suffers from mental illness? If yes, how do you know that he/she has a mental illness?
    a) Which type of mental illness does he/she suffer from? (Why)
    b) What do you think caused him or her to be mentally ill?
4. What do you think is the cause of mental illness?
5. What do you think are your chances of getting mentally ill?
6. If you were to be mentally ill, what would it mean to you? (Where would you seek help?)
7. Do you think there is anything that could be done to prevent you from being mentally ill? How effective would that be?
8. What difficulties do you see in seeking help from health professionals?
9. Are there any risks of being around the mentally ill? (If yes what are risks and what you think about them?)

Appendix 8- Focus Group Interview Schedule

1. What is mental illness?

a) Are most people in the community aware of mental illness?

b) What is the community conceptualisation of mental illness?

c) What do people in the community think are the causes of mental illness?

2. Are there mental ill individuals in the community?

a) Where do they seek help? Why?
b) Did they receive the help they required?
c) Is there any another to seek help for the mentally ill?

3. Where do people in the community get their knowledge about mental illness?

a) Is it important to know about mental illness?

4. Are there risks in seeking help?

a) How do people get to know about the risks involved in help-seeking?
b) Are there benefits in seeking professional help?

5. Is it dangerous to be mentally ill? (If yes danger for who people or the mentally ill)

6. Is there any benefit of being mentally ill?

Appendix 9: LETTER TO THE CHILD AND FAMILY CENTRE

455 Khwezi Street

Sobantu Village

3201

211509297@stu.ukzn.ac.za

03 September 2018

Child and Family centre

University of KwaZulu-Natal

Pietermaritzburg campus

Dear Dr Phindile, Mayaba

I am a master's student in the Discipline of Psychology, School of Applied Human Sciences at Pietermaritzburg Campus. As part of my studies, I am required to complete a dissertation. My chosen dissertation topic is on Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg. I plan to conduct research with participants from Sobantu. The study will be conducted in Sobantu village Pietermaritzburg. The research involves conducting four semi-structured interviews and one focus group which consist of five participants.

I would like to ask if I may refer certain participant for counselling if it happens that they experience emotional distress during their engagement in my study. My research will commence after I receive ethical clearance, possibly in October 2018 or later.

Your assistance would be much appreciated.

Yours faithfully,

Amanda Mwelase (211509297)

Email: mwelaseamanda@gmail.com

Contact No. : 067 031 0683

Prof D Wassenaar (Supervisor)

Email: Wassenaar@ukzn.ac.za

Appendix 10: LETTER FROM THE CHILD AND FAMILY CENTER

03 September 2018

To whom it may concern

This letter serves to provide the assurance that should any research participant interviewed by Ms Amanda Mwelase (Psychology masters student) require psychological assistance as a result of any distress arising from the research project titled: ***"Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg"***, the service will be provided by Psychology Masters students and/or Intern Psychologists at the Child and Family Centre, University of KwaZulu-Natal, Pietermaritzburg Campus.

I acknowledge that Ms Mwelase's project is under Prof Douglas Wassenaar's supervision.

Yours sincerely,

Dr Phindile L. Mayaba

Director: Child and Family Centre

CHILD AND FAMILY CENTRE

School of Applied Human Sciences

Discipline of Psychology

Postal Address: Private Bag X01, Scottsville, Pietermaritzburg 3209, South Africa

Telephone: +27 (0)33 260 5166/6368 **Email:** mayabap@ukzn.ac.za **Website:** psychology.ukzn.ac.za

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix 11: PROPOSAL APPROVAL LETTER FROM THE HSS RESEARCH ETHICS COMMITTEE

TM

22 October 2018

Ms Smangele A Mwelase 211509297
School of Applied Human Sciences — Psychology
Pietermaritzburg Campus

Dear Ms Mwelase

Reference number: HSS/1227/018M
Project title: Mental health literacy: Conceptualisation of Mental Illness among African residents in Pietermaritzburg.

Full Approval - Full Committee Reviewed Application

With regards to your response received 18 October 2018 to our letter of 04 September 2018, the Humanities and Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted FULL APPROVAL.

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

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

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

Yours faithfully

....

Dr S Naidoo (Deputy Chair)

/px

cc Supervisor: Prof DR Wassenaar cc Academic Leader Research: Dr M Mthembu
cc School Administrator: Mrs P Konan

Humanities & Social Sciences Research Ethics Committee
Professor Shenuka Singh (Chair)/Dr Shamila Naidoo (Deputy Chair)

Appendix 12: LETTER FROM THE COMMUNITY COUNCILLOR

To whom it may concern

This letter serves to provide the assurance that I Sandile Dlamini know about Ms Amanda Mwelase studies and her research project titled: ***"Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg"***, conducted in Sobantu ward 35 and I wish her the best of luck in her findings and future studies.

