Mental health literacy: Conceptions and attitudes towards depression and schizophrenia among African residents of the eThekwini District Municipality.

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Declaration

I, Nolwazi Nzama, declare that this dissertation is my own unaided work. All citations, references and borrowed ideas have been duly acknowledged. It is being submitted for the degree of Masters in Clinical Psychology in the College of Humanities, School of Applied Human Sciences, University of KwaZulu-Natal, Pietermaritzburg, South Africa. None of the present work has been submitted previously for any degree or examination in any other University.

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Mrs Xoli Mfene **Date**

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Dedication

To my siblings, who have been a source of courage and inspiration.

Abstract

While South Africa has made observable efforts to incorporate mental health interventions and infrastructure in urban areas, the observed improvements in well-resourced regions have not translated into townships and many under-resourced areas. Lack of interventions and mental health infrastructure are among the biggest challenges faced by individuals living in townships and under-resourced regions. This study aimed to identify perceptions of mental illness, in KwaMashu and Umlazi, in the eThekwini Municipal District of KwaZulu-Natal, South Africa. An adapted health literacy questionnaire by Jorm (1997) was used to collect data from 266 participants from KwaMashu and Umlazi townships. Qualitative data was analyzed through thematic analysis, while quantitative data was analyzed through chi-square and ordinal logistic regression. This study found that most eThekwini township dwellers perceived mental illness as a result of disharmony between the physical and spiritual realms. This may be ameliorated through seeking assistance from individuals equipped to practice as intermediaries between the physical and spiritual, such as diviners, herbal healers and faith-based healers. Out of the participants from Umlazi (58.4%) and KwaMashu (41.6%) who were able to identify some form of mental illness, such as stress and depression, none of the participants could identify the symptoms as relating to schizophrenia. Furthermore, participants living in Umlazi (60.7%) and KwaMashu (39.3%) perceived individuals living with mental illness as dangerous. In conclusion, this study calls for improvements of mental health interventions, particularly those directed to township dwellers. Furthermore, there needs to be more emphasis on disseminating knowledge of the available resources to identify and treat mental illness.

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List of Acronyms

DALY:	Disability Adjusted Life Years
LMIC:	Low- and Middle-Income Countries
STATSA:	Statistics South Africa
WHO:	World Health Organization
YLD:	Years Lived with a Disability
IDP:	Integrated Development Plan

Chapter One: Introduction

1.1. Introduction

Health literacy is the individual's ability to access, understand, and utilize information in a manner that promotes and maintains good health (Nutbeam et al., 1993). However, while the importance of health literacy is widely accepted, little is known about "mental health literacy" (Jorm, 2000). This means that most people with disabling "mental illness symptoms" often go unnoticed and undiagnosed, partly due to a lack of knowledge about mental disorders and information on mental health.

In a study conducted in Australia by Jorm et al. (1997), where structured interviews were used to assess vignettes portraying mental disorders, the results showed that most public members could not recognize mental disorders and had little understanding of psychiatric terms. While most participants could identify that the vignette portrayed an individual with some form of mental illness, many could not identify the correct name of the mental disorder (Jorm et al., 1997). This finding showed that mental health literacy was an uncommon phenomenon.

Improved mental health literacy allows the individual to possess knowledge of symptomatology and correct psychiatric labels, which are crucial when communicating with a health care practitioner (Jorm et al., 1997). Furthermore, since it is known that individuals with mental disorders are often misidentified and misdiagnosed by health care practitioners, the patient's ability to correctly communicate experienced symptoms and also use correct psychiatric terms will aid in the detection of mental disorders and referral to a "mental health practitioner" (Nutbeam et al., 1993).

In addition to the ubiquitous inability to identify mental disorders and lack of knowledge on the available mental health professionals, studies conducted in developed countries have shown that the general public also lacks knowledge on the origin of mental disorders (Jorm et al.,

1997). Thus, depression and schizophrenia are often seen by the general public to be caused by recent stressors from the social environment. While social epidemiologists and psychiatrists would agree on the role played by stressful events in depression and schizophrenia, life events are more of a trigger than a cause (Jorm, 2012). Furthermore, psychology's discourse would argue that all beings are born with a biological predisposition to a mental disorder, and the trigger only brings to the surface the underlying conditions (Forssell et al., 2016).

In some non-western cultures, the origin of mental illness is perceived to be caused by supernatural forces such as witchcraft and evil spirits (Forssell et al., 2016). The differences in beliefs about mental illness also lead to differences in help-seeking behavior (Jorm et al., 1997; Kometsi, 2016). In some non-western countries, mental illness is perceived as emanating from malevolent forces, often leading to greater use of traditional healers and noncompliance with medication (Forssell et al., 2016).

A study conducted in the United States results showed that two therapy modalities were perceived best for treatment (Forssell et al., 2016). Participant's “perceptions” of relationships as a buffer from depression were associated with a better outcome in behavioral therapy, while depression perceived to be emanating from existential phenomena was associated with better outcomes in cognitive therapy (Jorm et al., 1997).

Kleinman (1988) and Kometsi (2016) defined explanatory models of illness as the differing perceptions and explanations of mental illness by different communities. A concrete understanding of the available treatments and most preferred treatment options within a particular context would echo an understanding of society's explanatory models of mental illness (Forssell et al., 2016). Hence, studies on mental health conducted in developed countries have shown differing preferences for healing mental illness than studies conducted in the underdeveloped countries. However, even within the same country, there have been variations

in people's preferences, depending on educational level, socio-economic status, and other demographic determinants (Weeks, 2012).

Burns and Tomita (2015) carried out a systematic literature review of help-seeking behaviors in Africa. They found that patients with mental illness consulted mainly traditional healers, and many never reached formal health services. Labys et al. (2016) found that almost half of the participants in their study reported never having contacted a mental health specialist in the course of their health-seeking behavior, and two-thirds reported to have never made a hospital visit for mental health needs. Out of the total number of participants, only one in eight participants reported having seen a psychiatric hospital. This supported the systematic review conducted by Burns and Tomita.

This finding also supported the view that most people with mental illness lack access to biomedical treatment in low middle-income countries (LMIC) (Priester et al., 2016). This is particularly the case in rural areas where there is a severe scarcity of formal infrastructures such as hospitals and clinic facilities (Weeks, 2012). In rare instances, hospitals that do exist in rural areas are often too far from the general public, who in most cases cannot afford the transport costs (Weeks, 2012). Furthermore, health facilities in rural areas have been known to lack skilled personnel in mental health detection and treatment (Mendenhall et al., 2014). Thus, the inability to afford professional mental health attention, coupled with a lack of skilled personnel, leads many to perceive traditional healers as the first entry point into mental health care (Ndetei, 2013).

While psychological studies have noted that early treatment of mental illness is linked to better outcomes (Corrigan et al., 2014), it has been argued that a vast number of people in developing countries still lack awareness of mental illness and the proper channels for finding professional

help (Weeks, 2012). Moreover, developing countries' health system is hampered by a scarcity of professionals to attend to mental health issues (Shidhaye et al., 2015).

Thus, the unfortunate reality of most individuals with mental disorders in developing countries is that they are often left to suffer the progression of mental illness without ever being seen by a mental health professional or given the right treatment. This situation is particularly true in many black South African communities since they have received little development in health services.

1.2. Rationale for the study

Understanding local perceptions and attitudes towards mental illness and the related healthcare seeking behaviors is an integral component for developing good public mental health literacy. Mental health literacy may help health practitioners understand their patients better and improve treatment adherence to treatment and reduce engagement in interventions that are less helpful to patients (Ventevogel et al., 2013). Nielsen et al. (2017) conducted a study in mental health literacy and found that the public's perceptions and understanding of mental illness differed from that of the professionals. For example, a study conducted by Jorm et al. (1997) reported that their participants conceptualized depression as a medical illness.

Mental disorders are easily identified and managed when patients can recognize and communicate the experienced symptoms effectively to the health practitioner (Nielsen et al., 2017). However, studies in the area of mental health literacy have suggested that members of the public cannot correctly identify signs of mental disorders (Jorm, 2012), and there has been little understanding of the psychological symptoms that are used by professionals to identify and diagnose mental disorders (Jorm, 2000). Thus, due to the public's inability to recognize and communicate their psychological distress, more people who suffer from mental disorders have been likely to end up undiagnosed and untreated (Petersen, 2017).

Unfortunately, most studies on mental health literacy have been conducted in Western and developed countries (Furnham & Hamid, 2014). There is, therefore, a scarcity of such studies of this nature in African countries. A few available studies have been conducted in Nigeria (Kabir et al., 2004; Ganasen et al., 2008; Lasebikan, 2016), Ghana (Amoah et al., 2016) and South Africa (Petersen et al., 2017). While most of these studies focused on mental health literacy, they have emphasized Western health-seeking behavior and have overlooked indigenous methods of treating mental illness amongst those residing within the African context.

This leaves a gap in the literature, which the proposed study seeks to fill. This study aims to investigate mental health literacy among indigenous African residents of the eThekwini District Municipality. The focus is on perceptions and attitudes towards depression and schizophrenia. An exploration of issues related to treatment will also form an integral part of this study. Findings from this study will advance empirical knowledge and shed light on the African people's mental health literacy in eThekwini District Municipality and may inform interventions aimed at raising mental health awareness in South Africa.

1.3. Aim of the study

This study aims to provide insights on perceptions of mental health literacy among residents of eThekwini District Municipality. Unlike most current research that has studied mental health literacy discourse using qualitative methods, this study investigates perceptions of mental health literacy in eThekwini District using a mixed-method approach.

1.4. Objectives:

The objectives of this study are:

1. To examine the perceptions of mental illness among African residents of eThekwini District Municipality;
2. To explore the participants' treatment preferences for mental illness; and
3. To study the attitudes towards mental illness among African residents of the eThekwini district.

Research questions:

1. What are the perceptions of mental illness among African residents of eThekwini District Municipality?
2. What are the participants' treatment preferences for mental illness?
3. What are the attitudes toward mental illness among the African residents of the eThekwini District Municipality?

1.5. Operational definition of terms

Mental Health literacy: Knowledge and beliefs about mental disorders which aid their recognition, management or prevention.

Explanatory models of illness: Refers to patients' causal attributions of illness and have been shown to affect treatment preference and outcome.

Mental illness Symptoms: Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities.

Mental health practitioner: A mental health professional who, by virtue of education, credentials, and experience, is permitted by law to evaluate and care for patients within the scope of his or her professional practice.

Perceptions: The way in which something is regarded, understood, or interpreted.

1.6. Outline of the dissertation

This study has six chapters. Chapter one introduces the study, including the aim, objectives and questions informing the study within eThekwini District Municipality. Chapter Two discusses alternative definitions and provides a succinct overview of past studies on mental health literacy. This is followed by Chapter Three, which provides the methodology employed in this study. Chapter Four presents the analysis of the data through descriptive statistics and correlation tests.

Chapter Five provides a discussion comparing the results obtained in this study with what other researchers have done in the discourse of mental health literacy. Chapter Six ascertains if the study addressed the research problem and if it meets the study's aim and objectives. This chapter makes recommendations for the improvement of mental health literacy among township residents. Recommendations are ultimately expected to lead to a better understanding of the factors resulting in improved “perceptions” of mental illness treatment outcomes.

Chapter Two: Literature Review

2.1. Introduction

While the information on physical diseases has been widely disseminated and accepted, information on mental diseases has often taken a back seat (Jorm, 2000). The majority of under-developed communities have limited knowledge of mental illnesses and avenues for mental health care (Weeks, 2012). Furthermore, while the developed countries have reached greater milestones in conscientizing the population on mental disorders, countries in Africa are currently far behind, both in terms of economic means and personnel who are skilled in mental health care (Weeks, 2012). Thus, for many in the developing world, the option for mental health care is generally left to traditional and faith-based healers (Petersen, 2017).

2.2. Literature Review

2.2.1. Mental health literacy

Jorm et al. (1997) coined the term 'mental health' to refer to knowledge and beliefs about mental disorders which aid their recognition, management and prevention. When the term "mental health literacy" was conceptualized, Jorm et al. (1997) aggregated the term into six components. The first was the ability to recognize specific disorders or different types of psychological distress, which meant that the primary agent, someone with mental illness or close to someone with mental illness, needed to have preexisting knowledge that could help to realize the presence of a mental disorder and the need for treatment (Petersen, 2017).

The second component identified by Jorm et al. (1997) related to knowledge and beliefs about risk factors and causes. Knowledge and beliefs of mental illness are often constructed through cultural influences emanating from a particular world view (Tellers-Correia & Sampaio, 2016). Since mental illness is based on a particular cultural and epistemological framework that

encapsulates how symptoms and illness are constructed and detected (Johnson et al., 2017), an understanding of the causes of psychological distress would best be understood through the publics or patients' own "explanatory models of illness".

The third component identified by Jorm et al. (1997) was knowledge and beliefs about self-help interventions. This relates to the individuals' knowledge of what they can do to help themselves ameliorate the symptoms of psychological illness. Individuals using self-help methods to reduce psychological distress symptoms are most likely to seek support from their family and friends (Gloria & Steinhardt, 2016) or take on new hobbies and activities such as exercise, art classes, and support groups (Rosenbaum et al., 2014). This shows that the third component draws more from the individual's abilities to reduce illness symptoms without involving a mental healthcare professional.

The fourth component was perceived knowledge and beliefs about professional help available (Jorm et al., 1997). According to this view, help-seeking behavior moves from what individuals can do for themselves to seeking help from mental healthcare professionals (Jorm, 2000). However, this component is easily attained by people who have access to information and services for healthcare. In developing countries, seeking help from mental healthcare professionals is usually the last resort, after the utilization of services from traditional healers (Weeks, 2012).

While studies have documented the scarcity of mental health care services in developing and under-developed countries (Labys et al., 2016; Ndetei, 2013), even with the few mental healthcare services available, people are more likely to seek help from traditional healers who are perceived as easily accessible. Moreover, lack of information, stigma, fear of diagnosis and prescription medication often encompass the anxieties against the utilization of professional help (Mendenhall et al., 2014).

The fifth component referred to attitudes that facilitate recognition and appropriate help-seeking (Jorm et al., 1997). According to this component, identifying signs of mental illness and knowledge regarding proper help-seeking may be severely impaired by negative societal attitudes towards people with mental illness (Angermeyer et al., 2013; Stuber et al., 2014; Kometsi, 2016). This is likely to lead individuals with mental illness to conceal their symptoms or avoid seeking professional help due to fear of being stigmatized (Schomerus et al., 2014).

The last component identified by Jorm et al. (1997) was knowledge of how to seek mental health information. According to Weeks (2012), exposure to formal education may help individuals acquire knowledge and awareness of appropriate mental health interventions. However, it should also be noted that acquiring such formal education may be less useful to rural dwellers whose contact with a healthcare practitioner is usually through a mobile clinic, once a month (Oliver, 2015).

While most developed countries have attained an adequate level of access to mental healthcare and education, other societies in developing and under-developed countries are still struggling to attain such (Weeks, 2012). This makes Jorm et al.'s (1997) idea of adequate mental health literacy for all only a wish for many under-developed countries.

In addition to the scarcity of resources befalling many countries in the African continent, it is also critical to consider the complexities of different cultural epistemologies that inform the conceptualization of mental illness (Bishop & Dzidic, 2014; Kometsi, 2016). Most African countries conceptualize illness from the traditionalist or African worldview (Sorsdahl et al., 2010). For example, this has informed the perception that mental illness results from a disconnection between the living and the ancestral spirits (Ngubane, 1977).

2.2.2. The epidemiology of mental illness

It is critical for studies of mental illness to explore its global impact by focusing on epidemiology. Findings from the Global Burden of Disease Study of 2010 showed that 258 million people worldwide live with the non-fatal component of the disease burden (Lim et al., 2013). The non-fatal component of the disease burden is measured using the Disability Adjusted Life Years metric (DALY), a health metric that captures the loss of a healthy year of life due to disability (Whiteford et al., 2013; Ferrari et al., 2013).

Epidemiological research has shown that a vast proportion of the world's health problems results from mental, neurological, and substance use disorders (Salomon et al., 2013). According to Whiteford et al. (2015), mental disorders globally account for the highest proportion (56.7%) of people living with a non-fatal disease, followed by neurological disorders (28.6%) and substance use disorders (14.7%). According to Ferrari et al. (2013), depressive disorders and schizophrenia are common mental disorders across many cultures.

While depression may occur as early as three years of age (Ferrari et al., 2013), the average age of onset for schizophrenia is around 18 years in men and 25 years in women (Linke et al., 2015). The Global Burden of Disease study conducted in 1990 reported that depressive disorders were the fourth major leading cause of the health burden worldwide, accounting for 3.7 percent of the burden (Ferrari et al., 2013). Depressive disorders were ranked fourth after respiratory infections, diarrhea diseases, and conditions emanating during the prenatal period (Murray & Lopez, 1996). By the year 2000, depressive disorders had increased to being the third leading cause of the burden at 4.3 percent of DALYs worldwide (Whiteford et al., 2015).

Moreover, global estimates of depressive disorders were found to be the leading cause of disability, reflecting 13.4 percent of years of life lived with a disability (YLD) in women and

8.3 percent in men (Ferrari et al., 2013). Among depressive disorders, major depressive disorder is the largest contributor to the burden, reflecting 85 percent YLDs and DALYs worldwide (Lim et al., 2013). In South Africa, 41.9 percent of women and 24.3 percent of men are affected by depression (Schneider et al., 2016). Studies in South Africa have reported that nearly 20 percent of high school students a year think about fatally harming themselves (Collins et al., 2016).

Regarding schizophrenia, research has shown that it affects one percent of the population worldwide (Nonaka et al., 2013). In 2004 the WHO estimated that schizophrenia was the fifth leading course of global disease burden (Kesler & Ustun, 2004), with males and females representing 2.8 percent and 2.6 percent, respectively (Millier et al., 2014). The prevalence of depression is higher among patients with schizophrenia than the general population (Meesters et al., 2014; Balci et al., 2016). While variability in statistics has been reported in the literature, Mulholland and Cooper (2000) found that the prevalence of depressive symptoms amongst patients with schizophrenia ranged from 13 percent to 80 percent, on the one hand. On the other hand, Siris (2001) reported a prevalence of 25 percent to 81 percent.

Clonely et al. (2007) conducted a study on 2325 patients with schizophrenia and found 39.4 percent of patients to be depressed at enrolment. Furthermore, the prevalence of suicidal thoughts was higher amongst schizophrenic patients with depression than those without depression (Fuller-Thomson & Hollister, 2016; Gooding et al., 2017). Schaefer et al. (2013) found cognitive impairment to be a core feature of schizophrenia, appearing as a core feature among 70 percent to 85 percent of in-patients.

Furthermore, homelessness has been more highly represented amongst people with schizophrenia (Lee & Shin, 2015). Salkow and Fichter (2003) reported a prevalence of eleven percent of schizophrenia in homeless people. While the general population tends to perceive

people with mental illness as unpredictable and violent (Chong et al., 2016), Millier et al. (2014) reported that 99.97 percent of patients with schizophrenia would not commit a serious violent crime.

A closer inspection of mental disorders, both globally and locally, highlights the seriousness of the mental illness and the importance of effective mental healthcare. Nevertheless, there is little research about indigenous African peoples' perceptions of mental health. This proposed study seeks to add knowledge regarding indigenous African peoples' conceptualizations of mental illness.

