

**MENTAL HEALTH LITERACY: CONCEPTIONS AND ATTITUDES TOWARD
MENTAL DISORDERS AND BELIEFS ABOUT TREATMENT AMONG
AFRICAN RESIDENTS OF SISONKE DISTRICT IN KWAZULU-NATAL**

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Declaration

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Abstract

Nearly 1 in 10 people have a mental disorder worldwide, and there are many people with chronic or severe mental disorders who are unaware that they have a diagnosable disorder or that effective treatment is available. This may lead to delays in appropriate help-seeking and negative attitudes toward patients with mental illness. It is plausible that this is largely because of the public's non-alignment of biomedical understanding of mental illness which may imply lack of mental health literacy. Such assumptions, however, do not take into consideration the fact that various societies draw their knowledge from different worldviews, which in turn informs their conceptualisation of mental illness.

This study investigated conceptions and attitudes toward three mental disorders, namely, depression, schizophrenia, and alcohol dependency, and beliefs about their treatment among African residents of Sisonke District in KwaZulu-Natal. The sample was drawn from two municipalities of Sisonke District (Kokstad and Kwa Sani) using a survey. In total, 787 African participants of both genders were randomly recruited, and they completed a self-administered questionnaire. Data was analysed using Statistical Package for Social Sciences for Windows, Version 24.0.

The results show an endorsement of multiple explanatory models of illness, thus suggesting an embracement of both Western and indigenous influences in conceptualisation of mental illness. This study found that participants did not use standard psychological nomenclature to describe mental illness, but instead used very broad, over-encompassing terms which may be indicative of their worldview. Of the three disorders investigated, depression was mainly conceptualised using psychological and medical terms, and schizophrenia and alcohol dependency were conceptualised in psychological and social terms. In addition, only schizophrenia, among the three disorders investigated was conceptualised using supernatural descriptions such as bewitchment and *ukuthwasa*. The results also show that conceptualisation of mental illness is not haphazard; but is viewed as holistic and as encompassing social, psychological and physical factors. The results of the current study also revealed that participants' conceptions of mental illness are significantly related to their aetiological beliefs.

The results of this study highlighted the strong preference among the respondents for professional help-seeking, particularly from social workers and medical practitioners, for the treatment of depression and alcohol dependency. However, traditional healing

was seen as more helpful for treating schizophrenia. Furthermore, the results indicate that vitamins, minerals and tonics, pain relievers, antibiotics as well as tranquilisers were considered more helpful for the treatment of depression.

Regarding attitudes towards mental illness, the key findings in this study indicate that negative attitudes towards people with mental illness are widely maintained. Of the three disorders investigated in this study, most of the participants attributed stigmatising attitudes more toward alcohol dependency. Furthermore, the results suggest a general willingness to have a closer social distance with mentally ill individuals, especially when the relationship is perceived as less intimate. However, this finding was converse when the relationship was perceived to be more intimate.

The results of this study highlight the importance of awareness campaigns that take into consideration and respect the cultural differences of the people, collaboration between traditional and medical practitioners. Suggestions for future research, emphasising the use of discourse analysis to further explore indigenous communities' constructions of mental illness and their beliefs about its causes and treatment are recommended.

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Molimo o nthusitse ho fihlela mona (Ebenezer)

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Dedication

This thesis is dedicated to my parents for their undying love and support. Despite very little formal education, you sacrificed a lot, not only to raise and nature my siblings and I, but also to educate us. *May the good Lord bless thee and keep thee.*

&

To Lord God Almighty, I give thee thanks

Joale ke khošše ka mehla

Mohau oa Molimo;

Ke qadile ho iketla

Tšepong ea holimo

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	African National Congress
CAT	Computerized Axial Tomography
CHC	Community Health Clinic
CIDI-A	Composite International Diagnostic Interview, Automated
CIDI 3.0	Composite International Diagnostic Interview, Version 3.0
DALY	Disability-Adjusted Life-Year
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECA	Epidemiological Catchment Area
EEG	Electroencephalogram
GBD	Global burden of disease
GP	General practitioner
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
ICD-10	International Classification of Disease, Tenth Edition
KM	Kilometres
MHCUs	Mental Healthcare Users
MRI	Magnetic Resonance Imaging
NCS	National Comorbidity Survey
NCS-R	National Comorbidity Survey Replication
NIMH	National Institute for Mental Health
PET	Positron Emission Tomography
SASH	South Africa Stress and Health Study
PTSD	Posttraumatic stress disorder
SAPS	South African Police Services
UKZN's HSSREC	University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee
WHO	World Health Organization
YLDs	Years of Life Lived with Disability
YLLs	Years of Life Lost

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Chapter 1

Introduction

This chapter introduces the current study. It begins by offering a background that highlights the magnitude of issues related to mental illness worldwide. Emphasis is placed on the problem of lack of mental health literacy and its consequences, despite progress that has been made to date in the diagnosis and treatment of mental disorders. The research aims and objectives are then presented, followed by the rationale for the study. An overview of the entire thesis is also presented in this introduction, thus providing a brief summary of what is to be covered in all subsequent chapters. Lastly, definitions of key terms used in this thesis are provided at the end of the chapter.

1.1. Introducing Mental Health Literacy

Globally, the prevalence of mental illnesses is on the rise, and this accounts for a large burden of disease and disability in healthcare. According to The World Health Organization (2016), nearly 1 in 10 people have a mental health disorder worldwide. It is disconcerting to note that in spite of the progress made in the diagnosis and treatment of mental health disorders, only a few of those in need of treatment receive it. Pillay, Kometsi and Siyothula (2009) have raised a concern about the general public's access to mental healthcare. The fact that mental health resources are grossly inadequate across the globe notwithstanding (Saraceno & Saxena, 2002), it is plausible that poor access to mental healthcare is largely because the public lacks mental health literacy. Most probably, the public's lack of understanding about available treatment options (Jorm, 2000), and negative attitudes toward patients and mental health treatment facilities (Jagdeo, Cox, Stein & Sareen, 2009), compound the picture. Furthermore, the possibility that lack of access to mental healthcare could be due to mental health professionals not being in tune with how mental health is conceptualised in different contexts cannot be ignored. Thus, the conceptualisation of mental health literacy by both the public and professionals is key to alleviating the situation.

1.1.1. Definition of mental health literacy.

The term 'mental health literacy' was first introduced by Jorm, Korten, Jacomb, Christensen, Rodgers and Pollitt (1997) to refer to knowledge and beliefs about mental disorders which aid in their recognition, management or prevention. According to Jorm (2000), mental health literacy consists of several components, including: (a) the ability to recognise specific disorders or different types of psychological distress; (b) knowledge and beliefs about risk factors and causes; (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate help-seeking; and (f) knowledge of how to seek mental health information. However, Bourget and Chenier (2007) argue that the existing definition of mental health literacy does not specify which or whose knowledge and beliefs represent good mental health literacy. They suggest that mental health literacy should be broadly defined as a range of cognitive and social skills and capacities that support mental health promotion. In essence, the focus should not be on the knowledge of the diagnostic aspects of mental illness, but instead mental health literacy should involve acknowledgement that there is a mental health problem.

1.1.2. The problem of poor mental health literacy.

The problem of poor mental health literacy is not a recent phenomenon. Confused societal attitudes (including those of medical professionals) towards the mentally ill have existed for many centuries (Gangat, 2001), dating back to the pre-scientific era when mental illness was thought to be caused by supernatural forces (Barlow & Durand, 2004) or demonic possession (Butcher, Mineka & Hooley, 2011). These views are still widely held and continue to influence many societies' understanding of mental illness. Gangat (2001) notes that in the past a person suffering a severe psychotic episode with agitation and mental confusion was seen as being possessed by diabolic forces and such individuals were often 'treated' by the church, sometimes tortured, or even burned at the stake. Up to the early part of the 20th century, psychiatric illnesses in Africa, Europe and other parts of the world were primarily attributed to supernatural powers and the spirits of ancestors. It was believed that the ancestors were punishing the sick person or the relatives of the sick person, and the illnesses were also attributed to sorcery and witchcraft invoked by neighbours, relatives or others as a form of revenge, punishment or

simply because of jealousy (Gangat, 2001). Such understandings are still widely prevalent in many societies today (Emsley & Seedat, 2007), and as a result, these societies are considered to lack the knowledge and awareness of mental disorders and to hold negative beliefs about the effectiveness of available treatment options, facilities and services. This assertion has been confirmed by many authors (Jorm, Barney, Christensen, Highet, Kelly & Kitchener, 2006; Jorm et al., 1997; Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999).