Yours sincerely,
Cllr S. Dlamini

SOBANTU WARD 35

IsiZulu APPENDICES

APPENDIX 13: Iphepha elinolwazi kanye nemvumo yokuba inxenye yaloncwaningo

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

Usuku: 17 Ndasa 2018

Sawubona

Ingama lami ngu-Amanda Mwelase of funda eNyuvesi yakwa Zulu-Natal (University of KwaZulu Natal)-Pietermaritzburg. umfundi weziqu ze, masters, kwi-Research Psychology. Ngitholakala nge-email: mwelaseamanda@gmail.com

Uyamenywa ukuba ngokuba ube-inxenye yoncwaningo le- Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg'. Njengokudingekayo kuleziqu engizenzayo, ngenza ucwaningo mayelana ne mental health literacy kubahlali bama-Africans, abahlala ePietermaritzburg.

Injongo yalolucwaningo ukuthola ulwazi mayelana nezinkinga ngokwezempilo emiphakathini esiphila kuwo. Ukuba inxenye kwakho kulolucwaningo kuyosiza ukwazi kabanzi mayelana nalolulwazi oludingekayo. Uncwaningo lizindinga abantu ababili kwi-individual interview.

Uncwaningo lizoma kanje:

- ukuzazisa nokunika abantu ulwazi nemi niningwane yemi nje ngomuntu ophethe loluncwaningo.
- Ukwazisa umuntu ozoba ingxenye yoncwaningo ngalo kanye nokuthola ivumo yakhe

- Ukumphata lomhlangano lo ozondinga ukukhulumisana kwami (researcher) kanye nawe (participant)
- Ukuntsela umuntu (participant) ukuthi uhlelo luzo thatha isikhati esingakanani (30mintues) uma equbeka noma evuma ukubha inxenye yohlelo

Abukho ubungozi obuhlangene ngokuba inxenye yaloluncwaningo. Kodwa uma undinga usizo ngenxa yaloluncwaningo kwenziwe amalungiselelo okuthi ungaya eChild and Family Centre ukuze usizekale emoyeni.

Imininingwane yakho nezinto esixoxa ngazo zizoba imfihlo ngasosonke isikhathi.

Okunye ngeke sisho ukuthi uwubani uma sesikhuluma ngama-results alolincwaningo. Umphati wonngcwaningo uzonika wonke umuntu amagama okwenziwa uma esekipha okutholwe uncwaningo.

Ayikho inzunzo ongayithola kodwa ihloso ukuthi kutholwe inzuzo yokulandelayo:

- Ukuthola imibono yabantu mayelana nokuphathwa isifo seqondo
- Ukuthola ulwazi lokuthi abantu bancabanga ukuthi kubanga yini ukuba nesifo seqondo
- Ukuthola ulwazi kubantu ngezikholelo zabho (religious/cultural) ngalesisifo senqondo
- Ukuthola imibono yokuziphatha noma ukweza (attitudes) kwabantu mayelana nokuhamba kweqondo
- Ukubona ngehlalo yabantu (demographic factors) ehlangene nesifo seqondo.

Uphenyo lalolu ncwanigo selibekwe ethically laphendwe lavuwa iUKZN Humanities and Social Sciences Research Ethics Committee (inombolo yemvumelo: HSS/1227/018M).

Uma uneminye imibuzo ofuna ukusibuza yona, wamukelekile ukungithinta kulemininingwane engezansi

Imuntu owenza uncwaningo mwelaseamanda@gmail.com noma i-supervisor yakhe (ongiphethe) u-professor Douglas Wassenaar la wassenaar@ukzn.ac.za noma iUKZN Humanities & Social Sciences Research Ethics Committee: **HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**

Research Office, Westville Campus
Govan Mbeki Building
PrivateBagX54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557- Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

Imvumo

Mina …………………….. ngiyavuma ukubamba iqhaza kulolucwaningo lwe mental health literacy.