2.2.3. Treatment of mental illness

When studying mental illness and its impact on societies worldwide, it is critical to delve into the discussion of treatment for patients with mental disorders. Over the years, improved treatments for individuals with mental illness have been made available (Möller et al., 2013), ranging from psychotherapy to psychotropic medications (Mulrow et al., 2000; Schlaepfer et al., 2013). While studies have shown both psychotherapy and antidepressant medications to be equally important in treating depression individually (Cuijpers et al., 2015), there is also evidence to suggest that the combination of both treatment methods may be more effective in treating depression than each of the treatments alone (Craighead & Dunlop, 2014).

There is further evidence that the effect of combined treatment is exceptionally high in clinical samples, as opposed to samples recruited from communities (Möller et al., 2013). This finding has been understood to indicate that patients who are actively involved in seeking treatment are most likely to benefit from combined treatment than people selected from communities (Cuijpers et al., 2014). While combined treatment appears to have been favored in published studies, Cuijpers et al. (2014) acknowledged the importance and superiority of combined

treatment and noted an effect of publication bias that seemed to overestimate the effect of combined treatment over pharmacotherapy and psychotherapy alone.

While combined treatment has indeed been favorable in treating depression, it is not yet evident in the literature whether the effects of pharmacotherapy and psychotherapy are complementary to each other (Ferrari et al., 2013). Moreover, Ferrari et al. (2013) noted that it is still unclear whether they have effects independent of each other or whether combined treatments lead to higher effects than the sum of the two treatments alone.

Schizophrenia is a condition that requires lifelong treatment, even when symptoms have long subsided (Kesler & Ustun, 2004). Antipsychotic medications are the most frequently prescribed drugs for schizophrenia, and they control the experience of schizophrenia by affecting the brain's neurotransmitters, particularly dopamine (Mak et al., 2016). The therapeutic effects of psychotic medications on schizophrenia effectively deal with positive symptoms such as hallucinations and delusions (Van Oosterhout et al., 2016). While the prognosis for schizophrenia remains poor, it is believed that a treatment based on a combination of psychotropic medication and psychosocial support at early onset is most likely to improve the outcome (Mueser et al., 2013).

It is imperative to bear in mind that an understanding of treatment preferences within a particular cultural or social context will reflect society’s explanatory models of mental illness (Forssell et al., 2016). Studies of mental health conducted in most western countries show differences in preferences for treating mental illness compared to studies conducted in African countries. However, even within the same country, there will be variations in people’s treatment preferences, depending on educational level, socio-economic, cultural and demographic variables (Weeks, 2012). In a systematic review of literature on help-seeking behaviors in Africa, Burns and Tomita (2015) found that traditional healers mainly saw patients

with mental illness, and many of them did not seek help from western trained mental health professionals.

Labys et al. (2016), in their study, found that almost half of their participants reported never to have made contact with a mental health specialist, and two-thirds reported never having made a hospital visit for mental health needs. Furthermore, the same study also found that only one in eight participants reported having been treated in a psychiatric hospital. This shows that most people with a mental illness may lack access to professional mental healthcare (Priester et al., 2016) or prefer alternative traditional treatment options. This particularly may be the case in rural areas where there is a severe scarcity of formal infrastructure such as hospitals and clinic facilities (Weeks, 2012).

Furthermore, rural areas' available health facilities often lack skilled personnel in mental health detection and treatment (Mendenhall et al., 2014). In light of this, Ndetei (2013) argued that the inability to afford professional mental health services, coupled with a lack of skilled personnel, may discourage people from seeking professional help. This is likely to encourage seeking alternative and traditional healing methods that are perceived as easily accessible.

2.2.4. Culture and mental illness

When investigating individual perceptions of mental illness and the awareness of the available mental health services, it is crucial to understand culture and its influence on these phenomena. Studies exploring indigenous perceptions of mental illness found that they are often constructed through cultural influences emanating from a particular worldview (Bishop & Dzidic, 2014). They are based on a particular cultural and epistemological framework that encapsulates how illness and symptoms are constructed and detected (Tellers-Correia & Sampaio, 2016).

Thus, according to Ojelade et al. (2014), it would be expected that for Africans, their worldview would be based on an ontological framework that informs their perceptions of mental illness and what treatment modalities are perceived as most suitable (Weeks, 2012). For example, the view that mental illness results from the influence of supernatural spirits or bewitchment often informs the preference for traditional healing (Sorsdahl et al., 2010).

Traditional healing encompasses various types of indigenous African traditional practitioners such as herbalists, diviners and faith-based healers. Diviners are specialists in divination and act as intermediaries between the living and the ancestors (Stein 2008). On the other hand, herbalists are specialists in herbal medicines' production (Ngubane, 1977). In seeking treatment for mental illness, indigenous Africans may first consult a diviner for insight into what could have caused an illness, and the diviner would then make a referral to a herbalist for treatment.

Thus, it is envisaged that conducting a study of mental health literacy among indigenous Africans will produce invaluable knowledge regarding how people in eThekwini District Municipality conceptualize mental illness. Moreover, the proposed study may provide knowledge regarding understanding and preferences for mental illness treatment practices.

2.3. Theoretical framework: Explanatory Model of illness

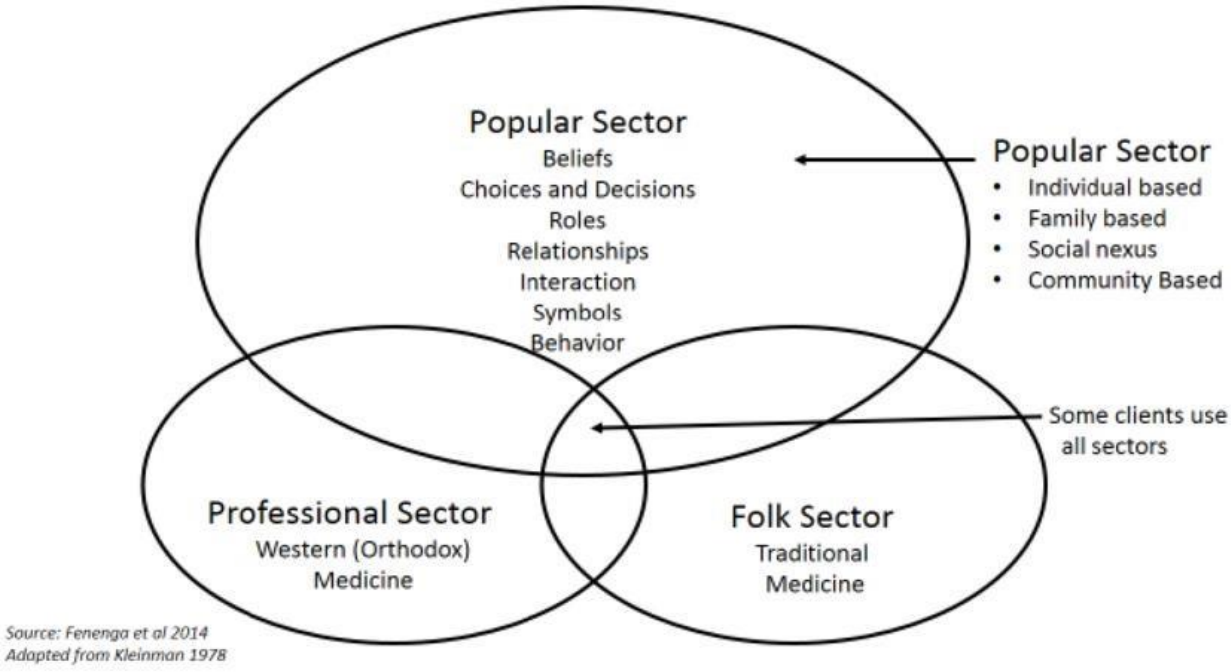
The explanatory model informs the proposed study. According to Kleinman (1988, p. 9), the explanatory model is defined as the "…notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process". According to Williams and Healy (2001), the health beliefs of individuals who have mental illness are important, most notably since they play a crucial role in models of health and illness behavior and have been found to have an indirect influence on health outcomes (Mo et al., 2016).

Moreover, with the field of health care advocating for a shift towards patient-centered service delivery, individual perceptions of mental illness must be brought into awareness to be able to incorporate the patients' perspectives of illness in the health care process (Baird & Sheffield, 2016).

With South Africa's shift from racial segregation and institutionalized racism, health care practitioners must consider the differing worldviews on illness. According to Bhui and Bhugra (2002), people explain their distress in many ways, often blaming social circumstances, relationship problems, witchcraft or sorcery, or a broken taboo (Weiss, 1997). Figure 1.1 presents the patients' health-seeking behavior, as seen by Kleinman (1978).

Figure 1.1

Healthcare Systems according to Kleinman 1978



Source: Fenenga et al. (2014, p. 4).

Kleinman (1988) recommended that a patient's explanatory models of illness should be elicited using a mini-ethnographic approach that explored their concerns: 'Why me?' 'Why now?'

‘What is wrong?’ ‘How long will it last?’ ‘How serious is it?’ ‘Who can intervene or treat the condition?’ Using open-ended questions to elicit patients’ narratives has allowed the clinician to better understand the individuals’ subjective experiences of illness, thus promoting collaboration and improving clinical outcomes and patient satisfaction.

Furthermore, understanding individuals’ explanatory models of mental illness is likely to provide insight into their prevailing cultural influences on their conceptualization of mental illness, their likelihood to adhere to treatment, and interventions that may be perceived as most suitable.

2.4. Summary

While the objects of psychiatry are the results of an amalgamation of social forces and philosophical perspectives rooted within a particular context, within a particular point in time it is critical that they also be understood through a lens of social and human sciences as well as clinical experience (Tellers-Correia & Sampaio, 2016). In this regard, clinical experience would facilitate a critical role in detailing new forms of presentation and new mental illness manifestations.

Combining various theoretical underpinnings conceived from social forces, clinical experience, social sciences, philosophical investigations and interpretations of previously established suppositions would produce empirical knowledge on mental illness that is validated to be the prevailing normative standard across various societies.

Chapter Three: Methodology

3.1. Introduction

This study drew on quantitative and qualitative data collected from residents of the eThekwini (Durban) District Municipality, Umlazi and KwaMashu townships in KwaZulu-Natal, South Africa. The Umlazi and KwaMashu townships were selected due to their rich political history within South Africa. This study used descriptive, correlation, regression statistics and open-ended questions to understand the demographic profile and the degree of mental health literacy among study participants. The statistics presented in this section are based on the STATSA's report of the 2011 National Census; the next national census will be conducted in the year 2021.

3.2. Study context

The study was conducted at two townships in eThekwini District Municipality, namely Umlazi and KwaMashu. These townships are populated predominantly by black South African dwellers of the Zulu nation. Umlazi township is located to the south of eThekwini, and it is the second-largest township in the southern hemisphere (Chili & Mabaso, 2016). According to Statistics South Africa (2011), this township has a population of 404 811and 104 914 households. There is only one hospital in Umlazi, Prince Mshiyeni Memorial Hospital (Gabela & Manivasen, 2014).

Due to the absence of a district hospital or a community health center, Prince Mshiyeni Memorial Hospital also offers district-level services. Umlazi township has 31 public health clinics (15 Provincial and 16 Local Authority) (Gabela & Manivasen, 2014). All the identified clinics make referrals directly to Prince Mshiyeni Memorial Hospital. Currently, Umlazi is receiving an increase in private and government investments, as seen in new shopping

complexes, primary and secondary schools, universities of technology, and libraries (IDP, 2015).

KwaMashu is located in the north of eThekwini. KwaMashu is one of the first of Durban's townships that emerged with the implementation of the apartheid Group Areas Act during the 1950s (Kynoch, 2016). This township is home to approximately 175 663 people, mainly isiZulu-speaking, with 50 683 households (STATSA, 2011). Over recent years, KwaMashu has benefited from infrastructural developments such as schools, shopping complexes, and further education and training institutions (Kynoch, 2016).

The community's health needs in KwaMashu have also been prioritized by the Provincial Department of Health (IDP, 2016). The KwaMashu Community Health Centre Clinic has recently opened to service the community's needs and surrounding areas. In 2016 construction of a new R2.7 billion, 500-bed hospital was underway and was scheduled for completion in 2019 (IDP, 2016).

3.3. Research paradigm

This study follows an interpretive paradigm, which holds that meaning and knowledge is socially constructed, and that it is made meaningful through actors understanding of events. Interpretive theory holds that human affairs cannot be understood properly unless we grasp the relevant meanings attached to the events (Bevir & Rhodes, 2002). Therefore, this study focused on analytically disclosing those meaning-making practices towards mental health issues, to create meaning as gathered from uMlazi and KwaMashu dwellers conceptions and understanding of mental health literacy.

The interpretive paradigm allows the researcher to capture the participants' beliefs and ideas, actions and institutions for treating mental health issues. The interpretive paradigm holds two premises, the first is that people act on their beliefs and preferences (Bevir & Rhodes, 2002). Thus, people will either choose a mental health care practitioner or a church pastor because they believe the use of such services will improve their mental health and wellbeing. The second premise holds that it is unlikely to read of people's beliefs and preferences from objective facts about them (Bevir & Rhodes, 2002), such as their social class, race or institutional position.

3.4. Research design

This study used a mixed method design. Mixed method design is characterized by the combination of at least one qualitative and one quantitative research component (Creswell, 2006). The study further used a triangulation design, which assisted the researcher to obtain different but complimentary data on eThekwini township dwellers mental health literacy. The triangulation of qualitative and quantitative data findings helps to better understand the research problem. The intention of using this design is to bring together the differing strengths and the nonverbal overlapping weaknesses of quantitative methods with those of qualitative methods (Creswell, 2006).

With the use of triangulation and mixed method designs, this study investigated perceptions of mental illness, treatment preferences for mental illness, and attitudes towards mental illness among African residents of the eThekwini district. The qualitative components covered a section of perceptions of the causes of mental illness and treatment preferences for mental illness. While the quantitative component covered the other section of perceptions of mental illness causes, treatment preferences and attitudes towards people with mental illness. Results

obtained from this study were then triangulated to provide more understanding and meaning to the findings.

3.5. Sampling

Parahoo (2006) defines a sample as the total number of participants from which data can potentially be collected. This study's sample was drawn from the population of African residents of the eThekwini district, 266 participants were selected from Umlazi (139) and KwaMashu (127) townships. The sample was selected using the study population of 404 811 individuals in Umlazi and 175 663 individuals in KwaMashu township. The population was then calculated against a proportion of 0.5 and a confidence interval of 0.05 points. The participants were selected from public spaces such as taxi ranks, shopping malls and any other spaces of social gatherings (Urbaniak & Plous, 2016). The participants' demographic profile comprised individuals aged 18 years and older, of both genders, and of African descent.

Participants were recruited using a random sampling method. The researcher interviewed individuals from the age of 18 years and over, that were found at the different social gatherings, within the two townships. With every individual participant that was interviewed, the researcher skipped five more individuals, and interviewed the sixth person found in the area.

This method was applied at all the different settings, until completion of the data collection process. In random sampling, each member of the population has an equal chance of being selected into a sample, and random sampling aims to select individuals who will represent the whole population (Creswell, 2013). Random sampling was suitable for this study because it is free from bias (Rossi et al., 2013). The study did not have a specific sampling criterion for the qualitative component of the study, since the study comprised of one data collection tool and all the participants that were identified responded to both qualitative and quantitative questions.

Participants who were interested in being part of the study were read the information sheet (appendix A) and signed the consent form (Appendix B and C) before data collection.

3.6. Inclusion and Exclusion Criteria

Since the proposed study only recruited participants over the ages of 18 years, children who were aged 17 and younger were excluded from taking part in this study. Traditionally, children under 18 years have not been granted autonomy because they are considered not competent to decide their wellbeing (Henkelman & Everall, 2001). Moreover, it has been argued that children have limited cognitive understanding and a lack of experience necessary for making informed consent (Field & Behrman, 2004).

3.7. Data collection

Data was collected at uMlazi and KwaMashu Township. The first part of data collection was conducted at uMlazi by two data collectors: Ms. Nolwazi Nzama and Ms. Nelly Msweli. The research sites that were selected for data collection were uMlazi B and D section. The malls that were visited were kwaMnyandu, and Rhino Mall, including the nearby taxi ranks and public spaces. The second phase of data collection was conducted at KwaMashu Township. The researchers were Ms. Nolwazi Nzama, Phumlani Ncube and Philani Ncube. The research was collected at Bridge city, KwaDube mall and nearby taxi ranks and social places.

Since the research study was not of a sensitive nature, the participants did not need to be singled out and made private from the general population, however, their responses on the study were anonymized, which allowed the participants to be open about what they knew and did not know about mental health issues. The questionnaire that was administered is divided into two parts. The first part is the biographical information and the second is made up of a vignette and

questions referring to the vignette. An English copy of the questionnaire may be found in Appendix E, and a Zulu copy in Appendix F.

3.8. Research Instrument

Since quantitative research method uses a fixed design that organizes in advance a detailed method of data collection and analysis (Robson, 2007), the researcher used an already existing instrument to achieve the aims and objectives of this study. This study used a questionnaire called the Mental Health Literacy and Stigma questionnaire – Shortened Version, adapted from a mental health literacy study conducted by Kometsi (2016) in Sisonke District, KwaZulu-Natal.

This questionnaire elicits information regarding perceptions of and attitudes toward mental illness and treatment preferences (Kometsi, 2016). The first part elicits the participants' demographic information. The second part presents a vignette depicting 'Zanele' with either schizophrenia or depression.

The vignette is followed by a series of questions aimed at eliciting the participants' perceptions of mental illness. The questionnaire asks both open and close-ended questions, and some items require participants to indicate their responses on Likert-scales.

3.9. Validity and reliability

According to Polit & Beck (2010), the validity of a questionnaire is the degree to which the research instrument measures what it is intended to measure. There are two types of validity: face validity and content validity (Haynes et al., 1995). Based on LoBiondo-Wood & Haber's (2010) interpretation, face validity is concerned with whether the questionnaire measures the concept being tested while content validity checks if enough relevant questions are covering

all aspects of the concept being studied (Parahoo, 2006). The validity of the data collection instrument used in this study was already established in Kometsi's (2016) study conducted in KwaZulu-Natal among indigenous Africans.

According to Robson (2007), a questionnaire's reliability refers to its ability to yield the same data when it is re-administered under the same conditions. Reliability for quantitative research focuses mainly on stability and consistency (Polit & Beck, 2010). A questionnaire's stability is the degree to which it produces similar results on being administered more than once. The reliability of this questionnaire was established by Kometsi (2016) using Cronbach's alpha and its coefficient was 0.89.

3.10. Data Collection Procedure

Participants were recruited randomly from public spaces that usually attract people, such as malls, taxi ranks, and other social places (Urbaniak & Plous, 2016). The researcher ensured that the participants understood their role, and that questions had been answered satisfactorily. Participants were then asked to sign a consent form. After that, they were presented with the questionnaire to complete. In cases where the participant could not read or write, the researcher read the questionnaire to the participant and recorded responses accordingly.