These views, however, according to Atilola (2015), assume that non-alignment of biomedical understanding of mental illness connotes lack of mental health literacy, or worse, ignorance. There are some shortcomings to this approach, for instance, such assumptions do not take into consideration the fact that various societies draw their knowledge from different worldviews, which in turn informs their explanatory models of illness. What may be considered a lack of mental health literacy in a society may also be a reflection that the public's knowledge of mental disorders is based on culture-induced explanatory models.

1.1.2.1. The consequences of lack of mental health literacy.

The following have been identified as some of the main consequences of lack of mental health literacy:

- a) There are many people with chronic or severe mental disorders who are unaware that they have a diagnosable disorder or that effective treatment is available. Inability to recognise disorders in oneself or others may lead to delays in seeking help or inappropriate help-seeking (Jorm, Barney, Christensen, Highet, Kelly & Kitchener, 2006). Research indicates that the majority of mental health patients first consult with general medical practitioners or complementary-alternative medical providers before consulting with mental healthcare professionals (Seedat et al., 2008), and there is a significant problem of non-detection in general practitioner or primary care settings (Hugo, Boshoff, Traut, Zungu-Dirwayi & Stein, 2003). It is disconcerting to note that in one Australian study when the public were asked to rate a range of interventions for their likely helpfulness in dealing with mental illness, self-help and non-standard interventions (e.g. meditation, yoga classes and increased physical activity such as running) were rated very highly (Jorm et al., 1997). In the same study, vitamins, minerals, tonics or herbal medicines were rated as more helpful than

pharmacological treatments. It is thus evident that more work needs to be done to educate the public about the psychological underpinnings of mental disorders and about the value of effective treatments (Hugo et al., 2003). Failure to provide this education may lead to unwillingness to accept help from mental health professionals, or inadequate adherence to treatment (Jorm et al., 1997). The effort to educate the public must, however, take into consideration the public's explanatory model of illness, on the one hand. On the other hand, mental health professionals must also be sensitised to the patients' explanatory models of illness. A synergy between patients' and professionals' explanatory models of illness may, according to McCabe and Priebe (2004), contribute to patient satisfaction with treatment and relationships with clinicians.

- b) Stereotypes and prejudices against patients with mental illness are widespread in many societies due to insufficient mental health literacy (Arvaniti, Samakouri, Kalamara, Bochtsou & Bikos, 2009; van 't Veer, Kraan, Drosseart & Modde, 2006). Unlike cancer patients and others who are suffering from medical conditions such as cardiovascular diseases, diabetes or renal diseases, and are often sympathised with and given the necessary support, mental health patients are often ridiculed, stigmatised and ostracised. Due to a lack of understanding of mental illness, these patients are often stereotypically perceived as dangerous, incompetent and unpredictable (Marie & Miles, 2008; Phelan & Link, 2004), and are sometimes blamed for their illness. Hugo et al. (2003) point out that cases of mental illness are often conceptualised as being due to lack of willpower rather than owing to a medical disorder. These authors argue that it is possible that ignorance and stigma prevent people with mental illnesses from seeking appropriate help, and that community attitudes and beliefs play a role in determining the help-seeking behaviour and successful treatment of the mentally ill. To remedy the situation, the WHO's Mental Health Global Action Programme recommends that the fight against stigma and discrimination should be driven through public education (WHO, 2002). It is thought that improved public mental health literacy would presumably lessen stigmatisation and encourage the use of currently available and effective interventions (Hugo et al., 2003).

- c) The annual cost of treating mental disorders is estimated to exceed billions of rands or dollars worldwide. In their systematic data review of the burden of mental illness, Eaton et al. (2008) reported that treatment-related costs of mental illness totaled from \$11 billion per year for simple phobia to more than \$200 billion per year for alcohol use disorders or drug use disorders in the United States of America. These estimates exclude costs for seeking help from alternative, non-mainstream and sometimes inappropriate sources. Apart from costs incurred seeking inappropriate services and unnecessary investigations (Jorm, 2000), more money is also spent treating disorders that have progressed to chronic stages which could have been treated with less cost had they been recognised by mental health professionals at their initial stages of development. In addition, Hugo et al. (2003) note that the personal and social costs that result from untreated mental disorders are considerable. On the one hand, they highlight the direct financial costs incurred which include medical care and government disability payments, and on the other, the indirect costs including lost employment, reduced productivity and vehicular accidents due to substance abuse. Furthermore, they refer to suicide, homelessness and disruptive influence on family life as examples of human costs that could be incurred.
- d) In South Africa, the task of helping patients and preventing mental disorders is largely left to professionals who cannot assist all patients given the shortage of mental health professionals and services in the country. According to Emsley (2001), post-apartheid South Africa has inherited a legacy of racially inequitable, fragmented and inadequately resourced mental healthcare services. The country has far too few mental health specialists and inadequately developed infrastructure to deliver mental health services in accordance with the needs of the inhabitants (Pillay & Lockhat, 1997), and mental health services remain chronically underresourced. South Africa has only 0.28 psychiatrists, 0.32 psychologists, 10.08 psychiatric nurses, 0.40 social workers and 0.13 occupational therapists, per 100 000 population (Lund, Kleintjies, Kakuma, Flisher & MHaPP Research Programme Consortium, 2010). These ratios fall well short of internationally recommended ratios (Pillay & Lockhat, 1997) and are instructive as they show that mental disorders among South Africans most often go untreated. Greater efforts are clearly needed to improve access

(and mental health literacy) of those who require mental health services (Seedat et al., 2008). Improved mental health literacy is likely to increase the necessity for more mental health professionals and services to a critical level sufficient to warrant health authorities' attention and intervention.

It is apparent from the consequences outlined above that the need to investigate and increase both the public's and professionals' level of mental health literacy is of critical importance. Most importantly, this investigation must be grounded in an examination of where the public draws their knowledge about mental illness from. Socio-cultural influences, with reference to the patients' worldview, must also be an integral part of this process as it ultimately informs their explanatory models of illness. Professionals, alike, need to be educated about the cultural bases of mental illness and how patients' explanatory models of illness could be elicited and used to increase their level of mental health literacy. Thus, the explanatory model of illness is a critical factor compounding mental health literacy for both health professionals and the public.

1.3. Research Aim and Objectives

1.3.1. Research aim.

Despite evidence that the prevalence of mental disorders is on the rise (Bhagwanjee, Parekh, Paruk, Petersen & Subedar, 1998) and the South African researchers' call to promote research into the issue of mental health literacy almost a decade ago, there is paucity of research in South Africa on the public's perceptions and awareness of mental disorders and their beliefs about the effectiveness of treatment (Hugo et al., 2003). Most studies on the topic of mental health literacy have been conducted abroad (Jorm, Christensen & Griffiths, 2006; Link, et al., 1999; Schomerus, Matschinger & Angermeyer, 2009) while only a few relevant studies have been conducted locally (Hugo et al., 2003; Samouilhan & Seabi, 2010). These studies have addressed only some aspects of mental health literacy, and no recent comprehensive South African studies of mental health literacy have been conducted to date. It is evident that there is a dire and long overdue need for large scale studies investigating mental health literacy in South Africa. This current study aims to bridge this gap in existing knowledge by assessing

the public's mental health literacy in Sisonke District, located in the province of KwaZulu-Natal, South Africa. If there are to be greater gains in prevention, early intervention, improved help-seeking behaviour, treatment compliance and patient support, then there is a definite need for a mental health literate society in which accurate basic knowledge and skills are more widely distributed (Jorm, 2000). In addition, it is crucial for mental health practitioners to be educated about patients' explanatory models of illness, because some patients may have different worldview regarding the causes, nature and treatment of illness than Western medical models.

1.3.2. Objectives.

As a way of realising the aim of this research into the issue of mental health literacy discussed above, this thesis explores a number of objectives, which are presented as questions to be addressed. Each primary objective is followed by a number of secondary objectives.

Objective 1- What are Sisonke District residents' conceptions of mental disorders, particularly depression, schizophrenia and alcohol dependency, and what are their notions regarding the causes of these disorders?

- a) What do the residents of Sisonke District understand is wrong or is happening with someone exhibiting mental illness symptoms that are indicative of depression, schizophrenia and substance dependency?
- b) What do the residents of Sisonke District think are the causes of mental illness, namely depression, schizophrenia and substance dependency?
- c) Is there a relationship between the residents' conceptions and aetiological beliefs of mental illness in Sisonke District?

Objective 2- What are the residents of Sisonke District's knowledge and attitudes toward help-seeking and interventions for mental illness?

- a) What are the preferred sources of support for mental illness among the residents of Sisonke District?
- b) What are the residents' beliefs and attitudes about specific mental health interventions?
- c) What are the predictors of attitudes and help-seeking behaviour?
- d) What are the residents' beliefs about prognosis of mental illness?
- e) Do the residents of Sisonke District know about institutions providing mental health services?

Objective 3- What are Sisonke District residents' attitudes towards mental illness?