Ngiyaqonda ukuthi angiphoqiwe ukuba inxenye lwalocwaningo ‘

Nginikiwe ithumba lokubuza imbuzo ngo phendulwa ngezinga ekade ngidinga

Ngiyaqonda lolucwaningo angeke lungizuzise masinyane noma sekuhambe isikhathi

Ngiyaqonda kuyoba imfihlo ukubamba kwami iqhaza

Uma kunezi kinga nembuzo email- mwelaseamanda@gmail.com noma abakwa-ethical researchers:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
PrivateBagX54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604557 - Fax: 27 31 2604609
Email: HSSREC@ukzn.ac.za

APPENDIX 14: Iphepha elinolwazi kanye nemvumo yokuba inxenye ye-focus group yaloncwaningo

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

Iphepha elinolwazi kanye nemvumo yokuba inxenye ye-focus group yaloncwaningo

Date: 17 Ndasa 2018

Sawubona

Ingama lami ngu-Amanda Mwelase of funda eNyuvesi yakwa Zulu-Natal (University of KwaZulu Natal)-Pietermaritzburg. umfundi weziqu ze masters kwi-Research Psychology. Ngitholakala nge-email: mwelaseamanda@gmail.com

Uyamenywa ukuba ngokuba ube-inxenye yoncwaningo le- Mental Health Literacy: Conceptualisation of Mental Illness among African Residents in Pietermaritzburg'. Njengokudingekayo kuleziqu engizenzayo, ngenza ucwaningo mayelana ne mental health literacy kubahlali bama-Africans, abahlala ePietermaritzburg.

Injongo yalolucwaningo ukuthola ulwazi mayelana nezinkinga ngokwezempilo emiphakathini esiphila kuwo. Ukuba inxenye kwakho kulolucwaningo kuyosiza ukwazi kabanzi mayelana nalolulwazi oludingekayo. Kulolucwaningo lizindinga abantu abayisi-nhlanu kwi-focus group. I-focus group ila abantu behlangene ndawonye ukuze bexoxe ngolwazi labho ngesihlokho (lapha isinhloko se-mental illness).

Uncwaningo lizoma kanje:

- ukuzazisa nokunika abantu ulwazi nemi niningwane yemi nje ngomuntu ophethe loluncwaningo.
- Ukwazisa abantu abazoba ingxenye yoncwaningo ngalo kanye nokuthola invumo yabho
- Ukumphata lomhlangano lo ozondinga ukukhulumisana kwabantu kanye nomphati wohlelo
- Ukubantsela ukuthi uhlelo luzo thatha isikhati esingakanani (60mintues) uma bequbeka noma bevuma ukubha inxenye yohlelo

Abukho ubungozi obuhlangene ngokuba inxenye yaloluncwaningo. Kodwa uma undinga usizo ngenxa yaloluncwaningo kwenziwe amalungiselelo okuthi ungaya eChild and Family Centre ukuze usizekale emoyeni.

Imininingwane yakho nezinto esixoxa ngazo zizoba imfihlo ngasosonke isikhathi. Umhloli walolucwanigo uzocela wonke amalunga efocus group alolucwaningo ukuba angaxoxingezinto esikhulume ngazo kwifocus group, yonke into exoxiwe ayincinde kwingubi ekuxoxwe kulona.

Okunye ngeke sisho ukuthi uwubani uma sesikhuluma ngama-results alolincwaningo. Umhloli uzonika wonke umuntu amagama okwenziwa uma esekipha okutholwe uncwaningo.

Ayikho inzunzo ongayithola kodwa ihloso ukuthi kutholwe inzuzo yokulandelayo:

- Ukuthola imibono yabantu mayelana nokuphathwa isifo seqondo
- Ukuthola ulwazi lokuthi abantu bancabanga ukuthi kubanga yini ukuba nesifo seqondo

- Ukuthola ulwazi kubantu ngezikholelo zabho (religious/cultural) ngalesisifo senqondo
- Ukuthola imibono yokuziphatha noma ukweza (attitudes) kwabantu mayelana nokuhamba kweqondo
- Ukubona ngehlalo yabantu (demographic factors) ehlangene nesifo seqondo.

Uphenyo lalolu ncwanigo selibekwe ethically laphendwe lavuwa iUKZN Humanities and Social Sciences Research Ethics Committee (inobholo yamvumelo: HSS/1227/018M).

Uma uneminye imibuzo ofuna ukusibuza yona, wamukelekile ukungithinta kulemininingwane engezansi

Imuntu owenza uncwaningo mwelaseamanda@gmail.com noma i-supervisor yakhe u-professor Douglas Wassenaar la wassenaar@ukzn.ac.za noma iUKZN Humanities & Social Sciences Research Ethics Committee:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Imvumo

Mina …………………….. ngiyavuma ukubamba iqhaza kulolucwaningo lwe mental health literacy.