3.11. Data Analysis

Qualitative data was analyzed using thematic analysis. Thematic analysis is a method for identifying, analyzing and identifying patterns within data sets in detail (Braun & Clarke, 2006). The use of thematic analysis in qualitative research aims at applying objectivity and improving the generalizability of the study (Polit & Beck, 2010). With the use of thematic analysis, the researcher started by familiarizing with the data through reading and rereading

participants responses. Through the identification of recurring themes the researcher generated initial codes, which is a list of what is in the data and what is interesting about the data.

The researcher then progressed into sorting all the relevant codes into potential themes. When the researcher had a set of candidate themes, the process of analysis progressed to reviewing and refining the identified themes. This process assisted the researcher to define and name themes that were most relevant to the study; each identified theme was defined through a detailed analysis.

Quantitative data was analyzed using IBM SPSS 24 statistical software. After capturing the data, the researcher cleaned data to remove errors, missing cases and anomalies, for efficient analysis. Then the next level of statistical analysis was descriptive statistics. Descriptive statistics were used to describe the basic features of the data (Holcomb, 2016). They provided simple summaries about the sample and the measures used to analyse the data (Grant & Thompson, 2016). Chi-square tests were then conducted to enable the researcher to identify statistically significant differences between variables (Kilic, 2016).

The researcher used a regression analysis to test the correlation between variables (Darlington & Hayes, 2016). Ordinal logistic regression analysis was conducted to examine the relationships between variables. All significant variables identified in the analysis were included in the initial regression model to be considered as potential confounders.

Non-significant variables in the model were removed through a backward step-wise procedure except the exposure variable. Interaction terms between the exposure variable and other significant variables retained in the model were also tested to examine of any effect modification. All tests of significance were conducted at the 95% confidence level ($p < 0.05$).

Both qualitative and quantitative data are presented in an integrated format. Integrative mixed methods design differ from the component designs in that mixing takes place throughout the inquiry from data collection to analytic processes and to interpretation. Iterative designs allow researchers to move back and forth between quantitative and qualitative methods.

3.12. Limitations of the Study

This study was conducted in KwaZulu-Natal, within eThekwini district, among a population of Zulu-speaking people. While the importance of participation in this study was emphasized when inviting eThekwini District residents to participate, some people still refused to participate in this study due to their lack of time, particularly since they were approached randomly while busy with their daily activities. Refusal to participate also occurred despite the scheduling of data collection on weekends when most people who work during the week were most likely to be available and generally less busy.

Moreover, it was challenging to plan the duration of data collection carefully since recruiting participants took time. Thus, the researcher had to prolong the duration of data collection while also incurring more costs. Furthermore, since participants had the liberty to withdraw from the study at any point they wished, data collection also included incomplete questionnaires. This delayed data collection, as the researcher had to include more participants in the study.

3.13. Ethical Considerations

The study was reviewed and approved by the UKZN humanities and social sciences research council, the study's approval reference is HSS/0221/018M.

The first and most basic ethical issue that was considered in this research is the invalidity of research questions. Since research is conducted to answer a particular research question, the

research conclusion was made to match with the research questions asked in the beginning. The research method is an essential part of every study. Therefore, the most appropriate research method was selected to conduct this study. The researcher insured that the method completely fit with the purpose of the research.

Furthermore, to abide by the ethical considerations, the participants were read an information sheet with all the details of the study and were allowed to ask questions for clarity. The researcher informed participants about all the activities in the research, which enabled the participants to make informed consent before starting research work. Moreover, one of the most important ethical considerations is the confidentiality of the information provided by the participant. Through the application of privacy any information related to participants or provided by the participants was not made available to anyone other than the researcher.

The participants were always referred to as coded numbers in the research reports. Furthermore, the participants were informed about the study's nature and risks associated with it, which in this case entailed the loss of time, while completing the research questionnaire. The participants were also informed that there was no monetary value to participating in the study, however, their participation would contribute to literature on mental health literacy and possibly lead to improvements in future mental health interventions.

3.14. Summary

The purpose of this chapter was to describe the method of data collection employed in this study. Quantitative research methods were employed using descriptive and inferential statistical analysis. The analysis was conducted using data collected in eThekwini to identify levels of mental health literacy. The study sample comprised of eThekwini dwellers. Chapter Four presents the results obtained from this study.

Chapter Four: Results

4.1. Introduction

This chapter presents the study's main findings, as informed by its objectives to provide an overview of mental health literacy amongst eThekwini District municipality residents. The data was collected from residents of Umlazi and KwaMashu Township. The data collection protocol was based on a vignette to ascertain the participants' perceptions of mental illness. While some of the participants were able to identify a form of mental illness such as stress or depression, none of the participants identified schizophrenia as a form of illness.

Therefore because of this outcome, the results are based on depression and not schizophrenia. This chapter first presents a descriptive analysis of the participants' demographic profile. After that, the participants' perceptions of mental illness, followed by their treatment preferences for mental illness. Lastly, it presents the results of the participants' attitudes towards mental illness.

4.2. Demographic analysis

The total sample was made up of 266 participants**.** Overall, there were more males in the sample (54.5%) than females (45.5%). Table 4.1 presents a descriptive analysis of the participants' demographic details.

Table 4.1

Demographic details of Participants (N=266).

Variables	Categories	Umlazi		KwaMashu	
		n	%	n	%
Age	**18-27**	39	28.1	41	32.3
	28-37	39	28.1	61	48.0
	38-47	33	23.7	16	12.6
	48-57	18	12.9	5	3.9
	58-67	8	5.8	2	1.6
	68-88	2	1.4	2	1.6
	Total	**139**		**127**	
Gender	**Male**	78	56.1	67	52.8
	Female	61	43.9	60	47.2
	Total	**139**		**127**	
Religion	**Christian**	63	45.3	50	39.4
	Not religious	74	53.2	41	32.3
	African traditional spiritual beliefs	1	0.7	4	3.1
	Other	1	0.7	0	0.0
	No information/refused	0	0.0	32	25.2
	Total	**139**		**127**	
Marital Status	**Married**	62	44.6	90	70.9
	Living together	57	41.0	30	23.6
	Widow/widower	0	0.0	2	1.6
	Divorced/separated	6	4.3	1	0.8
	Never married	13	9.4	4	3.1
	No information/refused	1	0.7	0	0.0
	Total	**139**		**127**	
Education	**Never went to school**	15	10.8	2	1.6
	Primary	3	2.2	5	3.9
	Secondary	71	51.1	81	63.8
	Tertiary	50	36.0	33	26.0
	No information/refused	0	0.0	6	4.7
	Total	**139**		**127**	

4.3. Data analysis

Since this was a mixed-method study, the collected data included both qualitative and quantitative forms of data. Thematic analysis was used to analyze qualitative data, and this data is illustrated by extracts. On the extracts, each participant is identified by codes made up of the first letter of the area, and the letter ‘P’ for participants, for example, ‘UP’ for Umlazi

participants and ‘KP’ for KwaMashu participants. Each participant was assigned a number, for example, UP1 – UP139 for Umlazi participants and KP1 – KP127 for KwaMashu participants.

Table 4.2 presents a summary of the themes from the thematic analysis. Quantitative data was analyzed using correlation and regression analysis, this is presented as tables in this chapter.

Table 4.2

Summary of themes from the thematic analysis

Research question	Theme(s)
• What are the perceptions of mental illness among African residents of eThekwini District Municipality?	• Symptoms of mental illness as stress and loneliness • Symptoms of illness due to supernatural forces • Symptoms of illness due to social problems
• What are the participants’ treatment preferences for mental illness?	• Treatment by medical/mental health workers • Treatment by traditional healers • Treatment by faith-based workers

4.4. Perceptions of mental illness.

4.4.1. The perception of mental illness by demographic variables

The results were mixed between participants who were able to identify the symptoms of mental illness and those who struggled to identify symptoms. Of the 266 Participants, 198 participants were able to identify that the person in the vignette, Zanele, suffered from some form of mental illness, either stress or depression. Furthermore, over 90% of participants could not identify the exact diagnosis that encapsulated the vignette’s symptom presentation.

Table 4.3 presents the perceptions of mental illness according to the demographic variables. Almost half of participants from KwaMashu perceived the presentation of symptoms in the vignette to be a result of ancestral anger (48.6%), and 63.4 percent of participants from Umlazi perceived the vignette to be the result of the individual's bad character.

Participants aged between 18 and 27 years reported genetic or inherited problems as the highest cause of mental illness (29.9%), while 36.0 percent of those aged 28 to 37 years reported God's will to be the primary cause of mental illness. When religious denomination was assessed, participants who were not affiliated with any religious denomination perceived the symptoms as an outcome of the individuals' bad character (65.5%). In comparison, Christian participants ranked highest on punishment for sins committed (63.9%). Males seemed to reflect the majority of negative perceptions of mental illness.

When compared to females, more males (52.4%) perceived mental illness as a result of a person's bad character compared to females (47.6%), a response to the way a person was raised (54%) compared to females (46%), and punishment for sins a person had committed (63.9%) compared to females (36.1%). Furthermore, more males (67.1%) than females (32.9%) perceived mental illness to be a result of supernatural forces, such as ancestral anger.

More males (53.7%) than females (46.3%) associated mental illness with God's will, and more males (52.6%) than females (47.4%) said it was due to failure to perform certain cultural rituals. Participants with secondary and tertiary level education represented the two highest percentages of respondents who perceived the symptoms to be the result of God's will (61.2%) and (23.1%) respectively, followed by failure to perform certain cultural rituals (61.2%) and (23.3%) respectively.

Table 4.3

The perception of mental illness by demographic variables (N=266).

Demographic variable	Response options	Own bad character		Chemical imbalance		The way she was raised		Stressful circumstances		Genetic problem		God's will		Failure to perform cultural rituals		Ancestral anger		Punishment for sins	
		n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Township	**KwaMashu**	53	36.6	67	40.4	75	42.6	32	41.6	35	41.5	56	41.2	55	41.4	34	48.6	16	44.4
	Umlazi	92	63.4	99	59.6	101	57.4	45	58.4	42	54.5	80	58.5	78	58.6	36	51.4	20	55.6
Gender	**Female**	69	47.6	75	45.2	81	46.0	33	42.9	29	37.7	63	46.3	63	47.4	23	32.9	23	36.1
	Male	76	52.4	91	54.8	95	54.0	44	57.1	48	62.3	73	53.7	70	52.6	47	67.1	13	63.9
Age	**18-27**	28	19.3	36	22.3	48	27.3	33	42.9	23	29.9	32	24.3	32	24.1	22	31.4	15	41.7
	28-37	52	35.9	61	36.7	59	33.5	14	18.2	33	42.9	49	36.0	47	35.3	24	35.7	15	41.7
	38-47	1	22.8	33	19.9	34	19.3	21	27.3	13	16.9	27	19.9	27	20.3	12	17.1	6	16.7
	48-57	19	13.1	20	12.7	21	11.9	8	10.4	1	7.8	16	11.8	16	12.0	9	12.9	0	0.0
	58-67	9	6.2	10	6.0	10	5.7	1	1.3	2	2.6	7	5.1	7	5.3	2	1.4	0	0.0
	68-88	4	2.8	4	2.4	4	2.3	0	0.0	0	0.0	4	2.9	4	3.0	1	1.4	0	0.0
Religion	**Christian**	46	31.7	56	33.7	64	36.4	27	35.1	35	45.5	34	25.0	36	27.1	28	40.0	23	63.9
	African traditional	0	0.0	0	0.0	4	2.3	1	1.3	0	0.0	3	2.2	3	2.3	3	4.3	1	2.8
	No religion	95	65.5	97	58.4	94	53.4	36	46.8	33	42.9	83	61.0	82	61.7	32	45.7	4	11.1
	Other	4	2.8	13	7.8	14	8.0	13	16.9	9	11.7	16	11.7	12	9.1	7	10.0	8	22.2
Marital Status	**Married**	66	45.5	83	50.0	87	49.4	47	61.0	48	62.3	69	50.7	67	50.4	42	60.0	24	66.7
	Living together	56	38.6	60	36.1	65	36.9	22	28.6	21	27.3	46	33.8	46	34.6	21	30.0	9	25.0
	Never married	13	9.0	13	7.8	14	8.0	6	7.8	4	5.2	13	9.6	12	9.0	5	7.1	3	8.3
	Other	10	6.9	10	6.0	10	5.7	4	2.6	4	5.2	8	5.9	8	6.1	1	1.8	0	0.0
Education	**No schooling**	16	11.2	16	9.8	17	9.8	0	0.0	2	2.7	16	11.0	15	11.6	3	4.4	1	2.9
	Primary	5	3.5	5	3.0	6	3.4	3	4.0	4	5.3	5	3.7	5	3.9	3	4.4	1	2.9
	Secondary	79	55.2	93	56.7	97	55.7	40	53.3	41	54.7	82	61.2	79	61.2	40	58.8	22	64.7
	Tertiary	43	30.1	50	30.5	54	31.0	32	42.7	28	37.3	31	23.1	30	23.3	22	32.4	10	29.4

4.4.2. Thematic analysis of the participants' perceptions about the causes of mental illness

The extracts below present a sample of the participants' qualitative understanding of the symptoms:

Theme 1: Symptoms of stress and loneliness

> *UP1: "Stress…sustained from too much time alone and not having anyone to talk to*."

> *UP2*: *"She is lonely…she doesn't go out much…and is now having social problems."*

Theme 2: Symptoms of illness due to supernatural forces

Most of the participants identified the presence of symptoms as a result of supernatural forces, such as denying a call by the ancestors or affliction from God due to sins committed.

> *KP4*: "*Denying a call by the ancestors… to be a diviner… leading to an illness of affliction by the ancestors."*

> *KP6: "She is called by the ancestors to be a diviner…she is having difficulties because of the calling."*

> *KP16: "She is punished by the Gods… for her wrong behavior towards others."*

Theme 3: Symptoms of illness due to social problems

The following extracts show that some of the participants were able to identify mental disorders such as depression. However, none of the participants were able to identify symptoms relating to schizophrenia.

UP3: "She is depressed; she lacks support and feels alone."

KP5: "She is depressed…she needs someone to talk to."

The above extracts show that the participants understood that something was wrong with the vignette case, but they could not correctly identify the mental illness, with some participants attributing the problem to ancestral calling, God's anger, social problems and stress.

4.5. Attitudes towards mental illness.

For this objective, the study explored the participants' overall attitudes towards mental illness, description of a person with symptoms of mental illness, willingness to associate with a person with symptoms of mental illness, and beliefs about the long-term outcome of a person with mental illness. Furthermore, the participant's discrimination and stigma towards people with mental illness were explored.

4.5.1. Attitudes towards mental illness by demographic variables.

Table 4.4 represents the participants' attitudes towards mental illness. Out of the 266 participants interviewed for the study, half of the respondents from KwaMashu (50.0%) and Umlazi (50.0%) reported that Zanele was most likely to be violent in the community. Participants from KwaMashu reported that someone with Zanele's symptoms would be less likely to drink too much alcohol (51.8%), and they would be less likely to take illegal drugs (51.2%), or have poor friendships (51.9%). Moreover, over one-half of the participants from KwaMashu (53.5%) reported that people with Zanele's symptoms were less likely to attempt suicide, have a good marriage (57.0%) and be a caring parent (59.8%).

Participants from Umlazi reported that people with Zanele's symptoms were most likely to drink too much alcohol (52.8%), most likely to take illegal drugs (52.0%), and were most likely to have poor friendships (53.0%), and attempt suicide (52.2%). On the contrary, there were more respondents from Umlazi who reported that people with Zanele's symptoms were most likely to be understanding of others feelings (52.0%), most likely to have a good marriage (54.6%), be a caring parent (56.9%), be a productive worker (54.3%), and be creative or artistic (57.4%).

When participants from both townships were compared, males (56.0%) reported that someone with Zanele's symptoms were most likely to be violent. Furthermore, many males reported that individuals with such symptoms were most likely to drink too much alcohol (56.0%) and take illegal drugs (56.0%). More females (60.5%) reported that individuals with Zanele's condition were most likely to attempt suicide. However, most participants appeared to lack knowledge of how such individuals would behave in relationships and communities.

Participants who reported having never gone to school reported that Zanele was most likely to commit suicide (14.1%), while participants with tertiary level qualifications reported that Zanele was most likely to be a productive worker (60.4%) and could be creative and artistic (54.1%). Married participants reported that Zanele was most likely to be violent (71.2%) and have poor relationships (71.2%). While most participants who lived with a partner reported that Zanele was less likely to be violent (39.0%) and she was also less likely to have poor relationships (36.9%).

Table 4.4

Zanele's Long term condition compared to other people in the community (N=266).