- a) What are Sisonke District residents' stigmatising attitudes toward mental illness?
- b) What are the residents' perceptions of dangerousness of mental illness?
- c) What are the predictors of these perceptions of dangerousness toward the mentally ill?
- d) What are their social distance attitudes towards mental illness?
- e) What are the predictors of social distance toward the mentally ill?

1.4. Rationale

The study is motivated by the following reasons:

1) If there are to be greater gains in mental illness prevention, early intervention, improved help-seeking behaviour, treatment compliance and patient support, then there is a need for a 'mental health literate' society in which accurate basic knowledge and skills are more widely distributed (Jorm, 2000). The current study aims to contribute towards this effort improve mental health literacy in South Africa.

2) Before responding to Mkhize and Kometsi's (2008) call for government to improve its efforts to raise the public's awareness of various aspects of mental health, it is imperative to first establish what the public knows about mental illness and their attitudes toward mental illness. Information derived from this study will assist KwaZulu-Natal's Department of Health to design targeted awareness campaigns and educational programmes addressing specific gaps in the public's knowledge and attitudes toward mental illness. This study will also aid South African

policy-makers and health authorities in their plans to improve mental health services delivery.

3) Furthermore, upon completion of this study, the researcher aims to use the information gathered to implement a research initiative to be named the 'South African Mental Health Literacy Project'. This project will be aimed at improving the general public's mental health literacy. The project is also intended to be used to raise mental health practitioners' awareness of the public's explanatory models of illness and to investigate how this awareness could be used to improve early mental illness recognition and adherence to treatment.

1.5. An Overview of the Thesis

This thesis is divided into nine chapters. The current chapter is an introductory chapter and offers both an overview of the topic of mental health literacy and an outline of the remainder of the thesis. It also presents the research aims, objectives and rationale for the study. A section containing the definitions of key terms concludes this chapter. Chapter 2 reviews relevant literature related to the main topic addressed in the study and therefore begins with a brief history of mental illness to provide a contextual background in order to demonstrate how the conceptualisation of mental illness has evolved over time. The current global state of the issue of mental illness and mental healthcare concerns in South Africa, with a particular focus on mental healthcare policy, service provision and usage of mental healthcare facilities, will also be presented in Chapter 2.

Chapter 3 discusses culture and the understanding of mental illness, with a particular focus on the social construction of mental illness from both Western and African perspectives. The relationship between aetiological and treatment beliefs will also be explored in this chapter. Chapter 3 will conclude with a discussion of the integration of Western and African practices for improved mental healthcare. Theories in which this research is grounded are presented in Chapter 4. Contact theory, explanatory models of mental illness, health related theories and stigma theory will be used to formulate and guide the development of arguments central to this research.

Chapter 5 offers an account of the detailed methodology followed throughout this research. The chapter begins with an overview of the study site, Sisonke District. Thereafter, the quantitative, cross-sectional, correlational research design selected for the study is presented, followed by details regarding the

sample and sampling techniques used. A discussion of the data collection instrument used, the process of data collection, as well as the data analysis method employed after data was gathered also form part of this chapter. Ethical considerations that emerged and how these were dealt with by the researcher are presented last in Chapter 5. The results of this study are presented two chapters. Chapter 6 presents the demographic characteristics of the sample and the results on conceptions and causes of mental disorders. Knowledge and attitudes toward help-seeking and interventions for mental health problems as well as attitudes toward mental illness are presented in Chapter 7. Chapter 8 critically discusses the presented results and the implications of the results in relation to the literature reviewed. Chapter 9 concludes the thesis; it offers a discussion of the unique contribution of this study and the recommendations for addressing the issue of mental health literacy in South Africa. The limitations of the study and suggestions for future research into the subject under investigation in this study, namely mental health literacy, are also presented in Chapter 9.

1.6. Definitions of Terms

It is important to note that not all terms contained in this study are defined here, but only a selected few, particularly those that are key to the study or those that are likely to be unfamiliar or open to various interpretations.

- Biopsychosocial model: An integrative model for explaining abnormal behaviour patterns in terms of the interactions of biological, psychological and sociocultural factors (Nevid, 2009).
- Epidemiology: The study of the distribution of diseases, disorders, or health-related behaviours in a given population (Butcher et al., 2011).
- Exorcism: The act of driving evil spirits from the body of the suffering person (Nolen-Hoeksema, 2008). In an exorcism, according to Sue, Sue, Sue and Sue (2010), elaborate prayers, noises, emetics (drugs that induce vomiting) and extreme measures such as flogging and starvation were used to cast evil spirits out of an afflicted person's body.
- General paresis: A disorder characterised in its advanced stages by mental deterioration and bizarre behaviour, resulting from massive brain deterioration caused by the sexually transmitted disease syphilis (Holt, Bremner, Sutherland, Vliek, Passer & Smith, 2012).

- Mental illness: According to Phares and Trull (1997), 'mental illness' refers to a large class of frequently observed syndromes that are comprised of certain abnormal behaviours or features. These abnormalities tend to co-exist in the same individual.
- Multidimensional integrative approach: An approach to the study of psychopathology that holds psychological disorders as always being the products of multiple interacting causal factors (Barlow & Durand, 2012).
- Psychological disorder: A psychological dysfunction within an individual associated with distress or impairment in functioning and a response that is not typical or culturally expected (Barlow & Durand, 2012). For the purposes of this thesis, the terms *mental illness*, *mental disorder*, *psychiatric disorders* and *psychological disorders* will be used interchangeably.
- Teleology: A term derived from the Greek words *telos* (end) and *logos* (discourse), which refers to an approach that seeks to explain the universe in terms of final (rather than immediate) causes (Mkhize, 2013).
- The medical model: A model based on the belief that abnormal behaviour patterns represent mental illness that have a biological, not demonic, basis and can be classified by their particular characteristics or symptoms (Nevid, 2009).
- The psychological model: A model based on the belief that mental disorders are caused by psychological and emotional factors rather than organic or biological ones (Sue et al., 2010).
- Trephining: A surgical method from the Stone Age in which part of the skull was chipped away to provide an opening through which evil spirits could escape (Sue et al., 2010).

Chapter 2

Literature Review

This chapter begins with a brief history of mental illness as a contextual background to the issue of mental health literacy that is central to this thesis. This initial section presents a summary that highlights how the understanding and conceptualisation of mental illness has evolved over the years from the prehistoric era to date. The central argument is that the perceptions and conceptualisations, at a particular time in history regarding the aetiology of mental illness, influence attitudes toward mentally ill patients and the type of treatment deemed appropriate. Contemporary views of what causes an individual's behaviour to become abnormal and the systems being used to classify and test such behaviour will conclude this historical background. Thereafter, the focus in the chapter will shift to the current global state of mental illness, through an examination of epidemiological issues, with particular reference to the United States of America, Australia, and South Africa. This chapter concludes with a discussion of issues pertinent to mental healthcare in South Africa.

It is important to highlight that the historical background provided in this section is largely based on a Western context and that there were other equally significant parallel historical developments elsewhere in non-Western countries. To substantiate this, Cartwright (2008) gives the examples of China and India as places where traditions of healing do not share the Western history of trying to separate physical from mental illness. Furthermore, he argues that in southern Africa, alongside the Western view of psychopathology, there are other important indigenous theories of mental illness that locate the cause of personal problems in difficulties in social relationships. To substantiate his argument, with regard to treatment, Cartwright (2008) states that in addition to psychologists and psychiatrists, people from southern Africa may consult indigenous healers or herbalists or prophets in the Zionist church. The African perspective towards mental illness is discussed in detail in Chapter 3 of this thesis.

2.1. Brief History of Mental Illness

2.1.1. The prehistoric era.

There is ample evidence to show that references to mental illness, insanity, or other forms of abnormal behaviour can be found throughout human history. Historians speculate that even prehistoric people had a concept of insanity. Proof of this is based on inferences from archeological artifacts such as fragments of bones, tools, artwork and so on (Nolen-Hoeksema, 2011). Human skulls, dating back to 5000 BC, that have holes drilled into the cardinal region, have been discovered. Presumably, it was thought that by boring a hole in the patient's skull using a surgical method called *trephining*, the evil spirit causing the illness could escape (Sue et al., 2010). The dominant understanding of mental illness during this prehistoric period was informed by the belief that individuals who became psychologically disturbed were possessed by evil, supernatural forces (Cartwright, 2008). The treatment of choice when a person was suspected of being possessed by evil spirits, used by the early Greeks, Chinese, Hebrews and Egyptians, was exorcism (Nevid, 2009; Sue et al., 2010). According to Bootzin, Acocella and Alloy (1993), this practice involved a wide variety of techniques such as prayer, noisemaking and the drinking of special potions. In most difficult cases, these authors state that the 'possessed' person could be submerged in water, whipped or starved in order to make the body a less comfortable habitation for the devil. At times the person would be killed during the process of the exorcism (Nolen-Hoeksema, 2008). Within this system of belief, referred to as demonology by Sue et al. (2010), some patients were held at least partly responsible for their misfortune.