Ngiyaqonda ukuthi angiphoqiwe ukuba inxenye lwalocwaningo

Nginikiwe ithumba lokubuza imbuzo ngo phendulwa ngezinga ekade ngidinga

Ngiyaqonda lolucwaningo angeke lungizuzise masinyane noma sekuhambe isikhathi

Ngiyaqonda kuyoba imfihlo ukubamba kwami iqhaza

Uma kunezi kinga nembuzo email- mwelaseamanda@gmail.com noma abakwa-ethiclmresearchers:

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Ngiyavuma:

Ngiyathembisa ukuthi izinto ezikulumwe kulengxoxo zincinwa ukunxoxwa kwilelingubi le-focus group angeke zinxoxwe nabanye abantu.

______________________ ______________________

Signature of Participant **Usuku**

Appendix 15 – Imvumo yokuqoshwa

Ngiyavuma:

Ukuba ngiqoshwe (ngirecodwe): Yebo/ Cha

_____________________ ________

Sayinda (Signature)

Appendix 16 - Demographic Questionnaire

Ingama:

Imyaka:

Ubhlanga:

Ubulili:

Appendix 17- isikhangiso

ASIKHULUME NGOKUKHATHAZEKA KWENGQONDO

Ungumuntu wase-Afrika futhi uhlala eMgungundlovu emphakathini wabantu abamunyama?

Ungaba nesithakazelo ekuhlanganyeleni kwi-focus group lapho sikhuluma mayelana nokukhathazeka kwengqondo?

Ngifuna abantu base-Afrika abahlala emphakathini wabantu abamunyama ukuba babe ingxenye yocwaningo lokucwaninga ukuhlola ulwazi lwabantu mayelana nokuphazamiseka kwengqondo.

Ngizokwenza i-focus group lapho kuzodingeka sixoxe ngokuphazamiseka kwengqondo

Uma unesithakazelo sokuhlanganyela kulolu cwaningo noma udinga olunye ulwazi, ngicela uxhumane nami nge-imeyili, ama-sms noma uthumele u-please call me.

imeyili: mhl21@gmail.com or inombolo yocingo : 074 326 6825

mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825	mhl21@gmail.com 074 326 6825

Appendix 18- iSchedule ye-individual interview

1. Uyazi ngokuphazamiseka kwengqondo?
2. Kuyini ukuphazamiseka kwengqondo? (kubangwa yini?)
3. Wake wabona umuntu ophethwe ukuphazamiseka kwengqondo
    a) Uma uthi yebo, wazi kanjani ukuthi uphazamisekele engqondweni?
    b) Wayephazamisekhe ngayipi indlela? (Indaba usho njalo?)
4. Yini ebanga ukuphazamiseka kweqondo kumuntu?
5. Wena mawucabanga lingakanani ithuba lokuthi ubenokuphazamiseka eqondweni?
6. Ngabe bukhona yini ubungozi ngalesisifo?
7. Kubalulekile yini ukwazi ngokuphazamiseka kwengqondo?
8. Ibuphi ubunzima ongaba nabho uma uyo ukuyo thola usizo kodokotela beqondo?
9. Ingabe zikhona izingozi zokuba ndawonye nabantu abaphazamiseke ngokweqondo? (ucabanga kanjani ngabo?)

Appendix 19- iSchedule ye-focus group

1. Kuyini ukuphathwa isifo seqondo?

a) Bayazi abantu bomphakathi ngesifo seqondo?

b) Bathi abantu bomphakhati kuyini ukuba nalesisifo?

c) Mani cabanga nje yini esibangayo lesisifo?

2. Bakhona abantu abanalesisifo emphakathini?

a) Balitholaphi usizo? Indaba baye lapho?

b) Bayaluthola usizo?

c) Zikhona ezinye indawo zokufuna lolusizo?

3. Engabe balutholaphi ulwazi abantu bomphakathi ngalesisifo?

a) Kubalulekile yini ukuthi nazi ngesifo seqondo?

4. Engabe bukhona yini ubungozi ngokufuna usizo ngalesisifo?

a) Nazi kanjani ngalokhu?

b) Kukhona yini amabenefits okuya kodokotela beqondo?

5. Engabe buyingozi yini uma umuntu ehambelwe iqondo? (uma yebo, kuyingozi kobani?)

6. Akhona yini amabenefits okuba nalesisifo?