Variables		Response options	Violent		Drink too much alcohol		Take illegal drugs		Have poor friendships		Attempt suicide		Understanding of other's feelings		Have a good marriage		Be a caring parent		Be a productive worker		Be creative or artistic	
			n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Township	**KwaMashu**	More likely	26	50.0	25	47.2	24	48.0	31	47.0	32	47.1	59	48.0	54	45.4	53	43.1	59	45.7	69	42.6
		Less likely	80	50.3	85	51.8	85	51.2	83	51.9	84	53.5	47	56.6	45	57.0	49	59.8	46	58.2	35	54.7
	Umlazi	More likely	26	50.0	28	52.8	26	52.0	35	53.0	36	52.9	64	52.0	65	54.6	70	56.9	70	54.3	93	57.4
		Less likely	79	49.7	79	48.2	81	48.8	77	48.1	73	46.5	36	43.4	34	43.0	33	40.2	33	41.8	29	45.3
Gender	**Female**	More likely	21	47.2	25	44.0	22	44.0	31	47.0	41	60.3	62	50.4	58	48.7	63	51.2	63	48.8	73	45.1
		Less likely	75	45.1	74	45.8	76	45.8	70	43.8	62	39.5	35	42.2	37	46.8	34	41.5	34	43.0	28	43.8
	Male	More likely	31	52.8	28	56.0	28	56.0	35	53.0	27	39.7	61	49.6	61	51.3	60	48.8	66	51.2	89	54.9
		Less likely	84	54.9	90	54.2	90	54.2	90	56.3	95	60.5	48	57.8	42	53.2	48	58.5	45	57.0	36	56.3
Age	**18-27**	More likely	24	46.2	22	41.5	22	44.0	26	39.4	25	36.8	32	26.0	29	24.4	29	23.6	30	23.3	38	23.5
		Less likely	36	22.6	40	24.4	40	24.1	38	23.8	38	24.2	27	32.5	29	36.7	29	35.4	30	38.0	26	40.6
	28-37	More likely	19	36.5	18	34.0	18	36.0	24	36.4	22	32.4	49	39.8	48	40.3	48	39.0	51	39.5	58	35.8
		Less likely	63	39.6	67	40.9	67	40.4	64	40.0	68	43.3	33	39.8	32	40.5	35	42.7	32	40.5	28	43.8
	38-47	More likely	8	15.4	11	20.8	9	18.0	12	18.2	9	13.2	18	14.6	19	16.0	22	17.9	22	17.1	33	20.4
		Less likely	28	17.6	25	15.2	27	16.3	27	16.9	29	18.5	18	21.7	14	17.7	15	18.3	15	19.0	9	14.1
	48-57	More likely	1	1.9	1	1.9	1	2.0	3	4.5	5	7.4	14	11.4	14	11.8	14	11.4	15	11.6	21	13.0
		Less likely	19	11.9	19	11.6	19	11.4	18	11.3	15	9.6	3	3.6	1	1.3	1	1.2	1	1.3	1	1.6
	58-67	More likely	0	0.0	0	0.0	0	0.0	0	0.0	6	8.8	8	6.5	7	5.9	8	6.5	9	7.0	8	4.9
		Less likely	10	6.3	10	6.1	10	6.0	10	6.3	4	2.5	1	1.2	2	2.5	1	1.2	0	0.0	0	0.0
	68-88	More likely	0	0.0	1	1.9	0	0.0	1	1.5	1	1.5	2	1.6	2	1.7	2	1.6	2	1.6	4	2.5
		Less likely	3	1.9	3	1.8	3	1.8	3	1.9	3	1.9	1	1.2	1	1.3	1	1.2	1	1.3	0	0.0
Religion	**Christian**	More likely	21	40.4	21	39.6	21	42.0	29	43.9	21	30.9	54	43.9	54	45.4	55	44.7	56	43.4	63	38.9
		Less likely	66	41.5	67	40.9	67	40.4	64	40.0	68	43.3	31	37.3	27	34.2	30	36.6	29	36.7	26	40.6
	African beliefs	More likely	4	7.7	4	7.5	1	8.0	5	7.6	3	4.4	2	1.6	2	1.7	3	2.4	2	1.6	3	1.9
		Less likely	1	0.6	77	0.6	1	0.6	0	0.0	2	1.3	3	3.6	3	3.8	2	2.4	3	3.8	2	3.1
	No religion	More likely	14	26.9	17	32.1	14	28.0	23	34.8	26	38.2	55	44.7	56	47.1	59	48.0	62	48.1	87	53.7
		Less likely	75	47.2	71	47.0	79	47.6	75	46.9	73	46.5	31	37.3	26	32.9	28	34.1	28	35.4	17	26.6
	Other	More likely	13	25.0	11	20.8	11	22.0	9	13.6	18	26.5	12	9.8	7	5.9	6	4.9	9	7.0	9	5.6
		Less likely	17	10.7	19	11.6	19	11.4	21	13.1	14	8.9	18	21.7	23	29.1	22	26.9	19	24.1	19	29.7

Marital status	Categories	Response options	Violent		Drink too much alcohol		Take illegal drugs		Have poor friendships		Attempt suicide		Understanding other's feelings		Have a good marriage		Be a caring parent		Be a productive worker		Be creative or artistic	
			n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
	Married	More likely	37	71.2	36	67.9	36	72.0	47	71.2	40	58.8	72	58.5	63	52.9	63	51.2	70	54.3	84	51.9
		Less likely	78	49.1	85	51.8	85	51.2	80	50.0	88	56.1	52	62.7	54	68.4	55	67.1	54	68.4	44	68.8
	Living together	More likely	12	23.1	14	26.4	11	22.0	16	24.2	24	35.3	38	30.9	41	34.5	43	35.0	44	34.1	61	37.7
		Less likely	62	39.0	60	36.6	62	37.3	59	36.9	49	31.2	27	32.5	23	29.1	26	31.7	23	29.1	16	25.0
	Never married	More likely	3	5.8	3	5.7	3	6.0	3	4.5	4	5.9	7	5.7	10	8.4	11	8.9	9	7.0	8	4.9
		Less likely	10	6.3	10	6.1	10	6.0	2	6.9	10	6.4	4	4.8	1	1.3	1	1.2	2	2.5	4	6.3
	Other	More likely	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	6	4.9	5	4.2	6	4.9	6	4.7	9	5.5
		Less likely	9	5.7	9	5.5	9	5.4	10	6.3	10	6.4	0	0.0	1	1.3	0	0.0	0	0.0	0	0.0
Education	**No schooling**	More likely	1	1.9	2	3.8	1	2.0	2	3.0	9	14.1	13	10.7	14	11.8	14	11.4	13	10.1	15	9.3
		Less likely	14	9.0	14	8.8	14	8.6	14	9.0	6	3.9	3	3.8	2	2.7	2	2.6	3	4.0	2	3.3
	Primary	More likely	3	5.8	3	5.7	3	6.0	4	6.1	1	1.6	4	3.3	2	1.7	4	3.3	4	3.1	5	3.1
		Less likely	4	2.6	5	3.1	5	3.1	4	2.6	7	4.5	3	3.8	4	5.5	2	2.6	4	5.3	2	3.3
	Secondary	More likely	41	78.8	35	66.0	33	66.0	42	63.6	40	62.5	69	57.0	69	58.0	74	60.2	72	55.8	94	58.0
		Less likely	85	54.8	93	58.1	95	58.6	91	58.3	92	59.4	47	59.5	49	67.1	53	67.9	47	62.7	37	61.7
	Tertiary	More likely	7	13.5	13	24.5	13	26.0	18	27.3	14	21.9	35	28.9	34	28.6	31	25.2	40	31.0	48	29.6
		Less likely	52	33.5	48	30.0	48	29.6	47	30.1	50	32.3	26	32.9	18	24.7	21	26.9	21	28.0	19	31.7

4.5.2. The relationship between Zanele's long term condition by demographic variables.

Table 4.5 presents Zanele's long term condition compared to other people in the community. Participants' gender (0.29), religion (-0.00), marital status (0.00), and township (0.09) were significantly less likely to influence participant's perceptions of Zanele's condition as a predictor of violence or the possibility of drinking too much alcohol in the future.

Furthermore, participant's responses showed that the odds of Zanele taking illegal drugs according to the demographic variables were statistically insignificant, represented by gender (0.14), religion (-0.00), marital status (0.00), township (0. 15), education (0.39) and age (0.19). The variables marital status (0.01) and age (0.01) were statistically significant on perceptions that Zanele was likely to have a good marriage. Furthermore, marital status was statistically significant on perceptions that Zanele was likely to be a caring parent.

Table 4.5

Ordinal Logistic Regression: Zanele's long term condition compared to other people in the community.

Questions	Variables	Odds Ratio	P > |t|	95% Confidence Interval	
				Lower Bound	Upper Bound
Be violent	**Gender**	0.29	0.26	-0.22	0.80
	Religion	-0.00	0.00	-0.00	0.00
	Marital Status	0.00	0.00	-0.00	0.01
	Township	0.09	0.27	-0.44	0.63
	Education	0.56	0.19	0.19	0.93
	Age	0.22	0.12	-0.02	0.46
Drink too much alcohol	**Gender**	0.29	0.26	-0.22	0.80
	Religion	-0.00	0.00	-0.00	0.00
	Marital Status	0.00	0.00	-0.00	0.01
	Township	0.09	0.27	-0.44	0.63
	Education	0.56	0.19	0.19	0.93
	Age	0.22	0.12	-0.02	0.46
Take illegal drugs	**Gender**	0.14	0.26	-0.37	0.65
	Religion	-0.00	0.00	-0.00	-7.43
	Marital Status	0.00	0.00	-0.00	0.01
	Township	0.15	0.28	-0.39	0.69
	Education	0.39	0.19	0.01	0.76
	Age	0.19	0.12	-0.05	0.43
Have poor friendships	**Gender**	0.11	0.26	-0.39	0.62
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	0.00	0.00	-0.00	0.01
	Township	0.29	0.27	-0.22	0.82
	Education	0.36	0.17	-0.01	0.72
	Age	0.16	0.12	-0.08	0.39
Attempt suicide	**Gender**	-0.35	0.26	-0.86	0.16
	Religion	-0.00	0.00	-0.00	0.00
	Marital Status	0.00	0.00	-0.00	0.01
	Township	0.09	0.27	-0.44	0.63
	Education	0.47	0.19	0.01	0.84
	Age	-0.05	0.12	-0.29	0.19
Be understanding of other people's feelings	**Gender**	-0.22	0.25	-0.70	0.26
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	0.20	0.12	-0.04	0.43
	Township	0.28	0.26	-0.23	0.79
	Education	0.42	0.19	0.06	0.78
	Age	-0.10	0.12	-0.35	0.13

Have a good marriage	**Gender**	-0.08	0.24	-0.56	0.31
	Religion	0.00	0.00	0.00	0.00
	Marital Status	**0.01***	0.06	-0.10	0.12
	Township	0.12	0.26	-0.38	0.62
	Education	0.56	0.19	0.11	0.93
	Age	**0.01***	0.12	-0.22	0.24
Be a caring parent	**Gender**	-0.15	0.25	-0.63	0.33
	Religion	0.00	0.00	0.00	0.00
	Marital Status	**0.01***	0.02	-0.02	0.04
	Township	0.08	0.26	-0.43	0.58
	Education	0.76	0.20	0.37	1.15
	Age	-0.00	0.12	-0.24	0.23
Be a productive worker	**Gender**	-0.19	0.25	-0.68	0.21
	Religion	0.00	0.00	0.00	0.00
	Marital Status	0.13	0.12	-0.10	0.36
	Township	0.28	0.26	-0.23	0.71
	Education	0.28	0.19	-0.08	0.65
	Age	-0.17	0.13	-0.41	0.07
Be creative or artistic	**Gender**	0.22	0.27	-0.29	0.74
	Religion	0.00	0.00	0.00	0.00
	Marital Status	-0.00	0.01	-0.02	0.01
	Township	-0.11	0.28	-0.66	0.44
	Education	0.30	0.22	-0.11	0.73
	Age	-0.39	0.14	-0.66	-0.12

*****Significant $p < 0.05$.

4.6. Participant's description of people with mental illness

4.6.1. Description of people with Zanele's condition by demographic variables.

Table 4.6 presents the participants' descriptions of people with Zanele's condition. When participants were assessed on how they would describe a person with Zanele's condition, 38.2 percent of participants between the ages 18 and 27 reported they would describe her as dangerous, while 35.5 percent reported they would describe her as unpredictable. Participants aged 28 to 37 years gave the most responses stating that someone with Zanele's condition was most likely to lack self-control (36.9%), be aggressive (37.1%), and frightening (36.7%).

Table 4.6

Description of people with Zanele's condition by variables (N=266).

Variables	Response options	Dangerous		Unpredictable		Lacking self-control		Aggressive		Frightening	
		n	%	n	%	n	%	n	%	n	%
Township	**KwaMashu**	35	39.3	56	39.7	71	42.3	64	44.0	73	43.2
	Umlazi	54	60.7	85	60.3	97	57.7	79	55.2	96	56.8
Gender	**Female**	39	43.8	66	46.8	77	45.8	59	41.3	78	46.2
	Male	50	56.2	75	53.2	91	54.2	84	58.7	91	53.8
Age	**18-27**	32	38.2	50	35.5	48	28.6	40	28.0	43	25.4
	28-37	31	37.1	46	31.9	62	36.9	54	37.1	58	36.7
	38-47	13	14.6	24	17.0	30	17.9	31	21.7	33	19.5
	48-57	4	4.5	14	9.9	19	11.3	14	9.8	19	11.2
	58-67	3	3.4	6	4.3	6	3.6	2	1.4	8	4.7
	68-88	4	2.2	2	1.4	3	1.8	3	2.1	4	2.4
Religion	**Christian**	40	44.9	55	39.0	66	39.3	57	39.9	59	34.9
	Not religious	31	34.8	68	48.2	84	50.0	67	46.9	89	52.7
	African beliefs	4	4.5	5	3.5	2	1.2	3	2.1	5	3.0
	Other	14	15.6	14	9.2	16	9.5	16	11.2	16	9.2
Marital status	**Married**	45	50.6	69	48.9	84	50.0	67	46.9	82	48.5
	Living together	30	33.7	55	39.0	64	38.1	56	39.2	64	37.9
	Never married	9	10.1	11	7.8	11	6.5	12	8.4	14	8.3
	Other	5	5.6	6	4.2	9	5.4	8	5.6	9	5.4
Education	**No schooling**	6	6.7	13	9.2	13	7.8	8	5.7	17	10.2
	Primary	2	2.2	4	2.8	5	3.0	5	3.5	5	3.0
	Secondary	52	58.4	76	53.9	98	59.0	80	56.7	94	56.3
	Tertiary	29	32.6	48	34.0	50	30.1	48	34.0	51	30.5

When both the townships were assessed on descriptions of someone with Zanele's condition, most participants in KwaMashu reported that they would describe the person as aggressive (44.0%) and frightening (43.2%). Out of the Umlazi participants, the majority reported that they would describe a person like Zanele as dangerous (60.7%) and unpredictable (60.3%).

Concerning gender, over half of the males reported they would describe someone like Zanele as unpredictable (53.2%), aggressive (58.7%) and dangerous (56.2%), while females reported that they would describe a person like Zanele as unpredictable (46.8%) and frightening (46.2%). Concerning religion, Christian participants reported they would describe a person like Zanele as dangerous (44.9%).

Under marital status, most participants who described Zanele as dangerous were married (50.6%), followed by participants who lived with a partner (33.7%). Participants who reported secondary education as their highest level of education described someone like Zanele as lacking self-control (59.0%), aggressive (56.7%), and frightening (56.3%). Participants with tertiary level education used unpredictable (34.0%) and aggressive (34.0%) as their descriptions for someone with Zanele's condition.

4.6.2. The relationship between descriptions of people with Zanele's condition by demographic variables.

Table 4.7 presents the relationship between the descriptions of people with Zanele's condition by demographic variables. When participants were asked about their perception of people with Zanele**'**s condition, age and gender had statistically insignificant odds of perceiving people like Zanele as dangerous, represented by 0.31 and 0.13, respectively. The variables age and education also showed statistically insignificant odds of describing Zanele as unpredictable, 0.28 and 0.27, respectively.

Education showed statistically significant odds of descriptions of people like Zanele as dangerous (0.03). While marital status showed statistically significant odds of people like Zanele as unpredictable.

Table 4.7

Ordinal Logistic Regression: Description of people with Zanele's condition.

Description	Categories	Odds Ratio	P > |t|	95% Confidence Interval	
				Lower Bound	Upper Bound
Dangerous	**Gender**	0.14	0.24	-0.34	0.61
	Religion	-0.00	0.00	-0.00	0.00
	Marital Status	0.00	0.01	-0.01	0.02
	Township	-0.48	0.26	-0.98	0.02
	Education	**0.03***	0.18	-0.31	0.37
	Age	0.33	0.12	0.01	0.55
Unpredictable	**Gender**	-0.05	0.25	-0.54	0.45
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	**0.01***	0.01	-0.01	0.03
	Township	-0.68	0.26	-1.19	-0.16
	Education	0.27	0.18	-0.09	0.63
	Age	0.29	0.12	0.06	0.52
Lacking self-control	**Gender**	0.15	0.27	-0.38	0.68
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	-0.12	0.14	-0.31	0.15
	Township	-0.33	0.28	-0.89	0.22
	Education	0.21	0.10	-0.18	0.60
	Age	0.08	0.13	-0.18	0.33
Aggressive	**Gender**	0.58	0.26	0.08	1.08
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	-0.49	0.15	-0.78	-0.19
	Township	0.13	0.27	-0.40	0.66
	Education	-0.32	0.18	-0.68	0.03
	Age	0.19	0.12	-0.05	0.43
Frightening	**Gender**	0.25	0.27	-0.28	0.78
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	-.258	0.16	-0.56	0.05
	Township	-0.03	0.29	-0.51	0.53
	Education	0.28	0.21	-0.13	0.61
	Age	-0.14	0.14	-0.41	0.13

*Significant $p < 0.05$.

4.7. Willingness to have contact with someone with Zanele's condition.

Table 4.8 presents the participants' willingness to have contact with someone who has a condition similar to Zanele's condition. Participants were asked if they would be willing to move next door to Zanele, spend an evening socializing with Zanele, make friends with Zanele, have a relationship with Zanele, have Zanele start working closely with them on a job, live in the same room with Zanele, or have people like Zanele living in their neighborhood.

4.7.1. Willingness to have contact with someone with Zanele's condition by demographic variables.

When participants were asked about their willingness to have contact with Zanele, the group aged 28 to37 years had the highest percentage of individuals who were willing to move next door to Zanele (37.4%), would be willing to spend an evening socializing with Zanele (39.9%) and would be willing to make friends with Zanele (39.5%).

The age group 18 to 27 had the second-highest percentages of participants willing to contact someone like Zanele. When they were asked if they were willing to have a relationship with Zanele, 37.0 percent reported they would be willing, and 43.3 percent reported they were willing to work closely with her on a job, while 38.2 percent reported they were willing to have Zanele looking after their children.

Concerning gender, more males (59.2%) than females (40.8%) expressed willingness to work closely with someone who has Zanele's condition. Furthermore, more males (57.0%) than females (43.0%) reported they would be willing to make friends with someone like Zanele. Likewise, more males (57.8%) than females (42.2%) said they would have a relationship with someone who has Zanele's condition.

Table 4.8

Willingness to have contact with someone with Zanele's condition by demographic variables. (N=266).

Variables		Move next door		Socialise		Make friends		Have a relationship		Work closely		Looking after your children		Live in the same room		live in your neighbourhood	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Township	**KwaMashu**	107	50.7	108	51.9	107	51.0	69	69.0	63	70.0	60	78.9	70	71.4	104	50.2
	Umlazi	104	49.3	100	48.1	103	49.0	31	31.0	27	30.0	16	21.1	28	28.6	103	49.8
Gender	**Female**	98	45.7	95	44.8	94	43.0	43	42.2	38	40.8	31	43.9	43	43.9	94	45.4
	Male	113	54.3	113	55.2	116	57.0	57	57.8	52	59.2	45	56.1	55	56.1	113	54.6
Age	**18-27**	52	27.5	60	28.8	58	27.6	37	37.0	39	43.3	29	38.2	39	39.8	56	27.1
	28-37	79	37.4	84	39.9	83	39.5	39	45.0	36	40.0	37	50.0	37	37.8	81	39.1
	38-47	39	18.5	38	18.3	37	17.6	11	11.0	9	10.0	6	7.9	11	11.2	36	17.4
	48-57	22	10.4	16	7.7	21	10.0	5	4.0	6	6.7	3	3.9	9	9.2	20	9.7
	58-67	9	4.3	8	3.8	9	4.3	1	1.0	0	0.0	0	0.0	0	0.0	10	4.8
	68-88	4	1.9	3	1.4	2	1.0	2	2.0	0	0.0	0	0.0	2	2.0	4	1.9
Marital status	**Married**	118	55.9	123	59.1	122	58.1	75	75.0	67	74.4	39	77.6	70	71.4	119	57.5
	Living together	70	33.2	63	30.3	67	31.9	22	22.0	23	25.6	14	18.4	21	21.4	65	31.4
	Never married	13	6.2	13	6.3	13	6.2	1	1.0	0	0.0	3	3.9	3	3.1	13	6.3
	Other	9	3.9	9	4.4	7	3.4	3	2.0	0	0.0	0	0.0	4	4.0	9	4.4
Religion	**Christian**	78	37.0	81	38.9	79	37.6	45	45.0	48	53.3	34	44.7	43	43.9	79	38.2
	Not religious	104	49.3	96	46.2	100	47.6	26	26.0	13	14.4	12	15.8	27	27.6	99	47.8
	African beliefs	3	1.4	3	1.4	31	1.4	2	2.0	3	3.3	2	2.6	2	2.0	3	1.4
	Other	26	12.3	78	13.5	28	13.4	27	27.0	26	28.9	28	36.8	26	26.5	26	12.6
Education	**No schooling**	16	7.8	15	7.4	14	6.9	2	2.1	0	0.0	0	0.0	2	2.2	16	8.0
	Primary	8	3.9	7	3.5	6	2.9	2	2.1	2	2.4	3	4.3	5	5.4	6	3.0
	Secondary	127	62.0	122	60.4	126	61.8	59	62.8	48	57.1	45	64.3	57	62.0	121	60.2
	Tertiary	54	26.3	58	28.7	58	28.4	31	33.0	34	40.5	22	31.4	28	30.4	58	28.9

Concerning religion, 53.3 percent of Christians reported that they would work closely with someone who has the same condition as Zanele, while 45.0 percent reported they would have a relationship with someone like Zanele and 44.7 percent reported they would have someone like Zanele looking after their children. Participants who identified as not religious had the highest proportion with a willingness to live next door to someone like Zanele (49.3%), while 46.2 percent reported they would be willing to spend an evening socializing with someone like Zanele.