2.1.2. The ancient era.

With the flowering of Greek civilisation and its continuation into the era of Roman rule (500 BC - 500 AD), naturalistic explanations of mental illness gradually became distinct from supernatural ones (Sue et al., 2010). Most authors (Austin & Burke, 2009; Cartwright, 2008; Holt et al., 2012) state that the first evidence of a shift to a naturalistic or biological view of mental illness can be found in the work of a Greek physician named Hippocrates (460 - 377 BC). Hippocrates believed that the brain was the central organ of intellectual activity and that deviant behaviour was caused by brain pathology (Sue et al., 2010). He therefore considered that any

changes in behaviour could be ascribed to changes in the brain. However, Hippocrates did not think that brain changes alone were responsible for behaviour changes. He also believed that mental health problems were diseases much like physical disorders (Holt et al., 2012) and were the result of imbalances in four essential fluids or humours in the body: blood, phlegm, yellow bile and black bile (Cartwright, 2008).

Based on careful observation of his many patients, including listening to their dreams, Hippocrates classified abnormal behaviour into the diseases of epilepsy, mania, melancholia and brain fever (Nolen-Hoeksema, 2008). For example, he believed that a disproportionate amount of black bile would cause melancholia, and he would prescribe naturalistic remedies to heal these kinds of problems, such as recommending solitude, a change in diet or abstinence from sexual activity (Cartwright, 2008), and if necessary, bloodletting (Sue et al., 2010). Although Hippocrates' understanding of mental illness was later found to be incorrect, Austin and Burke (2009) assert that his findings marked the rudimentary beginnings of the biomedical approach to understanding psychopathology, even though this approach only fully emerged centuries later.

During the Middle Ages, instead of building on biological causes of mental illness as proposed by Hippocrates, the naturalistic approach to understanding mental disorder fell out of favour. Cartwright (2008) states that with the collapse of the Roman Empire and the rise of Christianity, there was a return to ascribing mental illness to supernatural causes, and religion dominated all explanations of psychopathology. Mental illness was viewed as a punishment for sins committed, or as a form of demonic possession. Nolen-Hoeksema (2008) justifies this understanding of mental illness by quoting a scripture from the Bible (Deuteronomy 28: 15-28) in which Moses warns his people that if they "will not obey the voice of the Lord your God or be careful to do all His commandments and His statutes ... the Lord will smite you with madness and blindness and confusion of the mind...". Apparently this punishment was thought to involve the withdrawal of God's protection and the abandonment of the person to the forces of evil, manifesting as mental illness (Butcher et al., 2011). Individuals appearing to oppose the Christian faith were accused of being possessed by the devil and were thought to have various supernatural powers that could cause great harm to others (Cartwright, 2008). Witch hunts became very prominent and Sue et al. (2010) approximate that about 20 000 people, mainly women, were killed as witches in Scotland alone and that more than 100 000 people were executed throughout

Europe. These statistics have also been recorded by others (Holt et al., 2012). Diagnostic 'tests' included binding a woman's hands and feet and throwing her into a lake or pond. Based on the idea that impurities float to the surface, a woman who sank and drowned could be posthumously declared pure. A woman who floated however was in real danger of being harmed or killed. Nolen-Hoeksema (2008) writes that accused witches sometimes confessed to speaking with the devil, flying on the backs of animals and engaging in other unusual behaviours. It is possible that such people could have been experiencing delusions or hallucinations. To substantiate this, Gangat (2001) states that a person suffering a severe psychotic episode with agitation and mental confusion was seen as being possessed by diabolical forces.

The Church became the main vehicle through which such 'possessions' could be exorcised. According to Sue et al. (2010), during this period treatment of the mentally ill sometimes consisted of torturous exorcistic procedures seen as appropriate to combat the devil and eject him from the possessed person's body. Prayers, curses, confessions, obscene epithets and the sprinkling of holy water, as well as drastic and painful 'therapy' such as flogging, starving and immersion in hot water were used to drive out the devil. Formal segregation of mentally disturbed individuals began in the late Middle Ages, when the Church, supposedly out of charity, began to lock up the so-called 'insane' (Cartwright, 2008). This resulted due to the increasingly mounting pressure from social and religious reformers during the thirteenth century who challenged the Church regarding corruption and its abuses of the people.

2.1.3. The Renaissance era.

During the Renaissance (1400-1600), mentally ill patients began to be treated more humanely and ideas related to witchcraft were more openly challenged in Europe. People began to suggest that mental illnesses were diseases rather than forms of possession and bewitchment (Gangat, 2001). A German physician, Johann Weyer, postulated that such individuals were not possessed by the devil but were mentally unstable and therefore could not be held responsible for their actions (Austin & Burke, 2009). He published a revolutionary book in 1563 that challenged the foundations of ideas about witchcraft (Sue et al., 2010). Later, in 1584, Reginald Scot published a book called *Discovery of Witchcraft*, in which he also argued that so-called 'possessions' were medical illnesses and not

visitations from evil spirits (Cartwright, 2008). Although these books were severely criticised by the Church, they contributed significantly to the humanitarian perspective on mental illness. While these revolutionary ideas did not gain wide acceptance at first, the foundations of modern psychiatry were nevertheless being laid during this period (Gangat, 2001).

With an increased scientific understanding of mental illness, the Renaissance era was followed by the asylum era between the sixteenth and seventeenth centuries. It was during this era that general hospitals began to include special rooms or facilities for mentally ill patients (Nolen-Hoeksema, 2008). Asylums were built (Gangat, 2001) and institutionalisation of the mentally ill was on the increase (Austin & Burke, 2009). Treatment in these early hospitals was however far from humane. Asylums became well known for their inhumane treatment of mental patients, as these institutions were more like prisons than hospitals (Barlow & Durand, 2005). Treatment for these patients included restraining them for long periods of time, placing them in dark cells and subjecting them to torture-like treatments. Patients were often subjected to electric shocks, bleeding in order to rid the body of 'dangerous' fluids, powerful drugs and starvation (Cartwright, 2008; Gangat, 2010).

A significant contribution towards humane treatment of mentally ill patients was championed by a French physician named Philippe Pinel. He instituted what came to be known as the 'moral treatment movement' by arguing that mentally ill patients needed to be treated with kindness and consideration if they were to recover (Cartwright, 2008). He ordered patients' chains to be removed, dungeons where patients were kept to be replaced with sunny rooms, patients to be encouraged to exercise outdoors on hospital grounds, and be treated with kindness and respect (Butcher et al., 2011). It was surprising to many people that the freed patients did not become violent and that this humane treatment seemed to foster recovery and improve behaviour (Sue et al., 2010). In other parts of the world this humane treatment of mentally ill patients began to be adopted, and many patients were reported to have recovered from their mental illness once they were treated humanely. The changes that followed transformed the way mental illness was treated during this time. More nurses, doctors and professional therapists were trained to work with mentally ill patients to help them restore their sense of tranquility and recovery (Nolen-Hoeksema, 2008).

With the new and improved humane treatment of mentally ill patients, it was inevitable that the need for asylums and mental hospitals increased. According to Grob (1994), as more asylums were built, more people were admitted to these asylums and the need for the recruitment of additional mental health professionals grew. Patients could no longer be given the dedicated attention they needed due to the shortage of healthcare facilities and professionals. In addition to this, it is imperative to bear in mind that the inhumane treatment of mentally disturbed patients was never totally eliminated and asylums were still mysterious to the public. Carson and Butcher (1992) contend that little was done by mental health professionals to educate the public to reduce the general fear and stigma of insanity. They speculate that the reason for this silence was that early psychiatrists had little actual information to impart.

Nevertheless, parallel to the positive developments facilitated by the 'moral treatment movement' in the treatment of mental illness, was an inquiry into its causes. Towards the end of the nineteenth century, many developments occurred and new explanations regarding mental illness, its causes and possible treatment options emerged. This led to the advent of the scientific era in the history of mental illness.

2.1.4. The scientific era.

The basic knowledge of the anatomy, physiology, neurology and chemistry of the body increased rapidly during the scientific era or the late nineteenth century. The scientific era was characterised by a shift back towards a more biological approach to understanding the causes of mental illness, and the development of the first modern model of mental illness, the *medical model*. In 1845, a German psychiatrist, Wilhelm Griesinger, presented a systematic argument, in his book called *The Pathology and Therapy of Psychic Disorders*, that all mental disorders can be explained in terms of brain pathology (Nolen-Hoeksema, 2011). The biological emphasis was given impetus by the discovery that the sexually transmitted disease called syphilis resulted in massive brain deterioration causing a condition known as *general paresis* (Holt et al., 2012). The establishment of the idea that mental illness was caused by an underlying sickness was a breakthrough in the history of mental illness. This encouraged further research into other biological causes that could be related to mental illness and formed the foundation of the modern-day perspective into mental illness.