Out of all the married participants, 75.0 percent reported they would be willing to have a relationship with Zanele, while 74.4 percent reported they would be willing to work closely with someone like Zanele and 77.6 percent reported they would be willing to have someone like Zanele looking after their children. Overall, concerning education, the highest percentage of participants who reported they would be willing to have someone like Zanele looking after their children was those with secondary schooling as their highest level of education (64.3%), followed by those with a tertiary level education (31.4%).

4.7.2. The relationship between willingness to have contact with someone with Zanele's condition and demographic variables.

Table 4.9 presents the relationship between willingness to have contact with someone with Zanele's condition by demographic variables. Education and residing in the township had statistically insignificant odds of willingness to move next door to someone with Zanele's condition (0.84) and (0.74), respectively. The variable marital status was statistically insignificant on willingness to live in the same room with Zanele (5.74), followed by residing in a township (0.98). The variable gender was positively correlated with the participants' willingness to live in the same room with Zanele (0.04).

Table 4.9

Ordinal Logistic Regression: Willingness to have contact with someone with Zanele's condition.

Questions	Categories	Odds Ratio	P > |t|	95% Confidence Interval	
				Lower Bound	Upper Bound
How willing would you be to move next door to Zanele	**Gender**	0.00	0.33	-0.63	0.64
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	-0.00	0.02	-0.04	0.03
	Township	0.74	0.36	0.04	1.45
	Education	0.85	0.29	0.28	1.43
	Age	-0.28	0.17	-0.61	0.06
Willingness to spend an evening socialising with Zanele?	**Gender**	0.14	0.32	-0.48	0.76
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	0.00	0.00	-0.00	0.01
	Township	0.80	0.35	0.12	1.48
	Education	0.67	0.25	0.17	1.16
	Age	0.09	0.15	-0.21	0.38
Willingness to make friends with Zanele?	**Gender**	0.16	0.31	-0.46	0.77
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	-0.00	0.01	-0.03	0.02
	Township	0.64	0.34	-0.03	1.31
	Education	0.27	0.24	-0.20	0.74
	Age	-0.12	0.15	-0.42	0.18
Willingness to have a relationship with Zanele?	**Gender**	0.21	0.25	-0.29	0.70
	Religion	-0.00	0.00	-0.00	-0.00
	Marital Status	0.30	0.13	0.05	0.56
	Township	0.71	0.26	0.29	1.30
	Education	-0.12	0.19	-0.48	0.24
	Age	0.19	0.12	-0.06	0.43
Willingness to have Zanele start working closely with you on a job?	**Gender**	-0.02	0.25	-0.50	0.46
	Religion	-0.00	0.00	-0.00	-0.00
	Marital Status	-0.00	0.00	-0.01	0.00
	Township	0.76	0.25	0.26	1.25
	Education	-0.33	0.18	-0.68	0.02
	Age	0.12	0.11	-0.11	0.34
Willingness to have Zanele looking after your children?	**Gender**	-0.01	0.28	-0.56	0.54
	Religion	-0.00	0.00	-0.00	-0.00
	Marital Status	0.00	0.00	-0.00	0.01
	Township	0.76	0.29	0.19	1.33
	Education	0.13	0.11	-0.26	0.52
	Age	0.13	0.13	-0.13	0.38
Willingness to live in the same room with Zanele?	**Gender**	**0.04***	0.26	-0.47	0.55
	Religion	-0.00	0.00	-0.00	-0.00
	Marital Status	5.74	0.00	-0.00	0.00
	Township	0.98	0.27	0.45	1.51
	Education	-0.07	0.18	-0.43	0.29
	Age	-0.06	0.12	-0.29	0.18
Willingness to have people like Zanele living in your neighbourhood?	**Gender**	0.13	0.31	-0.47	0.74
	Religion	0.00	0.00	-0.00	0.00
	Marital Status	-0.00	0.02	-0.04	0.03
	Township	0.57	0.34	-0.09	1.23
	Education	0.32	0.25	-0.17	0.81
	Age	-0.31	0.16	-0.62	0.01

*Significant $p < 0.05$.

4.8. Stigma towards Zanele's condition.

4.8.1. Stigma towards Zanele's condition by demographic variables.

Table 4.10 presents the participants' stigma towards Zanele's condition. The majority of participants who resided in KwaMashu (60.5%) reported that they would avoid someone with Zanele's problem, while others reported that they would not employ someone like Zanele to work for them (60.5%). Most participants from Umlazi (61.6%) reported that Zanele's problem was a sign of personal weakness. Some participants reported that Zanele's problem was not a real medical illness (57.6%) and over half reported that people with a problem like Zanele were dangerous (54.7%).

When the data were aggregated according to age groups, ages 28 to 37 ranked the highest of participants who reported that Zanele's condition was a sign of personal weakness (46.3%) and not a real illness (46.6%). Participants aged between 18 to 27 years reported that people with symptoms like Zanele were most likely to be dangerous (42.2%), and reported that it was best to avoid people like Zanele so one would not develop the same problem (55.8%). Also, most participants within the ages 18 to 27 reported that they would not employ someone like Zanele to work for them (50.0%).

Overall, more males (55.1%) than females (44.9%) reported that Zanele's problem was not a real medical illness. Furthermore, more males (54.1%) than females (45.9%) reported that Zanele's condition was a sign of personal weakness. More males (54.7%) than females (45.3%) also reported that people with a problem like Zanele were dangerous. Furthermore, more males (60.5%) than females (39.5%) reported that they would not employ someone with a problem like Zanele. Participants with a secondary level education reported that Zanele's condition was

a sign of personal weakness (51.4%), compared to participants with tertiary level education (33.1%) and participants who reported having never gone to school (10.6%).

Table 4.10

Stigma towards Zanele's condition by demographic variables (N=266).

Demo-graphic variables	Response options	A sign of personal weakness		Not a real illness		People like Zanele are dangerous		Avoid Zanele so not to contract her problem		Not employ someone with a problem like Zanele's	
		n	%	n	%	n	%	n	%	n	%
Township	**KwaMashu**	56	38.4	50	42.4	29	45.3	26	60.5	23	60.5
	Umlazi	90	61.6	68	57.6	35	54.7	17	39.5	15	39.5
Gender	**Female**	67	45.9	53	44.9	29	45.3	19	44.2	15	39.5
	Male	79	54.1	65	55.1	35	54.7	24	55.8	23	60.5
Age	**18-27**	37	25.3	27	22.9	27	42.2	24	55.8	19	50.0
	28-37	53	36.3	55	46.6	24	37.5	15	34.9	17	44.7
	38-47	26	17.8	21	17.8	8	12.5	3	2.3	1	2.6
	48-57	18	12.3	11	9.3	2	3.1	1	7.0	1	2.6
	58-67	8	5.5	3	2.5	2	4.7	0	0.0	0	0.0
	68-88	2	2.7	1	0.8	0	0.0	0	0.0	0	0.0
Religion	**Christian**	59	40.4	42	35.6	24	37.5	26	60.5	23	60.5
	African traditional	0	0.0	0	0.0	4	6.3	0	0.0	0	0.0
	Not religious	77	52.7	66	55.9	24	37.5	3	7.0	2	5.3
	Other	10	7.9	10	8.4	12	18.8	14	32.5	13	34.2
Marital status	**Married**	74	50.7	68	57.6	45	70.3	32	74.4	27	71.1
	Living together	57	39.0	32	27.1	13	20.3	9	20.9	9	23.7
	Never married	7	4.8	13	11.0	5	7.8	2	4.7	2	5.3
	Other	8	5.5	5	4.2	1	1.6	0	0.0	0	0.0
Education	**No schooling**	15	10.6	5	4.4	2	3.3	1	2.6	1	2.9
	Primary	7	4.9	7	6.1	4	6.7	0	0.0	0	0.0
	Secondary	73	51.4	71	58.3	35	42.3	18	54.0	16	54.8
	Tertiary	47	33.1	31	27.2	19	31.7	20	51.3	17	50.0

4.8.2. The relationship between stigma towards Zanele's condition by demographic variables.

Table 4.11 presents the odds ratios for the relationship between perceptions about Zanele's condition and demographic variables. The variable education (0.24) was statistically insignificant on perceptions that Zanele's condition was a sign of personal weakness. Education also seemed to be statistically insignificant on perceptions that Zanele's condition is not a real illness (0.22). Residing in a township (0.26) appeared to be statistically insignificant on perceptions that someone like Zanele was likely to be dangerous.

Table 4.11

Ordinal Logistic Regression: Stigma towards Zanele's condition.

Questions	Variables	Odds Ratio	P > |t|	95% Confidence Interval	
				Lower Bound	Upper Bound
A sign of personal weakness	**Gender**	-0.07	0.26	-0.57	0.43
	Religion	0.00	0.00	0.00	0.00
	Marital Status	-0.00	0.01	-0.02	0.02
	Township	-0.33	0.27	-0.86	0.19
	Education	0.24	0.11	-0.15	0.63
	Age	-0.28	0.13	-0.53	-0.04
Not a real illness	**Gender**	**0.04***	0.25	-0.45	0.53
	Religion	0.00	0.00	0.00	0.00
	Marital Status	-0.16	0.12	-0.40	0.08
	Township	-0.01	0.26	-0.53	0.50
	Education	0.22	0.18	-0.13	0.58
	Age	0.13	0.12	-0.11	0.37
Dangerous	**Gender**	**0.03***	0.24	-0.44	0.51
	Religion	-0.00	0.00	-0.00	0.00
	Marital Status	-0.00	0.00	-0.00	0.00
	Township	0.26	0.25	-0.24	0.76
	Education	0.06	0.18	-0.29	0.4
	Age	0.26	0.12	0.03	0.49

Avoid Zanele's so you don't develop this problem	**Gender**	-0.06	0.26	-0.56	0.45
	Religion	-0.00	0.00	-0.00	0.00
	Marital Status	-0.00	0.00	-0.01	0.00
	Township	0.36	0.27	-0.18	0.89
	Education	**0.03***	0.19	-0.34	0.39
	Age	0.05	0.12	-0.18	0.29
Not employ someone like Zanele's	**Gender**	0.23	0.26	-0.28	0.74
	Religion	-0.00	0.00	-0.00	-0.00
	Marital Status	0.00	0.01	-0.02	0.03
	Township	0.66	0.27	0.12	1.19
	Education	-0.06	0.21	-0.47	0.35
	Age	0.69	0.1	0.42	0.97

*****Significant $p < 0.05$.

Furthermore, residing in a township also showed statistically insignificant (0.36) perceptions that someone like Zanele was best avoided, so not to develop a problem like hers. The variable gender showed statistically significant odds on attitudes that Zanele's problem is not a real illness (0.04) and that someone like Zanele is likely to be dangerous (0.03). Furthermore, the variable education showed statistically significant odds on attitudes stating that it is best to avoid someone like Zanele (0.03), so not to develop the same problem.

4.9. Discrimination against someone with Zanele's condition.

4.9.1. Discrimination against Zanele by demographic variables.

Table 4.12 presents discrimination against Zanele by demographic variables. When participants were asked if they would accept or discriminate against Zanele in the community, most participants from KwaMashu (61.8%) and Umlazi (93.4%) reported that they would not discriminate against Zanele. Furthermore, the majority of males (81.3) and females (78.2%) reported that they would not discriminate against Zanele. When the level of discrimination was assessed across the different age groups, all of the age groups ranked high on not discriminating

against Zanele, with 18 to 27 years at 70.0%, 28 to 37 years at 84.3% 38 to 47 years at 79.2%, 48 to 57 years at 91.3%, 58 to 67 years at 100.0%, and 68 to 88 years at 50.0%.

When the variable religion was assessed for discrimination, the majority of participants who reported they would not discriminate against Zanele (88.1%) identified themselves as not religious, followed by Christian participants (82.8%). Furthermore, participants living with a partner (86.7%), and those who were married (73.4%) reported they would not discriminate against someone like Zanele. Participants with tertiary level education reported the least amount of discrimination (5.3%), when compared to the other education categories.

Table 4.12

Discrimination against Zanele by demographic variables (N=266).

Variables	Response options	n	Yes %	n	No %
Township	**KwaMashu**	39	38.2	63	61.8
	Umlazi	9	6.6	127	93.4
Gender	**Female**	24	21.8	86	78.2
	Male	24	18.8	104	81.3
Age	**18-27 Years**	21	30.0	49	70.0
	28-37 Years	13	15.7	70	84.3
	38-47 Years	10	20.8	38	79.2
	48-57 Years	2	8.7	21	91.3
	58-67 Years	0	0.0	10	100.0
	68-88 Years	2	50.0	2	50.0
Religion	**Christian**	17	17.2	82	82.8
	African traditional spiritual beliefs	4	100.0	0	0.0
	Not religious	13	11.9	96	88.1
	Other	14	54.2	10	45.8
Marital status	**Married**	34	26.6	94	73.4
	living together	11	13.3	72	86.7
	never married	1	5.9	16	94.1
	Other	2	28.6	7	71.4
Education	**Never went to school**	3	17.6	14	82.4
	Primary	1	12.5	7	87.5
	Secondary	40	29.9	94	70.1
	Tertiary	4	5.3	71	94.7

4.9.2. The relationship between discrimination against Zanele by demographic variables.

Table 4.13 presents the relationship between discrimination against Zanele's condition by demographic variables. Residing in a township showed to have statistically insignificant odds (1.98) of discrimination against Zaneles' condition, followed by education (0.82), marital status (0.22) and age (0.21).

Table 4.13

Ordinal Logistic Regression: Discrimination against Zanele by community members.

Variables	Odds Ratio	P > |t|	95% Confidence Interval	
			Lower Bound	Upper Bound
Gender	0.11	0.40	-0.67	0.81
Religion	-0.00	0.00	-0.00	-5.00
Marital Status	0.22	0.22	-0.21	0.65
Township	1.98	0.45	1.10	2.86
Education	0.82	0.21	0.24	1.31
Age	0.21	0.19	-0.16	0.58

*Significant $p < 0.05$.

4.10. Treatment preferences for mental illness.

4.10.1. Treatment preferences by demographic variables

Table 4.14 presents the participants' treatment preferences for mental illness. Most participants from Umlazi (64.7%) reported that dealing with her own problem would be the best form of treatment, followed by a preference for over-the-counter medication, through a pharmacist (63.5%). In Umlazi, the highest percentage of participants (56.2%) reported their treatment preference to be a diviner, followed by a herbalist (55.9%).

When males were compared with females, more males (52.0%) reported a preference for treatment by a medical doctor, compared to females (48.0%). Furthermore, more males

(54.6%) showed a preference for treatment by a psychiatrist compared to females (45.4%). Moreover, more males showed preference for treatment by a psychologist (54.5%) compared to females (45.5%). On the education variable, women who had a secondary level education found doctors (62.2%), pharmacists (62.7%), and dealing with problems independently (61.7%) as the most preferred form of treatment for mental illness.

Table 4.14

Treatment preferences by variables (N=266).

Variables		Family GP/ Doctor		Pharmacist		A Counsellor		Social Worker		Telephone Counselling,		A Psychiatrist		A Psychologist		Help from close family		Help from close friends		Diviner		Herbalist		Faith healer		Church Minister/Priest/ Pastor		To deal with her problem on her own	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Township	**Umlazi**	113	57.1	54	63.5	104	52.3	107	52.7	98	52.4	107	51.7	110	52.1	109	52.4	100	52.1	67	43.8	67	44.1	71	45.2	98	49.7	33	64.7
	KwaMashu	85	42.9	31	36.5	95	47.7	96	47.3	89	47.6	100	48.3	101	47.9	99	47.6	92	47.9	86	56.2	85	55.9	86	54.8	99	50.3	18	35.3
Gender	**Female**	95	48.0	46	54.1	90	45.2	94	46.3	86	46.0	94	45.4	96	45.5	95	45.7	90	46.9	78	51.0	77	50.7	79	50.0	90	45.7	22	43.1
	Male	103	52.0	39	45.9	109	54.8	109	53.7	101	54.0	113	54.6	115	54.5	113	54.3	102	53.1	75	49.0	75	49.3	78	49.7	107	54.3	29	56.9
Age	**18-27**	55	27.8	31	36.5	59	29.6	61	30.0	57	30.5	62	30.0	65	30.8	65	31.3	60	31.3	39	25.5	38	25.0	39	24.8	54	27.4	15	29.4
	28-37	84	42.4	36	42.4	80	40.2	79	38.9	75	40.1	80	38.6	80	37.9	77	37.0	70	36.5	58	37.9	58	38.2	60	38.2	76	38.6	27	52.9
	38-47	30	15.2	10	11.8	30	15.1	33	16.3	25	13.4	34	16.4	35	16.6	35	16.8	32	16.7	29	19.0	29	19.1	31	19.7	36	18.3	9	17.6
	48-57	19	9.6	5	5.9	19	9.5	19	9.4	19	10.2	20	9.7	20	9.5	20	9.6	20	10.4	14	9.2	14	9.2	14	8.9	20	10.2	0	0.0
	58-67	9	4.5	3	3.5	10	5.0	10	4.9	10	5.3	10	4.8	10	4.7	10	4.8	9	4.7	9	5.9	9	5.9	9	5.7	10	5.1	0	0.0
	68-88	1	0.5	0	0.0	1	0.5	1	0.5	1	0.5	1	0.5	1	0.5	1	0.5	1	0.5	4	2.6	4	2.6	4	2.5	1	0.5	0	0.0
Religion	**Christian**	77	38.9	34	40.0	75	37.7	78	38.4	73	39.0	83	40.1	83	39.3	81	38.9	73	38.0	42	27.5	41	27.0	43	27.4	80	40.6	24	47.1
	African traditional	5	2.5	3	3.5	4	2.0	5	2.5	3	1.6	4	1.9	5	2.4	5	2.4	5	2.6	2	1.3	2	1.3	2	1.3	3	1.5	0	0.0
	No religion	90	45.5	23	27.1	94	47.2	96	47.3	87	46.5	96	46.4	97	46.0	96	46.2	89	46.4	92	60.1	92	60.5	94	59.9	96	48.7	10	19.6
	Other	26	13.0	25	29.4	26	13.0	24	11.8	24	12.8	23	11.6	26	12.3	26	12.5	25	13.0	17	11.1	17	11.2	18	11.4	18	9.1	17	33.3
Marital status	**Married**	117	59. 1	52	61.2	118	59.3	120	59.1	114	61.0	121	58.5	123	58.3	122	58.7	110	57.3	77	50.3	76	50.0	79	50.3	111	56. 3	32	62.7
	Living together	64	32.3	26	30.6	66	33.2	68	33.5	57	30.5	67	32.4	68	32.2	66	31.7	64	33.3	54	35.3	54	35.5	56	35.7	66	33.5	16	31.4
	Never married	11	5.6	6	7.1	9	4.5	9	4.4	10	5.3	13	6.3	14	6.6	14	6.7	12	6.3	14	9.2	14	9.2	14	8.9	14	7.1	3	5.9
	Other	6	3.0	1	1.2	6	3.0	6	3.0	6	3.2	6	2.9	6	2.8	6	2.9	6	3.1	8	5.3	8	5.3	8	5.1	6	2.5	0	0.0
Education	**No schooling**	12	6.1	1	1.2	12	6.1	11	5.5	11	5.9	12	5.9	12	5.7	12	5.8	12	6.3	16	10.7	16	10.8	16	10.5	12	6.2	0	0.0
	Primary	8	4.1	5	6.0	7	3.6	8	4.0	8	4.3	8	3.9	8	3.8	8	3.9	7	3.7	4	2.7	4	2.7	4	2.6	7	3.6	2	4.3
	Secondary	122	62.2	52	62.7	116	58.9	116	57.7	110	59.5	122	59.5	125	59.8	125	60.7	111	58.4	84	56.4	84	56.8	87	56.9	114	59.1	29	61.7
	Tertiary	54	27.6	25	30.1	62	31.5	66	32.8	56	30.3	63	30.7	64	30.6	61	29.6	60	31.6	45	30.2	44	29.7	46	30.1	60	31.1	16	34.0

4.10.2. Thematic analysis of treatment preferences

Overall, individuals who identified a form of mental illness also provided an understanding that a skilled health professional would be able to treat the symptoms outlined in the vignette.

Theme 1: help from health or mental health professional

Most participants reported that they would seek help from a health professional, such as a medical health care practitioner or a mental health care worker.

> *UP15: "Seek professional help, either by a doctor or a psychologist."*

> *KP62: "Yes… I would seek help… through either a medical health professional… a psychologist… or a social worker."*

Theme 2: Treatment by traditional healers

Out of the 266 participants that were interviewed, 43.8 percent in Umlazi and 56.2 percent in KwaMashu showed a preference for traditional treatment methods of healing. Most of these individuals (70%) understood the vignette symptoms as emanating from ancestral anger. The extracts below show that the participants reported that the preferred form of healing was to appease the ancestors by attending to their demands.

> *UP3: "Get the help of the nearest trusted traditional healer… to begin the process of answering her calling."*

> *KP164: "Needs help from a diviner… to help her connect with her spiritual side.*

Theme 3: help from faith-based workers

Furthermore, 45.2 percent of participants in Umlazi and 54.8 percent in KwaMashu seemed to have a preference for faith-based workers. The extracts below show that some of the participants reported their preferred form of healing to be a faith-based healer.

> *KP9: "Seek assistance by the church… maybe faith healers."*

> *KP17: "Go to the nearest church and talk to a church elder…with experience in spiritual healing.*

4.10.3. Likely helpful medicines for treating mental illness by demographic variables.

Table 4.15 presents the likely helpful medicines for treating mental illness. Participants from Umlazi reported traditional medicine (59.2%) and sleeping pills (56.5%) to be most helpful. Participants from KwaMashu reported vitamins (51.7%), tranquilizers (52.2%), and antidepressants (48.1%) to be most helpful. Furthermore, males reported antidepressants (61.5%) and antibiotics (60.0%) to be most helpful, while females showed a preference for vitamins, minerals and tonics, (46.6%), followed by traditional medicine (44.4%) and antibiotics (40.0%).

Married participants showed a preference for antidepressants (60.9%), antibiotics (68.3%), and tranquilizers (73.1%). Participants who identified as Christian showed a preference for vitamins, minerals and tonics (51.7%) and tranquilizers (52.2%). Participants with a secondary level education showed a preference for antidepressants (69.1%), traditional healers (63.0%), sleeping pills (65.4%), antipsychotics (64.3%), and tranquilizers (60.3%).

Table 4.15

Likely Helpful Medicines by variables (N=266).

Variables		Vitamins, minerals and tonics		Traditional Medicine		Pain relievers		Anti-depressant		Anti-biotics		Sleeping pills		Anti-psychotics		Tranquilizers such as Valium	
		n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Township	**KwaMashu**	30	51.7	58	40.8	34	54.8	75	48.1	28	46.7	37	43.5	76	47.2	35	52.2
	Umlazi	28	48.3	84	59.2	28	45.2	81	51.9	32	53.3	85	56.5	85	52.8	32	57.8
Gender	**Female**	27	46.6	63	44.4	26	41.9	60	38.5	24	40.0	37	43.5	70	43.5	29	43.3
	Male	31	53.4	79	55.6	36	58.1	96	61.5	36	60.0	48	56.5	91	56.5	38	56.7
Age	**18-27**	19	32.8	34	23.9	21	33.9	48	30.8	26	43.3	27	31.8	46	28.6	35	52.2
	28-37	22	37.9	49	34.5	26	41.9	62	39.7	20	33.3	32	37.6	60	37.3	20	29.9
	38-47	7	12.1	28	19.7	8	12.9	26	16.7	7	11.7	16	18.8	24	14.9	7	10.4
	48-57	9	15.5	17	12.0	3	4.8	15	9.6	5	8.3	6	7.1	20	12.4	3	4.5
	58-67	1	1.7	10	7.0	3	4.8	4	2.6	1	1.7	4	4.7	10	6.2	2	3.0
	68-88	0	0.0	4	2.8	1	1.6	1	0.6	1	1.7	0	0.0	1	0.6	0	0.0
Religion	**Christian**	30	51.7	44	31.0	25	40.3	72	46.2	21	35.0	33	38.8	71	44.1	35	52.2
	Not religious	19	32.8	85	59.9	26	41.9	69	44.2	31	51.7	42	49.4	77	47.8	19	28.4
	African beliefs	1	1.7	1	0.7	1	1.6	4	2.6	1	1.7	1	1.2	3	1.9	2	3.0
	Other	8	13.8	12	8.5	10	16.1	11	7.1	7	11.7	9	10.6	10	6.2	11	16.4
Marital Status	**Married**	26	44.8		43.7	34	54.8	95	60.9	41	68.3	47	55.3	90	55.9	49	73.1
	Living together	23	39.7	62	40.8	14	22.6	44	28.2	12	20.0	25	29.4	54	33.5	13	19.4
	Never married	9	15.5	6	9.2	11	17.7	13	8.3	6	10.0	11	12.9	1	8.1	5	7.5
	Other	0	0.0	73	6.3	3	4.8	4	2.5	1	1.7	1	2.4	14	2.5	0	0.0
Education	**No schooling**	1	1.9	15	10.9	1	1.7	2	1.3	1	1.8	2	2.5	11	7.0	1	1.6
	Primary	2	3.7	4	2.9	1	1.7	5	3.3	2	3.6	3	3.7	5	3.2	1	1.6
	Secondary	31	57.4	87	63.0	31	53.4	105	69.1	30	53.6	53	65.4	101	64.3	38	60.3
	Tertiary	20	37.0	32	23.2	25	43.1	40	26.3	23	41.1	23	28.4	40	25.5	23	36.5

4.11. Summary

Based on this research results, while some participants were able to identify symptoms of the vignette as resulting from either stress or depression, none of the participants identified schizophrenia as a form of illness. Based on the result of this study, residing in a township does not directly negatively affect perceptions of mental illness. Participant's variables such as gender, age, religion, marital status and education are most likely to influence individuals' perceptions of mental illness and treatment preferences.

Furthermore, in KwaMashu and Umlazi, age, gender, religion, marital status, and education are critical variables affecting township residents' perceptions of mental illness. The education and township variables were more welcoming towards people living with mental illness, and showed a willingness to coexist with someone like Zanele. Marital status, older age, and religion were found to have a lesser likelihood of willingness to be welcoming or to live side-by-side with someone like Zanele.

Chapter Five: Discussion

5.1. Introduction

While a lack of mental health literacy has been defined as a global problem, it significantly affects the third world countries (Weeks, 2012). Studies conducted in Sub-Saharan Africa and Australia have highlighted that a vast number of people living with mental illness are misunderstood, and most communities live most of their lives without the appropriate interventions for the experienced mental disorders (Petersen et al., 2017; Jorm et al., 2007). This has dire implications for the future of those living with mental illness and their families.

By understanding the perceptions of mental illness, and the largely overlooked social context experienced by people living in townships, the government of South Africa will be better able to implement policies and programs that would lead to improved mental health interventions. This chapter discusses the main findings of the study. The questions that informed the study are presented, to assist the reader to better link the main findings of the study with the findings obtained from the study.

The questions that informed the study are:

1. What are the perceptions of mental illness among African residents of eThekwini District Municipality?
2. What are the participants' treatment preferences for mental illness?
3. What are the attitudes toward mental illness among the African residents of the eThekwini District Municipality?

5.2. Perceptions of mental illness among African residents of eThekwini District Municipality.

Recent research has revealed that for South Africans, more especially township dwellers, mental health literacy is limited, leading many with mental health disorders to live most of their lives without ever being treated for the experienced conditions (Burns & Tomita, 2015). The difficulty with diagnosing most of the experienced mental health issues has been attributed to Western models' failure to align with the cultural and religious influences, that have so long been pioneering models of healing according to individual ways of knowing and understanding (Kleinman, 1998; Kometsi, 2016).

In this study, participants that responded to open-ended questions on their understanding of Zanele's condition appeared to be primarily informed by contextual beliefs of what illness is, and how it may best be treated. Mental illness perceptions seemed to center on religious and spiritual aspects that were also believed only to be ameliorated through a ceremonial cleansing. Out of the 266 participants interviewed in KwaMashu and Umlazi Township, the highest percentage of participants who reported having some understanding of mental illness was predominantly those in Umlazi township. Representing 59.6 percent on understanding of mental illness as a result of a chemical imbalance in the brain, and 58.4 percent on understanding of mental illness as a result of stressful circumstances.

On the variable marital status, participants who were married reflected the highest percentage of individuals who had some understanding of mental health disorders, representing 50.0 percent on chemical imbalance in the brain, followed by those living with a partner (36.1%). However, on the contrary, most negative perceptions of mental illness were observed amongst participants from Umlazi township, where they reported that mental illness is a result of the individuals own bad character (63.4%). Previous research has also suggested that people living

with mental illnesses are perceived as violent and dangerous by most community members, leading them to live as outcasts in society as they tend to be avoided and ostracized by their family members and communities (Baird & Sheffield, 2016).

Similar to the qualitative and quantitative findings of this study, when Burns and Tomita (2015) conducted a study on mental health literacy in Sub-Saharan Africa, they found that mental illness was understood as demonic possession, affliction by the supernatural forces and punishment for sins. Thus, in a world that already carries its own meaning and ways of treatment, future interventions must work hand-in-hand with the existing system to offer a holistic approach to mental health treatment. The implementation of new treatments that consider the preexisting methods of healing will be better received by the communities that are already holding their own worldviews and explanatory models.

Furthermore, while it appears to many psychiatric professionals that mental illness is less understood in townships and many under resourced areas, where people have less access to medical and psychiatric services, what cannot be denied is the reality that mental illness exists across cultures, and how each culture tackles symptoms that are out of the norm is different. Unlike the western world, in the African context, this is where faith- based healers, diviners and herbal healers are often sought since they hold knowledge and wisdom passed down from centuries, and this knowledge often carries meanings of illness, treatment methods, and ways of prevention (Burns & Tomita, 2015).

These healers are approached for assistance mainly because they form part of the explanatory models surrounding African spirituality, where when a person is presenting with symptoms of illness, it is often thought that an individual's being is not aligned with the cosmic entities. The above understanding explains the understanding of mental illness that most participants

provided, and their preference for traditional healing as the best form of treatment and management of symptoms.

Therefore, while the western models are useful in treating mental illness, there needs to be a shift towards patient-centered service delivery that incorporates individual perceptions of mental illness in the health care process (Baird & Sheffield, 2016; Kometsi, 2016). Not only will this approach be applicable to the majority of people, but it will also not be too alien from what people already know. Furthermore, using the adopted mental health care systems, fused with pre-existing healing methods, will not bring about feelings of change from what individuals have grown to know.

While there has been increased exposure to medical facilities and mental health interventions over time, people living in less advanced areas have fewer available options apart from indigenous knowledge, which may fall short due to the ever-changing nature of societies and the lack of advancement in resources. The lack of understanding of mental illness and the available treatment options were observed amongst participants that were interviewed in KwaMashu township, who reported a preference for pain relievers (54.8%), vitamins, minerals and tonics (51.7%) for treating mental illness. This finding is largely due to the reality that a large part of South Africa, mainly rural areas and townships, are currently faced with a lack of educational facilities and infrastructure (Weeks, 2012).

The non-availability of basic infrastructures such as roads, hospitals and educational facilities makes it impossible for individuals to access modern health treatment. Furthermore, this prevents those who are providers of indigenous knowledge from working closely with other professionals, who are tasked with the role of working with existing communities (Lyager, 2010).

When taking into account the current backlog in service delivery, particularly in hard-to-reach areas, individuals in previously disadvantaged areas indeed have less understanding of recent developments in mental health issues when compared to those residing in more advanced environments. Advanced communities have become more modernized, and the majority of people have adopted western ways of knowing.

Thus, many of the interventions targeted at modern communities are better received because most people within the elite communities have advanced to a level where they no longer embrace indigenous systems. Rather, many strive for better schooling opportunities and seek advanced infrastructural facilities and employment opportunities, which also influences the type of health care they can afford (Burns & Tomita, 2015).

Therefore, it is critical to analyze mental health literacy in an under-developed context to consider structural issues such as the lack of health facilities and educational infrastructure while also still considering the existing ways of knowing that have offered remediation for social ills for centuries. Other studies that have been conducted on mental health have identified a relationship between age, education and mental health literacy, where perceptions of mental health improve as age and education level increase (Vibha et al., 2008). Similarly, this study found a significant association between older age, education and willingness to coexist with people living with mental illness where 27.5 percent of those aged 18 to 27 and 37.4 percent of those aged 28 to 37 were willing to live next door to Zanele.

Likewise, on willingness to spend a night socializing with Zanele, 28.8 percent of those aged 18 to 27 and 29.9 percent of those aged 28 to 37 were willing. Similarly, 62.0 percent of people with a secondary level education were willing to live next door to Zanele, while 60.4 percent reported that they would be willing to spend an evening socializing with Zanele. This increase in willingness to coexist with people presenting with symptoms of mental illness is largely due

to the understanding that most participants within these age categories have completed secondary schooling and have entered employment. Which allows them to be better able to access facilities that are pivotal for the treatment of mental illness (Weeks, 2012).

5.3. Participants' treatment preferences for mental illness.

The type of religious grouping that an individual is affiliated with is understood to influence mental health literacy and whether the individual will utilize mental health services. Indeed, Weeks (2012), Burns & Tomita (2015) and Collins et al. (2016) have argued that religion has an overriding effect on mental health-seeking behavior, which is independent of socioeconomic processes. Thus, it appears that if an individual's religion forbids one from using mental health services to treat symptoms of mental illness, one would be unlikely to utilize such methods.

When correlations were conducted on religious affiliation and preference of treatment professionals, it was found that many of the participants who were affiliated with the Christian religion (40.6%) preferred the church to treat "mental health symptoms", while those with no religion (60.5%) preferred treatment by a herbalist. Thus, in a system where individuals have aligned with certain belief models, which also control their health seeking behavior, improvement in health systems can only come about when new interventions take into account a client-centered approach. The client-centered approach should not only respect the individual's belief system, but also offer a holistic approach, where treatment works hand-in-hand with the existing belief system.

According to Weeks (2012), being married is an important determinant of health-seeking behavior, most notably since it involves two parties who are willing to recognize certain symptoms and seek the necessary help. However, contrary to this, other studies that have been conducted on health-seeking behavior and marital status have revealed that there are economic

and geographic situations which pose a barrier to mental health-seeking behavior, as opposed to looking at marital status alone (Garrenne et al., 2000). In line with this notion, the present study found that most married participants preferred that someone with Zanele's problem should deal with their problem independently (62.7%).

When correlation tests were conducted on the category of marital status and treatment preferences, married participants reported a preference for tranquilizers such as valium (65.8%) and pain killers (60.2%). This reflected that married people residing in townships are no more likely to have mental health information than people with better resources and better opportunities. Therefore, mental health literacy is most likely an outcome of the variation in service delivery and access to infrastructural services that are pivotal in treating mental illness (Weeks, 2012).

5.4. Attitudes towards mental illness among African residents of eThekwini district municipality.

Out of the 266 participants interviewed for this study, 50% revealed that a person with Zanele's symptoms was most likely to be dangerous in the community, represented by 50.0 percent in KwaMashu and 50.0 percent in Umlazi. Furthermore, when the responses of participants from KwaMashu and Umlazi were compared, Umlazi participants had increased percentages stating that a person with Zanele's symptoms was most likely to drink too much alcohol (52.8%), take illegal drugs (52.0%), have poor friendships (51.9%), and attempt suicide (52.9%).

Moreover, contrary to the findings obtained in KwaMashu, most respondents from Umlazi also reported that people with Zanele's symptoms were most likely to understand others' feelings (52.0%), have a good marriage (54.6%), be a caring parent (56.9%), be a productive worker

(54.3%) and be creative or artistic (57.4%). This is interesting to note since one would expect both townships to have similar outcomes, as both had previously been disadvantaged, and both faced a similar scarcity of mental health resources.

When participants' age was correlated with attitudes towards mental illness, 30.0 percent of those aged 18 to 27 reported that they would discriminate against someone with symptoms like Zanele, while 50.0 percent of those aged 68 to 88 years reported they would also discriminate against someone like Zanele. These findings, particularly for those aged 68 to 88 years, were consistent with results obtained throughout the study, where the same age group reported they would be less willing to coexist with someone like Zanele as they perceived them to be dangerous and unpredictable.

In addition, when individuals' perceptions of mental illness were measured against the level of schooling, it was found that participants with a secondary level education defined people with Zanele's symptoms as dangerous (58.4%), unpredictable (53.9%), lacking self-control (59.0%) and frightening (56.3). Such findings were interesting since exposure to secondary schooling has been perceived in other studies as a point where people are privileged, have better access to knowledge, accurate information, and better health care services (Kirk, 1996; Weeks, 2012).

5.5. Summary

Participants in this study provided responses that seemed to be informed by contextual beliefs of what illness is, and how it may best be treated. Perceptions of mental illness seemed to center on religious and spiritual aspects, which were also believed to be ameliorated through the assistance of a traditional healer or faith-based healer.

Only a few participants identified the symptoms as relating to mental illness, such as stress or depression. While none of the participants identified the symptoms as relating to schizophrenia.

Thus, for mental health interventions to be adapted to less-resourced environments, the existing treatment modalities must be considered to formulate new interventions that are client-centered and offer a holistic approach to mental health treatment.

Chapter Six: Conclusion and Recommendations

6.1. Introduction

This study aimed to uncover mental illness perceptions in KwaMashu and Umlazi, particularly focusing on depression and schizophrenia. The study's objectives were to investigate the perceptions of mental illness among African residents of eThekwini district municipality, explore participants' treatment preferences for mental illness, and study the attitudes towards mental illness among African residents of eThekwini district municipality.