Clinical observations and technological developments created an era in which the brain was studied scientifically. As a result, it was suggested that most of the specific symptoms of mental illness could be understood in terms of brain mechanisms (Gangat, 2010). Butcher et al. (2011) note an interesting point that although the discovery of the organic bases of mental disorders addressed the 'how' behind causation, it did not, in most cases address the 'why'. This is sometimes true even today. These authors substantiate this claim with the following example: although it is known what causes certain mental disorders, for instance, Alzheimer's disease, it is not known yet why some individuals are afflicted and others are not.

At the turn of the twentieth century, Emil Kraepelin, a follower of Griesinger, observed that certain symptoms tend to occur regularly in clusters called syndromes (Sue et al., 2010). He believed that each cluster of symptoms represented a mental disorder with its own distinctive and clearly identifiable causes, course and outcome. He subsequently developed a classification system for a number of disorders, most notably dementia praecox (known today as schizophrenia), manic depressive psychosis (now bipolar affective disorder), as well as paranoia (delusional disorder) (Cartwright, 2008; Gangat, 2010). Kraepelin's views about the classification of mental illness served as a precursor to the Diagnostic and Statistical Manual of Mental Disorders (DSM) that is currently used to make a diagnosis (Austin & Burke, 2009).

Despite the growing interest in the medical model and its contribution to the advancement in the understanding and classification of mental illness, some scientists began to realise that not all mental disorders could be explained in terms of brain pathology. Sue et al. (2010) suggest that it became apparent that the inability, for example, to attain personal goals and resolve interpersonal conflicts could lead to intense feelings of frustration, depression, failure, and anger, which may consequently lead to disturbed behaviour. This led to the development of the theories which were based on the *psychological model* of mental illness. The first major theory was psychoanalysis, developed by Sigmund Freud, which posited that unconscious, unresolved conflicts from childhood are at the root of abnormal behaviour (Nevid, 2009). According to Gangat (2010), unlike Kraepelin, Freud was more interested in symptoms referred to as hysterical or conversion phenomena. These were unexplained pains, paralysis, seizures and blindness with no obvious physical cause. At first Freud treated his patients by using hypnosis. Later he used

a technique called free association, in which the patient expressed any thoughts that came to mind (Passer & Smith, 2008). Most of Freud's patients talked about painful and long-forgotten childhood experiences, often sexual in nature. Some of these patients attained symptom relief through this process of talking.

Freud's ideas led to a plethora of psychological theories and psychotherapeutic methods for treating mental disorders, all of them claiming to have a better understanding of human behaviour and mental illness. Behavioural, cognitive and humanistic theories are among such early psychological theories. These theories will not be explained in detail here; instead only their brief postulation will be provided. Behavioural theories are based on the belief that most forms of abnormal behaviour are learned in the same way that normal behaviour is learned (Nevid, 2009). Several theorists challenged behavioural theorists and placed the emphasis on the cognitive processes that influence behaviour and emotion. Cognitive revolutionists, such as Albert Bandura, argued that people's beliefs about their ability to execute the behaviours necessary to control important events (self-efficacy beliefs) are crucial in determining their well-being (Nolen-Hoeksema, 2008). This theory became very popular and moved psychology into the study of the thought processes behind serious emotional problems. Nevertheless, according to Nevid (2009), humanistic theorists such as Carl Rogers and Abraham Maslow challenged the belief that human behaviour is the product of either unconscious processes or just thinking. They proposed that people have an inborn force toward self-actualisation (reaching of one's full potential) and pathology occurs when the environment frustrates the innate tendency toward self-actualisation (Passer & Smith, 2008). With so many theories emerging, there has been a great deal of conflict regarding which theories best explain abnormal behaviour and which treatments are more effective. According to Cartwright (2008), often the treatment method that is chosen simply depends on the therapist's chosen theoretical orientation.

The introduction of psychotropic drugs in the 1950s has also been regarded as an important landmark in the history of mental illness (Austin & Burke, 2009). Drugs like lithium, chlorpromazine and imipramine were considered as miracle drugs because, for the first time, symptoms associated with mania, psychosis and depression could be controlled through the use of medication (Cartwright, 2008). This enabled the discharge of many patients who had been admitted to hospitals for long periods and out-patient treatment, on medication, became possible. Furthermore, periods of admission to psychiatric hospitals were shortened,

treatment became more cost effective (Sue et al., 2010), and deinstitutionalisation of mentally ill patients became popular. The discovery of these drugs established an entirely new discipline, *psychopharmacology*, and led to a major and powerful alternative to the techniques of psychotherapy that had held sway until then (Gangat, 2001).

In summation, it is apparent that mental illness has existed since the beginning of humankind and that confused, stigmatising and degrading understandings have been attributed to this form of illness from then to date. Many authors (Emsley & Seedat, 2007; Jorm et al., 2006; Jorm et al., 1997; Link et al., 1999) claim that such understandings are still widely present. This comes as no surprise because laborious efforts, from the pre-historic era to present, made in an attempt to understand mental illness, have not yielded consensus regarding its causes, classification and treatment. Instead, various theories are in competition for dominance over other perspectives. In spite of their commendable contributions, none of the theories considered above can claim to provide a comprehensive conceptualisation of mental illness; instead, many questions remain. Though none of these models offers a complete view, each of them has something unique to contribute to the understanding of mental illness. Passer, Smith, Holt, Bremner, Sutherland and Vliek (2009) assert that these models, nonetheless, provide a deeper understanding of how biological, psychological and environmental factors contribute to the manifestation of mental illness.

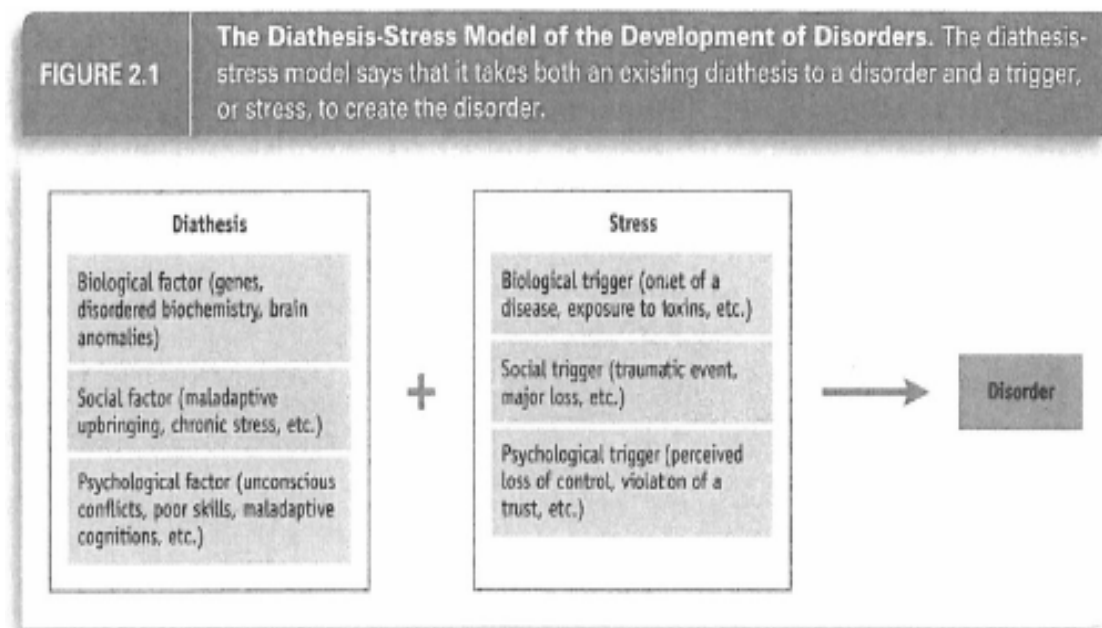
2.1.5. The present: diathesis-stress model.

More recently, many authors (Cartwright, 2008; Holt et al., 2012; Nevid, 2009; Passer et al., 2009) endorse a model that integrates biological, psychological and socio-cultural factors as a way forward to enhancing a better understanding of mental illness. Contemporary theorists and mental health practitioners find it useful to incorporate these factors into a more general framework called the *diathesis-stress model* of abnormal behaviour (Butcher et al., 2011). Cartwright (2008) suggests that such a framework draws on the strengths of many different models of mental illness in a way that best assists the patient. According to the diathesis-stress model, certain people have a vulnerability or predisposition, called a diathesis, which increases their risk of developing a particular disorder (Nevid, 2009). Nolen-Hoeksema (2011) and Passer et al. (2009) posit that a diathesis may

be biological (such as genetic predisposition to the disorder), psychological (such as low self-esteem), or socio-cultural (such as growing up with the stress of racial discrimination).