The study results showed that mental illness in townships was largely perceived as an affliction from supernatural forces, and individuals with mental health issues were perceived to need a cleansing for demonic possession or treatment by traditional healers. Furthermore, while some participants were able to identify some form of mental illness, such as stress or depression, none of the interviewed participants identified the symptoms related to schizophrenia. Based on the study results, age, gender, religion, marital status, and education were critical aspects affecting perceptions of mental illness among township residents.

Participants who had a secondary or tertiary education were found to be welcoming and accepting towards people living with mental illness, while married participants and those living with a partner reported being less welcoming and less tolerant. Being of older age was found to have a lesser likelihood of being welcoming or living side-by-side with someone like Zanele.

6.2. Significant contributions

Results obtained from this study shed light on township dwellers mental health literacy. Majority of participants interviewed in this study were able to identify symptoms of depression, while none of the participants identified symptoms of schizophrenia. Findings showed that the majority of individuals in township areas of KwaZulu-Natal still lack knowledge of mental

health, largely due to the lack of mental health services and poor dissemination of information on mental health issues. Thus, the findings obtained from this study call for the need to establish mental health facilities that will both treat mental health disorders and disseminate information on mental health issues. Furthermore, findings from this study will add to literature, and assist future researchers when conducting research within the area of mental health literacy. Moreover, findings obtained from this study will likely assist policy makers when allocating funding for mental health interventions.

6.3. Recommendations

Researchers in the field of mental health need to put more emphasis on the status of education in all under-developed areas. Education in both developed and developing nations has contributed greatly to identifying illness symptoms and seeking the appropriate help (Kirby, 2002; Weeks, 2013). Researchers need to carry out more quantitative research in determining what level individuals living in townships and other under-developed areas stay in school, and qualitative research to determine the content of education in these areas.

Since education has been identified to be an important factor in determining mental health literacy in townships, it is important that more attention is directed toward providing township dwellers with information and skills to identify symptoms of mental illness. Furthermore, efforts need to me directed towards ensuring a holistic treatment of mental illness, that takes into account the traditional forms of healing.

This study observed that the impact of indigenous knowledge on understanding and treating mental illness in the African community is still a widely used approach and prevents many from using more recent mental health treatment models. Thus, researchers must focus more on this area to formulate a holistic approach for treating mental illness, most particularly since

indigenous and religious beliefs have been found to have contributed to knowledge and have upheld communities in the developing world for centuries.

The government is responsible for ensuring that mental health interventions take a holistic approach, incorporating indigenous knowledge with new interventions that have been found useful and adopted from other nations. Furthermore, with a holistic approach, there need to be well-resourced mental health facilities established within the communities. The availability of such resources will provide exposure to a vast number of professionals with modern and effective treatments. Such professionals require to remain respectful of each person's worldview and also must be geared towards the community's mental health improvement.

Researchers have a responsibility to create a compilation of the total number of mental health services, certified traditional healers and registered religious-based organizations that are available to people living in townships and many under-resourced environments. This approach will provide the government with a clear direction of where to focus the country's budget for mental health initiatives. Qualitative research will be important because it will provide a narrative picture of how well individuals living in under-resourced areas are educated about mental health matters.

6.4. Limitations

This study has potential limitations. It only involved Zulu people in eThekwini, so it cannot necessarily apply to other African ethnic groups nor other geographical areas. The participants interviewed for the study were found in social gatherings during the week. This excluded individuals who were either at work or chose not to socialize with the general public.

The title of this study seeks to uncover participants' understanding of depression and schizophrenia. However, very few participants understood the vignette's symptoms as a result

of mental illness, stress, and depression, while none identified schizophrenia. Thus, the research context and the communities' pre-existing knowledge on mental illness informed and directed the study's result.

The results presented on the ordinal logistic regression model posed limitations on reporting, as they were based on the overall outcomes of each variable, and the results have not been aggregated according to the different categories within each variable. Thus, it was impossible to report on the odds of socializing with someone like Zanele amongst Christian participants and those who identified as not belonging to any religious denomination.

6.5. Conclusion

Participants that provided their understanding of mental illness appeared to be informed by contextual beliefs of what illness is and how it may best be treated. Perceptions of mental illness focused on spiritual aspects that were also believed to be ameliorated through spiritual healers, who would then implement ceremonial healing and cleansing. While some participants identified the symptoms presented in the vignette related to either stress or depression, none of the participants identified symptoms of schizophrenia.

Out of those participants from eThekwini District Municipality, those who had a secondary or tertiary level education had the highest percentage of people who had some understanding of mental health issues. Participants who were married had the lowest percentages of mental health disorders, followed by those living with a partner and those who belonged to the Christian religious faith.

Participants from Umlazi seemed to hold beliefs that a person living with mental illness was most likely to present with maladaptive behavior such as drinking too much alcohol, taking

illegal drugs, poor friendships, and attempting suicide. Participants from KwaMashu seemed to be more tolerant and understanding of people living with mental illness.

Furthermore, being younger was associated with being more tolerant of people living with mental illness, unlike the older age groups. Participants with tertiary level education showed more understanding and willingness to associate with someone like Zanele, while participants with secondary education were less welcoming.

Based on the logistic regression model results, residing in a township, age, religion, and education level were all critical variables affecting individual perceptions of mental illness. Such factors influenced the likelihood of seeking mental health assistance and the willingness to coexist with individuals with mental illness. Thus, the current context must be taken into account when implementing mental health interventions. This will allow those involved in implementing mental health programs to implement interventions in line with people's mental health needs.

Furthermore, when attempting to formulate inclusive mental health interventions, it is imperative that an understanding of the levels and trends of indigenous knowledge systems and mental health resources is obtained through further research and other knowledge systems to provide services that would be utilized by all those in need.

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Appendix A: Ethical Clearance

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

04 February 2019

Ms Nolwazi Nzama 209514976
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Dear Ms Nzama

Protocol reference number: HSS/0221/018M
Project title: Mental health literacy: Conceptions and attitudes towards depression and schizophrenia among African residents of eThekwini District Municipality.

Full Approval – Full Committee Reviewed Application

With regards to your response received 25 January 2019 to our letter of 04 December 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

[redacted]
Dr Shamila Naidoo

/px

cc Supervisor: Mrs X Mfene
cc Academic Leader Research: Dr M Mthembu
cc School Administrator: Ms Priya Konan

Humanities & Social Sciences Research Ethics Committee
Dr Shamila Naidoo (Deputy Chair)
Westville Campus, Govan Mbeki Building
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Appendix B: Gatekeeper Permission

Councillor

Mezzanine Floor Shell House
Cnr. Anton Lembede & Samora Machel Street, Durban, 4001
P O Box 1014, Durban, 4000
Tel: 031 322 7830, Fax: 031 311 2827
www.durban.gov.za

Our Ref: Cllr M.A.K Dladla
076 704 3794
Your Ref: 031 906 7379
Enquiries: 22/01/2019

To Whom It May Concern

I, Councillor M.A.K Dladla of Ward 82 eThekwini Municipality, hereby confirm that **Nzama Nolwazi Sizakele K. (ID No.: 900410 0830 085)** who is a student at the **University of KwaZulu Natal** contacted my office and requested to conduct a research on **"Mental Health Literacy"**.

I, as a Councillor, have no objection to that and therefore appeal to you that she be given further necessary assistance.

Your kind assistance will be highly appreciated.

Yours Faithfully

Cllr M.A.K Dladla
(Ward 82 eThekwini Municipality)
0767043794
0319067379
Muziwenyanga.Dladla@durban.gov.za

Councillor Muziwenyanga Alfred Xumakwabo Dladla
[redacted]
COMMISSIONER OF OATHS
ETHEKWINI MUNICIPALITY
EX OFFICIO DISTRICT OF DURBAN IN
TERMS OF SECTION 6 OF ACT 16 OF 1963
(AS AMENDED) CITY HALL SECRETARIAT
Dr Pixley Ka Seme Street, Durban, 4001

Appendix C: Informed Consent (English)

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INFORMED CONSENT

Hello

Ms. Nolwazi Nzama, a Masters Clinical Psychology student at the University of KwaZuluNatal, is conducting a study in KwaZulu-Natal on people's attitudes to some public health issues facing South Africans today. The aim of the study is to gain a better understanding of what people know and understand about these health problems, and we would like to include your views. The questions will cover areas such as awareness of this health problem, where people go for help, and how the problem may be treated. You do not have to answer any questions you don't want to.

It takes about 30 minutes to fill-in this questionnaire. Even if you agree to complete this questionnaire, you are free to withdraw from the survey at any time and there will be no consequences to you for withdrawing.

No harm is foreseeable to you as a participant in this study. This study has been ethically reviewed and approved by the University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee. In the event of any problems or concerns/questions regarding this study, you may contact the researcher, Ms Nolwazi Nzama (0787543437), her supervisor Mrs Mfene (033 260 5588), or Ms Phumelele Ximba at the UKZN Research Ethics Office (031 260 3587).

Please note these important facts before participating in this study:

1. Your anonymity and confidentiality will be ensured. There is no place in this form where you will be required to write personally identifying information such as your names, identity numbers, address or telephone numbers. Your responses will remain anonymous. Please be assured that you cannot be personally identified by participating in this study.
2. You are free not to answer any particular question if you don't want to.
3. The results of this study will be disseminated in a form of a theses. Furthermore, the findings will be presented at conferences and published for scientific advancements in accredited journals.
4. The information sheet contains the Researchers contact details. Participants' may contact the researcher to enquire about the findings of the research study. This will also be emphasized to research participants.

5. Your participation in this study is voluntary. You are not forced to participate in this study
6. Participation in this study will not provide you with a monetary value. However, outcomes of this study will provide knowledge on mental illness, and R15.00 air-time to thank you for your time and participation will be provided.
7. You need to be 18 years old or older to take part in this study. No one under the age of 18 is allowed to take part in this study. If you are under the age of 18, please let me know and do not continue filling this questionnaire.

Do you have any questions about this research?

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Consent to Participate:

I hereby confirm that I have read and understood what this study is about, and by completing this questionnaire I consent to participating in this research project.

I understand that I am at liberty (free) to withdraw from participating in this research at any time, should I so desire.

Signature of Participant

……

Appendix D: Informed Consent (Zulu)

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IMVUME ENOLWAZI

Sawubona,

Umfundi (Masters student), Nolwazi Nzama, wase-Nyuvesi yakwa Zulu-Natali wenza ucwaningo kulesisifundazwe (province) olubheka izimvo zabantu mayelana nezimo ezithinta ezempilo, umphakathi wase Nignizimu (South) Afrika obhekene nazo kulezi zikhathi zanamuhla. Inhloso yalolucwaningo ukuthola ukuthi yini abantu abayaziyo nabayiqondayo ngezinkinga zempilo, ngakho singathanda ukuthola nowakho umbono. Imibuzo izothinta izinto ezifana nokuba nolwazi lokuthi zikhona zona izinkinga zempilo, ukuthi bayaphi abantu uma bedinga usizo, nokuthi lezi zinkinga zilashwa kanjani. Awuphoqelekile kodwa ukuphendula imibuzo ongathandi ukuyiphendula.

Cishe kuzothatha imizuzu ephakathi kuka 20 no-30 ukuphendula imibuzo yale nhlolovo. Noma ungavuma ukuphendula yonke imibuzo, uzobe usanalo ilungelo lokushiya ucwaningo nganoma isiphi isikhathi uma uthanda, akukho okubi okungakuvelela uma ulushiya lolu cwaningo, ngisho emva kokuba usuqalile.

Akukho futhi okubi esibona ukuthi kungakuvelela uma ubamba iqhaza kulolu cwaningo. IKomidi lase Nyuvesi yakwa Zulu-Natali elibhekene nokuthi ucwaningo lwenziwa ngendlela enobulungiswa (UKZN Research Ethics Committee) selizihlolile futhi lazamukela izimiso zalolu cwaningo eziqinisekisa ukuphatha abantu ngendlela efanelekile. Uma kwenzeka uba nenkinga noma imibuzo mayelana nocwaningo, ungathintana nomncwaningi u-Nolwazi Nzama ku-078 7543437, umphathi wakhe u-Mrs Mfene (031-260 5588) noma u- Miss Phumelele Ximba osebenza e-hhovisi lase UKZN elibhekene nobulungiswa uma kwenziwa ucwaningo (Research Ethics Committee) ku-031 260 3587.

Sicela uqaphele lama phuzu abalulekile ngaphambi kokuthi ukhethe ukubamba iqhaza kulolu cwaningo:

1. Akekho oyoba nolwazi lokuthi wena ungubani. Ayikho indawo kuleli fomu lapho ongadinga ukubhala okwazisa ukuthi ungubani, njenge gama lakho, inombolo yomazisi wakho, ikheli lakho, noma inombolo yakho yocingo. Futhi azikho izimpendulo zakho ezingakuveza ukuthi ungubani. Sicela ube nesiqiniseko sokuthi ayikho neze indlela yokuthola ukuthi wena ungubani uma ubamba iqhaza kulolu cwaningo.
2. Unelungelo lokungawuphenduli umbuzo ongathandi ukuwuphendula.
3. Imiphumela yalolu cwaningo izoba ingxenye yoMqulu weMasters (Master's Thesis) futhi izoshicilelwa emibhalweni ezigabeni zezinhlobo zezincwadi ezifinyeziwe ezibizwa ngokuthi ama jeneli (journals) amukelwe ngokusemthethweni.
4. Ukubamba kwakho iqhaza kulolu cwaningo kuzoba isinqumo sentando yakho.
5. Ukuba yinxenye yalesisifundo akunayo imivuzo. Imiphumela yalolu cwaningo izongeza ulwazi ngokwezifo senqondo, futhi uma usuqedile ukuphendula imibuzo yalolucwaningo uzophiwa iair-time ka R10 ngesikhathi sakho ozobe usisebenzisile.
6. Kufanele ube neminyaka engu-18 noma ngaphezulu ukuze uvumeleke ukubamba iqhaza kulolu cwaningo. Umuntu ongaphansi kweminyaka engu -18 akavumelekile, ngakho uma wena uneminyaka engaphansi kuka-18 ngicela ungazise futhi ngicela ungaqhubeki nokuphendula imibuzo yale nhlolovo.

Ngabe unayo imibuzo mayelana nalolu cwaningo?

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Imvume yokuba ingxenye yocwaningo:

Ngiyaqinisekisa ukuthi sengifundile (sengichazelwe) futhi ngaqonda ukuthi lolu cwaningo lumayelana nani, futhi ngokuphendula imibuzo ekule nhlolovo nginika imvume yokubamba iqhaza kulo lolu cwaningo.

Ngiyaqonda nokuthi nginenkululeko yokuyeka ukubamba iqhaza kulolu cwaningo nganoma isiphi isikhathi engingakhetha ukuyeka ngaso.

iSignesha yoMbambiqhaza

……

Appendix E: Research Questionnaire (English)

Source: Kometsi, M. J. (2016). Mental health literacy: conceptions and attitudes toward mental *disorders and beliefs about treatment among African residents of Sisonke District in KwaZulu-Natal* (Unpublished doctoral thesis). University of KwaZulu-Natal, Durban.

PLEASE FILL IN THIS QUESTIONNAIRE ***ACCURATELY*** AS POSSIBLE.

Demographic Information:

Age……..

Gender:

1. Female ☐
2. Male ☐

Marital Status

1. Single ☐
2. Married ☐
3. Separated/Divorced ☐
4. Widowed ☐
5. Living with a partner ☐

Which township do you stay in?

1. KwaMashu ☐
2. Umlazi ☐

Race / Ethnicity

1. African ☐
2. Coloured ☐
5. Other ☐ *specify*……

What is your highest level of education?

1. Never went to school ☐
2. Primary ☐
3. Secondary ☐

4. Tertiary ☐

Religious Affiliation

1. Christian ☐ Name of church…….
2. African religion ☐ Name of church…….....
3. Atheist ☐
4. Other ☐ *specify*……..

Home Language:

1. isiZulu ☐
2. isiXhosa ☐
3. Other ☐ *specify*……

Below is a scenario describing health problems of an individual and her life issues. She is not a real person, but there are people like her. If you happen to know someone who resembles her in any way, that is a total coincidence. After reading/listening to this scenario please answer the questions that would follow. Remember, there are no right or wrong answers.

Vignette

Zanele is 30 years old. Until a year ago, life was pretty okay for her. But then things started to change. She thought that people around her were making disapproving comments and talking behind her back. She was convinced that people were spying on her and they could hear what she was thinking. Zanele lost her drive to participate in work and family activities and retreated to her bedroom, eventually spending most of the day there. Zanele was hearing voices of her grandmother who passed away 10 years ago. These voices were telling her what to do and what to think. Zanele also reported seeing visions of her late grandmother. She has been living this way for the past six months.

Q1. What, if anything, would you say is wrong with Zanele?

.....
.....

Q2. What do you think is the cause of Zanele's problem/s?

……
……

Q3. What would you call Zanele's problem?

……
……

Q4. How do you think Zanele could best be helped?
.....
.....

Q5. If you had a problem right now like Zanele, would you go for help?

a. Yes ☐

b. No ☐

If you responded "Yes" to Question 5 above: Answer Questions 6 & 7. If you answer "No", proceed to Question 8

Q6. Whom would you ask for help? .....
Q7. What might stop you from seeking help from this person/place?
.....
.....

Q8. In your opinion, how likely it is that Zanele's situation might have been caused by:

	Very likely	Don't know	Less likely
a. Own bad character			
b. Chemical imbalance in the brain			
c. The way she was raised			
d. Stressful circumstances in her life			
e. Genetic or inherited problems			
f. God's will			
g. Failure to perform certain cultural rituals			
h. Ancestral anger			
i. Evil spirits/sorcery			
j. Punishment for sins she committed			

Q9. There are a number of different people, some professional, some not, who could possibly help Zanele. Are each of the following people likely to be helpful, harmful, or neither for Zanele?

	Helpful	Harmful	Neither
a. Family GP / Doctor			
b. Pharmacist /Chemist			
c. A Counsellor			
d. Social Worker			
e. Telephone Counselling, like Life Line			
f. A Psychiatrist			
g. A Psychologist			

h. Help from close family member			
i. Help from close friends			
j. Sangoma (Diviner)			
k. Nyanga (Herbalist)			
l. uMthandazi (Faith healer)			
m. A Church Minister/Priest/ Pastor			
n. To deal with her problem on her own			

Q10. Do you think the following different MEDICINES are likely to be helpful, harmful, or neither to Zanele?

	Helpful	Harmful	Neither
a. Vitamins, minerals and tonics			
b. Traditional medicine			
c. Pain relievers such as asprin, panado, grandpa, compral			
d. Antidepressant			
e. Antibiotics			
f. Sleeping pills			
g. Anti-psychotics			
h. Tranquilizers such as valium			

Q11. The next few questions ask what you think are Zanele's chances of recovery. What would be the likely result if Zanele had the sort of professional help you think is most appropriate? Would you say.... (*please choose one)*

a. Full recovery with no further problems ☐

b. Partial recovery, but problems would probably re-occur ☐

c. No improvement ☐

Q12. What would be the likely result if Zanele did NOT have any professional help? Would you say.... (*please choose one*)

a. Full recovery with no further problems ☐

b. Partial recovery, but problems would probably re-occur ☐

c. No improvement

Q13. Suppose Zanele received the sort of help that you think is most appropriate for her problems, for each of the following, how do you think Zanele would be IN THE LONG TERM, compared to other people in the community?