It is important to note that a diathesis may not be enough on its own to lead to the development of the disorder. In most instances, mental disorders are believed to develop when some kind of a stressor, or trigger, operates on a person who has a diathesis for that disorder (Butcher et al., 2011). Nolen-Hoeksema (2011) suggests that this trigger could be a biological one, such as an illness that changes hormonal balances. She adds that it could also be a psychological or social-cultural one, such as a traumatic event. Passer and Smith (2009) offer the following example to illustrate this: a person who has a genetic predisposition to depression or who suffered a traumatic loss of a parent early in life may be primed to develop a depressive disorder if faced with the stress of a loss later in life. Barlow and Durand (2012) suggest that the diathesis and the stress must interact to produce a disorder. Figure 2.1 below presents a concise summary of the diathesis-stress model.

Figure 2.1: The diathesis-stress model



Source: Nolen-Hoeksema (2011, p.28)

An important aspect of the diathesis-stress model is that the bigger the diathesis (or the stronger the predisposition), the less stress is required to trigger a disorder; the smaller the diathesis, the more stress is required (Holt et al., 2012). Nevid (2009) and Passer et al. (2009) argue that if a person encounters a low level of stress or has effective skills for handling stress, the disorder may never develop even if a diathesis is present. Yet it is also possible that the diathesis could be so strong that the disorder develops even under the most benign life circumstances.

2.2. Contemporary Views of Abnormal Behaviour

Having presented the contemporary perspective on the conceptualisation of mental disorders, it is important to briefly discuss contemporary views of what comprises abnormal behaviour. In spite of the progress made in the study of mental illness and available sophisticated technology to aid this, defining what counts as abnormal behaviour (or mental illness) remains problematic. The influences of time and culture on where to draw the line between normal and abnormal behaviour also add to the complication of defining mental illness. Nevertheless, according to Holt et al. (2012), decisions regarding what constitutes abnormal behaviour seem to be governed by the following three criteria: distress, dysfunction and deviance. Beginning with distress, Passer and Smith (2008) propose that behaviour is likely to be labeled as abnormal if it is distressing to the individual and/or others. They argue that people who are excessively anxious, depressed, dissatisfied or otherwise seriously upset about themselves or about life circumstances may be viewed as disturbed, particularly if they seem to have little control over these reactions.

Regarding dysfunction, Passer et al. (2009) state that behaviours are also judged abnormal if they are dysfunctional either for the individual or for society. To justify this, they argue that behaviours that interfere with a person's ability to work or to experience satisfying relationships with other people are likely to be seen as maladaptive and self-defeating, especially if the person is unable to control such behaviours. Lastly, behaviour is judged as abnormal by how deviant it is from the norms of the society. Holt et al. (2012) define norms as behavioural rules that specify how people are expected to think, feel and behave. Some of these norms are made explicit and appear as law, while others may be less explicit. Deviation from these norms is often used as a criterion for labelling behaviour as abnormal (Nevid, 2009). However, Sue et al. (2010) caution that this criterion could be extremely

subjective because it depends on the individual being diagnosed, the diagnostician, and the particular cultural context. Cartwright (2008) concurs with this point of view and suggests that what is considered normal behaviour would depend on an individual's cultural or social perspective. He provides the example of hearing voices when nobody is around, which could be considered a symptom of psychosis from a typical Western perspective. However in traditional Zulu culture, hearing voices may be associated with *ukuthwasa*, which is an ancestral calling to become a traditional healer. It is apparent that both personal and social judgments have played and continue to play a significant role in considerations regarding the conceptualisation of mental illness.

Similar to establishing an understanding of how abnormal behaviour is currently judged, it is equally important to understand how behaviour is classified and communicated among mental health practitioners once deemed to be abnormal. According to Butcher et al. (2011), the two major classification systems currently used by most mental health professionals are the International Classification of Disease System (ICD), published by the World Health Organization, and the DSM, published by the American Psychiatric Association. The ICD is used mainly in Europe, whereas the DSM is used in the United States and in many other parts of the world (Barlow & Durand, 2012), including South Africa.

The DSM classification was previously based on the bio-medical model and it grouped together the signs and symptoms to identify and diagnose mental illness (Cartwright, 2008). It specified five axes or dimensions along which a clinician evaluated and recorded a person's behaviour or diagnosis. Major disorders were listed on Axis I, and mental retardation (currently called intellectual disability) and personality disorders on Axis II. Medical or physical diseases from which the person was suffering were noted on Axis III. Psychosocial stressors that the individual faced were recorded on Axis IV. On Axis V, the clinician rated the highest level at which the individual was able to function in daily life (Nolen-Hoeksema, 2011).

In spite of its success in classifying mental disorders and its popularity, the DSM system has been criticised for a number of reasons, including some of the following. Austin and Burke (2009) raise concerns regarding the reliability and validity of the DSM system. They question whether a diagnosis would remain constant if the same patient were to be assessed by a number of psychologists (inter-rater reliability) or whether it could be known with certainty that the DSM system measures what it claims to measure (validity). That is, if a psychiatrist makes

a diagnosis of schizophrenia using the criteria set out in the manual, how can it be ascertained that the patient actually suffers from schizophrenia? Authors like Nevid (2009) and Cartwright (2008) challenge the DSM system as based too heavily on the medical model, in which abnormal behaviours are assumed to be symptoms of underlying disorders or mental illnesses. They support this argument with a medical example in which dizziness, fatigue, anxiety and high blood pressure are symptoms that can be used to diagnose hypertension in a patient. However, such an approach, of identifying symptoms, may not be applicable in diagnosing certain mental disorders.

Austin and Burke (2009) also criticise the DSM system for adopting what they called an individualistic approach. They argue that, according to the DSM system, the syndrome is assumed to exist only as an isolated problem in the patient, and the group or family context is not given priority when the diagnosis is being considered. Cartwright (2008) states that the DSM system is further criticised for creating diagnostic categories that have a Western cultural perspective. He uses the diagnosis of anorexia nervosa as an example because it is a disorder characterised by a Western phenomenon - the restricted intake of food and excessive weight loss. Cartwright (2008) adds that the DSM system does not give enough emphasis to the role played by cultural beliefs and their relationship to mental illness. Butcher et al. (2011) are critical of diagnostic labels used in the DSM, arguing that they are little more than labels applied to a defined category of socially disapproved of or otherwise problematic behaviours. In addition, they maintain that a diagnostic label can make it difficult to examine a person's behaviour objectively, without preconceptions about how they will act. For example, when a person is labeled 'schizophrenic' or 'depressed', others are more likely to make certain assumptions that may or may not be correct about that person, and to attribute certain behaviours to the diagnosed condition. A final criticism that has been leveled at the DSM system is that it merely describes disorders but does not explain why they might occur (Cartwright, 2008).

In spite of its limitations, it is crucial to bear in mind that the DSM system has been under development since 1952, and has undergone a number of modifications since its inception in an attempt to improve on the limitations identified over the years. The latest version, DSM-5, was published in 2013 with the aim of improving the validity of the previous editions and of grounding the DSM in solid research (Rodríguez-Testal, Senin-Calderon & Perona-Garcelan, 2014). According to Machado, Caye, Frick and Rohde (2013), the main amendments

introduced by the DSM-5 include: 1) grouping disorders, especially those based on neurobiological mechanisms, on the basis of shared aetiological factors; 2) adopting a more developmentally-oriented approach that recognises that a large portion of mental disorders begin in childhood or adolescence 3) replacing the multi-axial structure with a uniaxial approach; 4) redefining the diagnostic criteria for several disorders; and 5) adding diagnostic criteria for new diagnoses, for example hoarding disorder and disruptive mood dysregulation disorder. Critics, however, argue that the new DSM-5 raises many questions about the diagnostic validity which it attempts to improve on, and they contend that the new model takes a classification approach nearer to neurology and genetics than to clinical psychology (Rodriguez-Testal et al., 2014).

At present, the process of classification and diagnosis of mental illness is aided by technologies and psychological tests. Some mental health practitioners refer their patients for medical examination and laboratory tests, such as a test for hypothyroidism in the differential diagnosis of major depressive disorder, to rule out possible medical causes (van Reinsburg & Berk, 2001). Specialised neurological examination technologies, such as electroencephalogram (EEG), computerised axial tomography (CAT scan), magnetic resonance imaging (MRI), and positron emission tomography (PET scan), are often used because brain pathology is sometimes involved in some mental disorders (Butcher et al., 2011). EEG is used most often to detect seizure activity in the brain and to detect tumours and stroke, and a CAT scan can reveal brain injury, tumours and structural abnormalities (Nolen-Hoeksema, 2008). MRI provides colour images of the tissue and can make out details one-tenth the size of those detected by CAT scans (Holt et al., 2012). PET scans are useful for supplementing MRI and CAT scans in localising sites of trauma and identifying varying patterns of metabolism that might be associated with different disorders (Austin, 2009).