	More likely	Less likely	Don't know
a. Be violent			
b. Drink too much alcohol			
c. Take illegal drugs			
d. Have poor friendships			
e. Attempt suicide			
f. Be understanding of other people's feelings			
g. Have a good marriage			
h. Be a caring parent			
i. Be a productive worker			
j. Be creative or artistic			

Q14. Now, for the next few questions, we would like you to tell us what DO YOU THINK OR BELIEVE about these statements?

	Agree	Disagree	I don't know
a. A problem like Zanele's is a sign of personal weakness			
b. Zanele's problem is not a real medical illness			
c. People with a problem like Zanele's are dangerous			
d. It is best to avoid people with a problem like Zanele's so that you don't develop this problem			
e. I would not employ someone I knew she had a problem like Zanele's			

Q15. Do you think that Zanele would be discriminated against by others in the community, if they knew about her problems?

a. Yes ☐

b. No ☐

Q16. The next few questions ask about how willing you would be to have contact with someone like Zanele

	Willing	Unwilling	Don't know
a. How willing would you be to move next door to Zanele?			
b. How willing would you be to spend an evening socializing with Zanele?			
c. How willing would you be to make friends with Zanele?			
d. How willing would you be to have a relationship with Zanele?			
e. How willing would you be to have Zanele start working closely with you on a job?			
f. How willing would you be to have Zanele looking after your children?			
g. How willing would you be to live in the same room with Zanele?			
h. How willing would you be to have people like Zanele living in your neighbourhood?			

Q17. People with a problem like Zanele's are:

	Strongly agree	Strongly disagree	I don't know
a. Dangerous			
b. Unpredictable			
c. Lacking self-control			
d. Aggressive			
e. Frightening			

Q18. Has anyone in your family or close circle of friends ever had problems similar to Zanele's?

a. Yes ☐ b. No ☐

Q19. If you were to come into contact with people having a problem like Zanele's, would your contact with them, be friendly and cooperative?

a. Yes ☐ c. I don't know ☐

b. No ☐

Q20. The following questions are about mental health, media and mental health organizations. Have you seen, read, or heard any news or stories about mental health in the last 6 months?

a. Yes ☐ b. No ☐

Q21. If you answered 'Yes' to Q35, did you read about, see or hear these news or stories in/from....

a. The newspaper ☐
b. Magazine ☐
c. Radio ☐
d. Television ☐
e. Internet ☐
f. Community Health Worker ☐
g. Other(specify)…… ……..

Q22. What is the nearest place in your area that provides treatment for people with mental health problems?

……
……

Q23. Is there anything else you would like to say or mention about Zanele's problem?

……
…..…….....
.....

THANK YOU

Appendix F: Research Questionnaire (Zulu)

Source: Kometsi, M. J. (2016). Mental health literacy: conceptions and attitudes toward mental *disorders and beliefs about treatment among African residents of Sisonke District in KwaZulu-Natal* (Unpublished doctoral thesis). University of KwaZulu-Natal, Durban.

SICELA UPHENDULE LE NHLOLOVO NGOKUYI **KONAKONA NGEMPELA** NGOKWAZI KWAKHO.

Imininingwane yabantu:

Iminyaka …….

Ubulili:

3. Ungowesifazane ☐
4. Ungowesilisa ☐

Isimo Somshado

6. Awushadile ☐
7. Ushadile ☐
8. Uyahlukanisa/Usuwahlukanisa ☐
9. Ungumfelwa/Ungumfelokazi ☐
10. Kukhona umuntu ohlalisana naye ☐

Lapho ohlala khona

3. EMlazi Township ☐
4. KwaMashu Township ☐

Ubuzwe

African ☐

Coloured ☐

Okunye ☐ *chaza*……

Lapho owagcina khona kwezemfundo

Awukaze uye esikoleni ☐

Primary ☐

Secondary ☐

Imfundo ephakeme ☐

Inkolo yakho

UngumKristu ☐Sicela uchaze isonto…….....

Ukholo lwesintu ☐Sicela uchaze isonto…….

Awulandeli nkolo ☐

Okunye ☐Sicela uchaze uma ukholelwa kokunye…….

Ulimi lwakho lwasekhaya:

isiZulu ☐ isiXhosa ☐

Okunye ☐ *chaza*……

Ngezansi kunomfanekiso wezenzakalo zezinkinga ngokwezempilo zomuntu kanye nezimo zempilo yakhe. Lo muntu ochazwayo akayena owangempela, kodwa bakhona abantu bangempela abafana naye. Uma kwenzeka ukuthi kukhona umuntu omaziyo onempilo efana neyakhe, kusho ukuthi kuqondene nje. Emva kokufunda/nokuzwa ngale zenzakalo, sicela uphendule imibuzo elandelayo. Khumbula, azikho izimpendulo eziliqiniso noma eziliphutha, izimpendulo zakho zingumbono wakho.

Umfanekiso wezenzakalo

UZanele uneminyaka engu30. Ngaphambi kwalo nyaka osudlulile, impilo ibimuhambela kahle. Kodwa izinto zase ziyashintsha. Ubesecabanga ukuthi abantu abaseduzane naye bebekhuluma ngendlela yokungamamukeli futhi bemuhleba. Ubenesiqiniseko sokuthi abantu bayamupopola futhi bayakwazi ukuzwa ukuthi ucabangani. UZanele uphelelwe uthando lokubamba iqhaza emsebenzini nasezintweni zomndeni, wazivalela ekamelweni, wagcine esechitha cishe usuku lonke khona ekamelweni. UZanele ubezwa amazwi kagogo wakhe owahamba emhlabeni eminyakeni eyishumi edlule. UZanele uphinde wathi uke abe nemibono ka gogo wakhe osewandlula emhlabeni. La mazwi abemutshela ukuthi enzeni nokuthi acabangeni. Usephile ngalendlela izinyanga eziyisithupha.

Q1. Yini, uma kukhona, okungahambi kahle ngoZanele?

…….....

.....

Q2. Yini ocabanga ukuthi ibanga inkinga noma izinkinga zikaZanele?
……
……

Q3. Ungayibiza ngani inkinga kaZanele?
……
……..

Q4. Uma ucabanga angasizwa kanjani uZanele?
……
……

Q5. Ukube wena njengamanje ubunenkinga efana nekaZanele, ungalubheka usizo?

Yebo ☐

Cha ☐

Angazi ☐

Uma uphendule wathi 'Yebo' kunombolo 5 wemibuzo, qhubeka uphendule unombolo 6 & 7 wemibuzo, noma uqhubeke uye kunombolo 8.

Q6. Ungaya kuphi ukuyocela usizo?
……

Q7. Yini engakuvimba ekutheni ubheke usizo kulomuntu/kulendawo?
……

	Maningi amathuba	Akhona wona amathuba	Mancane amathuba	Angazi
a. Ukuthi ungumuntu onganasimilo				
b. Ukuthi amakhemikhali (izithako ezincinyane) engqondo yakhe awahambi kahle				
c. Indlela akhuliswe ngayo				
d. Izimo empilweni yakhe ezibanga ingcindezi (stress)				
e. Izinkinga eziwufuzo				
f. Intando kaNkulunkulu				

g. Ukungawalendeli amasiko akhe ngendlela				
h. Ukudinwa kwamadlozi (izinyanya) akhe (ukufulathelwa amadlozi noma ulaka lwabaphansi)				
i. Imimoya emibi				
j. Ukuthi ujeziselwa izono zakhe				

Q8. Ngokubona kwakho, mangakanani amathuba okuthi isimo sika Zanele sibangwe yilokhu okulandelayo:

Q9. Ziningi izinhlobo zabantu, abanye abangochwepheshe, abanye abangasibo, okungenzeka bakwazi ukumsiza uZanele. Bheka laba bantu ababaliwe abalandelayo. Ngokubona kwakho, makanganani amathuba omuntu ngamunye okuthi akwazi ukumsiza uZanele, noma amulimaze ngandlela thize, noma angenzi nokukodwa kwalokhu?

	Anganosizo	Angamulimaza	Angangenza nokukodwa kwalokhu
a. Udokotela			
b. Usokhemisi			
c. Umeluleki			
d. Usonhlalakahle (Social Worker)			
e. Ukwelulewa ocingweni, njenge Life Line			
f. Udokotela womqondo (Psychiatrist)			
g. Isazi somqondo (Psychologist)			
h. Usizo oluphuma kumalungu omndeni asondelene nawo			
i. Usizo oluphuma kubangani asondelene nabo			
j. iSangoma			
k. Inyanga			
l. uMthandazi			
m. Umfundisi			
n. Ukuzixazululela yena izinkinga zakhe			

Q10. Uma ucabanga le MITHI elandelayo ehlukahlukene inganosizo, ingamulimaza, noma ingangamenza nokukodwa kwalokhu uZanele?

	Anganosizo	Angamulimaza	Angangamenza nokukodwa kwalokhu
a. Vitamins, minerals and tonics Ama-vithamini, ama minerali (njengeziphuzo eziqukethe okusansimbi) noma iziphuzo/imithi equkethe izakha-mzimba (tonics)			
b. Imithi yesintu			
c. Amaphilisi ezinhlungu, njenge asprin, panado, grandpa, compral			
d. Antidepressant (Imithi yodokotela besilungu yokudambisa ukhwantalala isifo sokudumala/sokudangala ngokweqile i-depression)			
e. Antibiotics (Imithi/amaphilisi odokotela besilungu abulala noma adambisa amagciwane omkhuhlane)			
f. Amaphilisi okulala			
g. Anti-psychotics (Imithi/amaphilisi odokotela besilungu adambisa izimpawu zokulahlekelwa umqondo/ukuhlanya)			
h. Tranquilizers such as valium Imithi yodokotela besilungu yokwelapha uvalo (anxiety), ukwethuka (panic) futhi esiza ukwelula izicubu (amamasela) zomzimba ezibophene (relaxation)			

Q11. Imibuzo elandelayo ikubuza ukuthi wena ucabanga ukuthi mangakanani amathuba okuthi angalapheka uZanele. Uma uZanele engathola usizo lwochwepheshe ocabanga ukuthi kungayilo olungafaneleka, ikuphi okunokwenzeka kulokhu okulandelayo? Ungathi....

(*sicela ukhethe okukodwa)*

d. Angalapheka ngokuphelele, angabe esaba nalezi zinkinga futhi ☐

e. Angalapheka lapha nalapha, kodwa hhayi ngokuphelele, futhi izinkinga zakhe zingabuye zibuye futh ☐

f. Angangalapheka ☐

Q12. Yini enganokwenzeka uma uZanele ANGANGALUBHEKA NHLOBO usizo lochwepheshe?

Ungathi.... (*sicela ukhethe okukodwa*)

a. Angalapheka ngokuphelele, angabe esaba nalezi zinkinga futhi ☐

b. Angalapheka lapha nalapha, kodwa hhayi ngokuphelele, futhi izinkinga zakhe zingabuye zibuye futhi ☐

c. Angangalapheka ☐

Q13. Asike sithi uZanele uyaluthola lolu sizo wena ocabanga ukuthi ilona olufanelekile ekulapheni izinkinga zakhe, kulokhu okulandelayo, ucabanga ukuthi uZanele angaba njani EMVA KWESIKHATHI ESIDE, uma umqhathanisa nabanye abantu emphakathini?

	Maningana amathuba	Ayalingana amathuba	Mancane amathuba	Kuncike kokuthile	Angazi
a. Angaba nodlame					
b. Angaphuza utshwala kakhulu					
c. Angathatha izidakamizwa ezingekho emthethweni					
d. Angaba nobungani obuntekenteke					
e. Angazama ukuzibulala					
f. Angazwelana nabanye abantu					
g. Angaba nomshado ohamba kahle					
h. Angaba umzali okhathalelayo (caring parent)					
i. Angaba umsebenzi okhiqiza umsebenzi omuningi					
j. Angaba nekhono lezobuciko					

Q14. Manje, kule mibuzo elandelayo, sicela ukuthi usitshele ukuthi UCABANGANI NOMA UKHOLWANI mayelana nalezi zitatimende.

	Ngivumelana nakho kakhulu	Ngivumelana nakho	Angivumelani kodwa futhi angiphikisani nakho	Ngiyaphikisana nakho	Ngiphikisana nakho kakhulu	Angazi
a. Inkinga efana nekaZanele iluphawu lokuba ntekenteke komuntu						
b. Inkinga efana nekaZanele akusona isifo sangempela						
c. Abantu abanenkinga efana nekaZanele bayingozi						
d. Kungcono ukubagwema abantu abanenkinga efana nekaZanele ukuze ungazitholi usunalenkinga nawe						
e. Bengingeke ngiqashe umuntu onenkinga efana nekaZanele						

Q15. Uma ucabanga abantu bomphakathi bangamucwasa na uZanele uma bangase bazi ngezinkinga zakhe?

c. Yebo ☐

d. Cha ☐

Q16. Imibuzo elandelayo ibuza ukuthi ungazimisela kangakanani ukuzimbandakanya nomuntu onjengoZanele

……..……
……

	Ngingazimisela ngempela	Mhlawumbhe ngingazimisela	Mhlawumbhe ngingangazimisela	Ngingangazimisela ngempela	Angazi
a. Ungazimisela kangakanani ukuba umakhelwane kaZanele?					
b. Ungazimisela kangakanani ukuchitha isikhathi uzipholele noZanele?					
c. Ungazimisela kangakanani ukuba umngani kaZanele?					
d. Ungazimisela kangakanani uku thandana noZanele (uma ungowesifazane, ukuthandaba nowesilisa onezinkinga ezifana nezika Zanele)					
e. Ungazimisela kangakanani ukusebenzisana noZanele?					
f. Ungazimisela kangakanani ukuthi uZanele anakekele izingane zakho?					
g. Ungazimisela kangakanani ukuhlala egumbini/ekamelweni elilodwa noZanele?					
h. Ungazimisela kangakanani ukwamukela ukuthi abantu abafana noZanele bahlale emphakathini wakho?					

Q17. Abantu abanenkinga efana nekaZanele:

	Ngivumelana nakho kakhulu	Ngivumelana nakho	Angivumelani kodwa futhi angiphikisani nakho	Ngiyaphikisana nakho	Ngiphikisana nakho kakhulu	Angazi
a. Bayingozi						
b. Abahlelekile						
c. Abakwazi ukuzibamba						
d. Banodlame						
e. Bayathusa						

Q18. Ukhona umuntu emndenini wakho noma kubangani bakho osondelene nabo oseke waba nezinkinga ezifana nezikaZanele?

c. Yebo ☐

d. Cha ☐

e. Angazi ☐

Q19. Uma ungase uzithole usuxhumene nomuntu onezinkinga ezifana nezikaZanele, ngabe ukuxhumana kwakho naye kungaba nobungane kanye nokubambisana?

a. Yebo ☐

b. Cha ☐

Q20. Imibuzo elandelayo imayelana nesimo somqondo, abezindaba, kanye nezinhlangano zezimo zomqondo. Ngabe usuke wabona, wafunda, noma wezwa izindaba ezimayelana nezimo zomqondo ezinyangeni ezingu6 ezedlule?

a. Yebo ☐

b. Cha ☐

Q21. Uma uthe 'Yebo'' kumbuzo 20 ngasenhla, ngabe lezi zindaba uzifundile, uzibone noma uzizwe....

h. Kwi phephandaba (Newspaper) ☐

i. Kwi phephabhuku (Magazine) ☐

j. Umsakazo (Radio) ☐

k. Kumabonakude (Television) ☐

l. Internet ☐

m. Unompilo ☐

n. Okunye (chaza) .....

Q22. Iyiphi indawo eseduze kunazo zonke endaweni ohlala kuyo elapha abantu abanezinkinga zengqondo? ……..

Q23. Ngabe kukhona okunye ongathanda ukukusho mayelana nenkinga ka Zanele?

……

……

……

……

…….....

SIYABONGA

ORIGINALITY REPORT

7%	%	7%	%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	"The Stigma of Mental Illness - End of the Story?", Springer Science and Business Media LLC, 2017 Publication	1%
2	Anthony F. Jorm, Jo Medway, Helen Christensen, Ailsa E. Korten, Patricia A. Jacomb, Bryan Rodgers. "Attitudes Towards People with Depression: Effects on the Public's Help-Seeking and Outcome When Experiencing Common Psychiatric Symptoms", Australian & New Zealand Journal of Psychiatry, 2016 Publication	<1%

Appendix G: Turnitin Receipt

Mental health literacy: Conceptions and attitudes towards depression and schizophrenia among African residents of the eThekwini District Municipality.

3 Christian Ritter, Jennifer L.S. Teller, Mark R. Munetz, Natalie Bonfine. "Crisis Intervention Team (CIT) Training: Selection Effects and Long-Term Changes in Perceptions of Mental Illness and Community Preparedness", Journal of Police Crisis Negotiations, 2010 Publication <1%

4 Molelekoa J Kometsi, Nhlanhla J Mkhize, Anthony L Pillay. "Mental health literacy: conceptions of mental illness among African residents of Sisonke District in KwaZulu-Natal, South Africa", South African Journal of Psychology, 2019 Publication <1%

5	Mary-Clare Race, Adrian Furnham. "Mental Illness at Work", Springer Science and Business Media LLC, 2014 Publication	<1%
6	Anthony F. Jorm, Helen Christensen, Kathleen M. Griffiths. "The Public's Ability to Recognize Mental Disorders and their Beliefs about Treatment: Changes in Australia Over 8 Years", Australian & New Zealand Journal of Psychiatry, 2016 Publication	<1%
7	"Handbook of Disease Burdens and Quality of Life Measures", Springer Science and Business Media LLC, 2010 Publication	<1%
8	Kamaldeep Bhui, Dinesh Bhugra. "Explanatory models for mental distress: Implications for clinical practice and research", British Journal of Psychiatry, 2018 Publication	<1%
9	Harvey A. Whiteford, Alize J. Ferrari, Louisa Degenhardt, Valery Feigin, Theo Vos. "The Global Burden of Mental, Neurological and Substance Use Disorders: An Analysis from the Global Burden of Disease Study 2010", PLOS ONE, 2015 Publication	<1%
10	Tanya M. Caldwell. "Mental health nurses' beliefs about likely outcomes for people with schizophrenia or depression: A comparison with the public and other healthcare professionals", Australian and New Zealand Journal of Mental Health Nursing, 3/2001 Publication	<1%

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11 Anthony F. Jorm. "Changes in depression awareness and attitudes in Australia: the impact of beyondblue: the national depression initiative", Australian and New Zealand Journal of Psychiatry, 1/2006
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12 Jonathan C. Clayfield, Kenneth E. Fletcher, Albert J. Grudzinskas. "Development and Validation of the Mental Health Attitude Survey for Police", Community Mental Health Journal, 2011
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22 "Mental Health and Illness in the Rural World", Springer Science and Business Media LLC, 2020
Publication

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Phillipa Hay, Anita Darby, Jonathan Mond.
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Three Disciplines", Journal of Clinical
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literacy in Singapore", Social Work in Health
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Publication

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