In addition to these afore-mentioned technologies, psychological tests are also used to determine emotional, behavioural or cognitive responses that could be associated with a specific disorder (Austin, 2009). This is achieved through the administration of intelligence, neuropsychological and personality tests. Intelligence tests are used to assess the structure and pattern of cognition, and neuropsychological tests determine the possible contribution of brain damage or dysfunction to the patient's condition (Barlow & Durand, 2012). Personality tests assist in predicting how people will behave in different settings, including work, school or in therapy (Coon & Mitterer, 2010). Information derived from these tests

can also assist both with the diagnosis and monitoring of treatment progress (van Reinsburg & Berg, 2001). It is beyond the scope of this thesis to discuss various psychological tests that have gained wide acceptance both locally and internationally. Nevertheless, Austin (2009) emphasises that all psychological tests have to be reliable as well as valid in order for their results to be of any use to the clinician. It must be noted that a significant challenge with most of these psychological tests is that they are not normed for all South Africans. This means that tests meant for a Westernised population are still erroneously being used for diagnosing indigenous South Africans presently. Botha and Moletsane (2012) argue that although test users are obliged to include a caveat specifying that the results may have been influenced by cultural differences, this does not necessarily compensate for the reduction in reliability and validity when cultural appropriateness of those tests remain questionable.

To conclude this section, a review of contemporary views of mental illness sheds light into how people's behaviour is at present normed and classified as maladaptive. Advancements in the classification, diagnosis and testing used worldwide provide standardised ways of conceptualising mental illness. However, the review above shows that this standardisation and norming falls short of acknowledging cultural differences and runs the risk of classifying what could be considered normal in one culture as abnormal in another. This creates a gap in promoting, understanding and conceptualisation of mental illness from an African perspective and thus motivates the need for more studies, such as the current one, to be conducted to address this gap in existing knowledge.

2.3. Current Global State of Mental Illness

The focus of the current study is on mental health literacy of African residents of Sisonke District in KwaZulu-Natal. It is imperative to examine the current global state of mental illness as the background that highlights the significance of this study by comparing the magnitude of the problem globally and locally. In this section the findings of epidemiological studies will be presented with a focus on issues related to the prevalence, different diagnostic procedures, aetiology, classification and treatment of mental illness. Studies conducted in South Africa and various parts of the world will be reviewed to demonstrate these issues. To

demonstrate the extent of the burden of mental illness, various global burden of disease (GBD) studies will be reviewed.

2.3.1. Epidemiology.

Epidemiology comprises the study of the distribution of disorders in a defined population, together with an examination of the factors that influence that distribution (Rutter & Sandberg, 1985). The ultimate goal of epidemiology is to provide the scientific underpinnings for the prevention and control of disease across the spectrum of healthcare, from infectious diseases like acquired immunodeficiency syndrome (AIDS) to chronic conditions like diabetes (Costello, Egger & Angold, 2005). In the field of mental health, psychiatric epidemiology can be viewed as a subspecialty of epidemiology that involves investigation of the kinds of health and behavioural problems described in the DSM (Singh & Mkhize, 2006), including the ICD. Kessler (2000), Robins and Regier (1991), as well as Elwood, Little and Elwood (1992) point out that psychiatric epidemiology traditionally lags behind other branches of epidemiology because of difficulties encountered in conceptualising and measuring mental disorders. To substantiate this, they argue that much contemporary psychiatric epidemiology continues to be descriptive, focusing on the estimation of disorder prevalences and subtypes, when other branches of epidemiology instead are making progress in documenting risk factors and developing preventative interventions.

Added to problems of psychiatric epidemiological studies, Wittchen, Essau, von Zerssen, Krieg and Zaudig (1992) mention five unresolved issues which make it difficult to offer clear and definitive statements about the prevalence of mental disorders across different countries and settings. The reasons for these difficulties include the use of: (i) different diagnostic procedures; (ii) different sampling procedures; (iii) different criteria in defining caseness; (iv) different time frames for the diagnosis (e.g. lifetime, 6-month, current diagnosis); and (v) differences in the use of severity ratings for diagnostic decisions. These authors add that another critical issue is related to the use of different diagnostic classification systems. They provide the example of European and American epidemiological studies, which are exclusively based on the ICD) and the DSM, respectively. Nevertheless, the situation is changing, descriptive psychiatric epidemiology has undergone an unprecedented period of growth over the past twenty years (Kessler, 2000), and

psychiatric epidemiology is no longer only about count (Insel & Fenton, 2005). Descriptive issues are being resolved, more analytical questions are being addressed, and preventative interventions are being implemented (Kessler, 2000). Several instruments have been designed that are now being used with samples from the general populations.

Epidemiological studies serve a number of important uses. Lin and Standley (1962) succinctly summarise the purposes of epidemiological studies in the field of mental health as: (a) to assess the prevalence of different types of mental ill-health in a population as a basis for the prevention, treatment and control of these diseases; (b) to uncover associations between population characteristics and disease that may clarify the origins of mental disorder; (c) to test aetiological hypotheses from laboratory or clinical studies; and (d) to assess rates of spontaneous recovery in order to evaluate the effectiveness of preventative and therapeutic measures. Epidemiological studies also provide baseline data for other investigations, assist administrators in allocating resources, and generate hypotheses for further research (Links, 1983).

Prior to the appearance of the more detailed and explicit set of criteria for mental disorders, the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSM-III), there were what Dohrenwend and Dohrenwend (1982) describe as two generations of epidemiologic studies aimed at investigating the true prevalence of mental disorders in communities all over the world. These studies encountered a host of methodological problems centred around the issue of how to conceptualise and measure mental disorders in communities. These initial studies used measures of overall mental impairment rather than specific diagnoses, and reported impairment rates were independent of diagnosis and could not be translated into equivalent clinical diagnostic categories (Weissman, 1987). Nevertheless, Dohrenwend and Dohrenwend (1982) provide the following summary of consistent findings that emerged from these first and second generations of epidemiologic studies: (a) serious psychopathology is not rare in community populations; (b) only small minorities of the 'cases' have ever been in treatment with members of the mental health professions; and (c) psychopathology in general and its major subtypes are not randomly distributed within communities. Most likely these findings would also apply to the South African context.

Fortunately, there have been a number of new and promising developments in mental health epidemiologic studies. This is due to the

achievements in clinical psychiatry in developing measures to obtain more precise and reliable diagnoses, and the development of methods to collect information on signs and symptoms to make a diagnosis (Weissman, 1987). Notable examples are the Psychiatric Epidemiology Research Interview and the Diagnostic Interview Schedule (Dohrenwend & Dohrenwend, 1982). The latter became the first fully structured research diagnostic interview that could be used by lay interviewers to generate diagnoses according to the definitions and criteria of the DSM-III (Andrade et al., 2003). Instruments such as these have made it possible to assemble estimates of the national prevalence of mental disorders in a number of countries, using consistent diagnostic criteria (Henderson, 2000).

Large epidemiological studies of adult mental disorders in the general population have been carried out in numerous countries throughout the world (Kessler, 2000). These studies indicate that the prevalence of mental illness is on the rise both locally (Bhagwanjee et al., 1998) and internationally (Demyttenaere et al. 2004). This, however, must be interpreted with caution because increasing prevalence rates may also be due to the improvement in detection rates. The WHO estimates that 450 million people worldwide suffer from a mental or behavioural disorder (WHO, 2004). This number is so high that almost the whole population in a country will at some time have direct experience of such a disorder, either in themselves or in someone close to them (Jorm et al., 1997). Due to the limited scope of the current study, only epidemiological studies conducted in the United States of America, Australia and South Africa will be reviewed here. American studies are reviewed because of their role in the history of psychiatric epidemiology, especially the development of epidemiological instruments used worldwide. Australian studies are included because of their leading role in studies of mental health literacy in general.

2.3.1.1. United States of America.

Prior to the early 1980s, estimates of the number of people in the United States who had mental disorders were based on studies in single geographic regions (Norquist & Regier, 1996). However, mental health epidemiological studies have gone through a period of unprecedented growth since then (Kessler, 2000). The benchmark epidemiological study of psychiatric disorders is the National Institute for Mental Health's (NIMH) Epidemiological Catchment Area (ECA) study,

conducted in the United State of America in the early 1980s (Kaliski, 2001) in response to the 1978 President's Commission on Mental Health to identify research and service gaps (Leeman, 1998; Norquist & Regier, 1996). A total of 18 571 households and 2 290 institutional residents (persons from mental hospitals, nursing homes, and prisons) 18 years and older were randomly selected to participate in this study to provide both regional and standardised estimates of the prevalence and incidence of mental and addictive disorders (Bourdon, Rae, Locke, Narrow & Regier, 1992; Norquist & Regier, 1996).

The results of the ECA study revealed that approximately 28% of adults in the non-institutionalised community had experienced an active mental or addictive disorder during the past year (Regier et al., 1993). Bourdon et al. (1992) reported that the results of the study indicated that in any 6-month period, 19.5% of the adult population of the United States of America, or 1 in every 5 people ages 18 and older, suffers from a diagnosable mental disorder. The disorders with the highest lifetime prevalence involve substance use (16.7%), followed by anxiety disorders (14.6%) and depressive disorders (8.3%). For current month (1-month) rates, however, according to Regier et al. (1988), the disorders with the highest prevalence rates were anxiety (7.3%), affective disorders (5.1%) and substance use (3.8%). Schizophrenic disorder, somatisation disorder and antisocial personality disorder occurred in smaller numbers of people (Norquist & Regier, 1996). In general, findings of the ECA survey showed the following: 1) that the rates of depression are twice as high for females as for males; 2) that males are more likely than females to have alcohol dependence; and 3) that substance abuse is more common in persons under the age of 30 than in older persons (Sadock & Sadock, 2003).

A decade after the ECA study, another important set of epidemiological data was derived in the United States of America from the National Comorbidity Survey (NCS) that was conducted between 1990 and 1992 in 48 states. This survey was more extensive; it sampled the entire American population using sophisticated methodological improvements (Butcher et al., 2011). A national probability sample of 8098 respondents participated in this survey (Leeman, 1998). According to Norquist and Regier (1996), the results of the NCS study showed that 29% of adults in the non-institutionalised community had experienced an active mental or addictive disorder during the past year, and 19% reported a disorder at some time

in their life but not within the past year. In addition, 48% of participants reported having had symptoms of a mental or addictive disorder at some time in their lives.

The disorders most frequently reported in the NCS study were affective disorders, substance use disorders and anxiety disorders. The prevalence estimate for lifetime major depression was 17.1%, with a relatively higher prevalence in females, young adults, and persons with less than a college education (Blazer, Kessler, McGonagle & Swartz, 1994). The 12-month prevalence estimates for the same disorder was 10.3%. A detailed summary of these results is included in Figure 2.2 below. According to a report by Kessler et al. (1994), more than half of all lifetime disorders occurred in the 14% of the population who had a history of three or more comorbid disorders. Less than 40% of those with a lifetime disorder had ever received professional treatment, and less than 20% of those with a recent disorder had been in treatment during the past 12 months.

Figure 2.2: The lifetime and 12-month prevalence estimates of the NCS study

Disorders	Male				Female				Total			
	Lifetime		12 mo		Lifetime		12 mo		Lifetime		12 mo	
	%	SE	%	SE	%	SE	%	SE	%	SE	%	SE
Affective disorders												
Major depressive episode	12.7	0.9	7.7	0.8	21.3	0.9	12.9	0.8	17.1	0.7	10.3	0.6
Manic episode	1.6	0.3	1.4	0.3	1.7	0.3	1.3	0.3	1.6	0.3	1.3	0.2
Dysthymia	4.8	0.4	2.1	0.3	8.0	0.6	3.0	0.4	6.4	0.4	2.5	0.2
Any affective disorder	14.7	0.8	8.5	0.8	23.9	0.9	14.1	0.9	19.3	0.7	11.3	0.7
Anxiety disorders												
Panic disorder	2.0	0.3	1.3	0.3	5.0	1.4	3.2	0.4	3.5	0.3	2.3	0.3
Agoraphobia without panic disorder	3.5	0.4	1.7	0.3	7.0	0.6	3.8	0.4	5.3	0.4	2.8	0.3
Social phobia	11.1	0.8	6.6	0.4	15.5	1.0	9.1	0.7	13.3	0.7	7.9	0.4
Simple phobia	6.7	0.5	4.4	0.5	15.7	1.1	13.2	0.9	11.3	0.6	8.8	0.5
Generalized anxiety disorder	3.6	0.5	2.0	0.3	6.6	0.5	4.3	0.4	5.1	0.3	3.1	0.3
Any anxiety disorder	19.2	0.9	11.8	0.6	30.5	1.2	22.6	0.1	24.9	0.8	17.2	0.7
Substance use disorders												
Alcohol abuse without dependence	12.5	0.8	3.4	0.4	6.4	0.6	1.6	0.2	9.4	0.5	2.5	0.2
Alcohol dependence	20.1	1.0	10.7	0.9	8.2	0.7	3.7	0.4	14.1	0.7	7.2	0.5
Drug abuse without dependence	5.4	0.5	1.3	0.2	3.5	0.4	0.3	0.1	4.4	0.3	0.8	0.1
Drug dependence	9.2	0.7	3.8	0.4	5.9	0.5	1.9	0.3	7.5	0.4	2.8	0.3
Any substance abuse/dependence	35.4	1.2	16.1	0.7	17.9	1.1	6.6	0.4	26.6	1.0	11.3	0.5
Other disorders												
Antisocial personality	5.8	0.6	...	...	1.2	0.3	...	...	3.5	0.3	...	...
Nonaffective psychosis†	0.6	0.1	0.5	0.1	0.8	0.2	0.6	0.2	0.7	0.1	0.5	0.1
Any NCS disorder	48.7	0.2	27.7	0.9	47.3	1.5	31.2	1.3	48.0	1.1	29.5	1.0

*UM-CIDI indicates University of Michigan Composite International Diagnostic Interview; NCS, National Comorbidity Survey.

†Nonaffective psychosis includes schizophrenia, schizophreniform disorder, schizoaffective disorder, delusional disorder, and atypical psychosis.

Source: Kessler et al. (1994, p.12).

Another epidemiologic study of mental illness in the United States of America is the National Comorbidity Survey Replication (NCS-R). This was a nationally representative face-to-face household survey conducted between

2001 and 2003 using the fully structured World Health Organization World Mental Survey Initiative version of the Composite International Diagnostic Interview (CIDI) (Kessler, Chiu, Demler & Walters, 2005). The results of the NCS-R, as reported by Kessler et al. (2005), show lifetime prevalence estimates as follows: anxiety disorders (28.8%), mood disorders (20.8%), impulse control disorders (24.8%), substance use disorders (14.6%), and any disorder (46.4%). Median age of onset for anxiety and impulse control disorders was 11 years, and 20 and 30 years for substance use and mood disorders respectively. In general, the lifetime prevalence estimates are higher in this study than in earlier studies.

2.3.1.2. Australia.

In an attempt to avoid relying on imported estimates from other countries, in 1992 Australia decided that it should establish its own estimates of the distribution of mental disorders. However, the actual study was only conducted later in 1997. Henderson, Andrews and Hall (1999) report that a household sample of 10 600 persons aged 18 years and over completed the Composite International Diagnostic Interview in its automated presentation (CIDI-A). According to these authors, the CIDI-A was developed in Sydney and it systematically explored the diagnostic criteria required for the most common mental disorders defined by the ICD-10 and the DSM-IV. The results of this study revealed that in any twelve months, 17% of adult Australians had a mental disorder and by far the most common were anxiety or affective disorders and substance misuse (Andrews, Hall, Teesson & Anderson, 1999). Men (11.1%) were much more likely to have a substance-use disorder than women (4.5%), and women (12.1%) were much more likely than men (7.1%) to have an anxiety or affective disorder, with a prevalence rate of 7.4% and 4.2% for women and men respectively (Henderson et al., 2009). Furthermore, 1 in 4 of all the participants suffered from more than one mental disorder. The prevalence of mental disorder decreased with age. Young adults aged 18-24 years had the highest prevalence of mental disorder (27%), declining steadily to 6.1% of those aged 65 years and older (McLennan, 1997).

Another important Australian study, the 2007 National Survey of Mental Health and Wellbeing, was designed to update the evidence on mental health in Australia, with a particular focus on service use information (Slade, Johnston, Teesson et al., 2009). In that study, a nationally representative household survey of 8841 individuals between the ages 16 and 85 years was carried out using the World

Mental Health Survey Initiative version of the Composite International Diagnostic Interview (Slade, Johnston, Browne, Andrews & Whiteford, 2009). The results of that survey, according to Slade, Johnston, Teesson et al. (2009), reported that one in five (20.0%) Australians continued to experience mental illness. Slade, Johnston, Browne et al. (2009) added that the prevalence of any 12-month mental disorder was 20.0%, with anxiety disorder (14.4%) being the most common class of mental disorder followed by affective disorders (6.2%) and substance use disorders (5.1%). One in four people (25.4%) with 12 month mental disorders had more than one class of mental disorder (Teesson, Slade & Mills, 2009).

Regarding help-seeking, Burgess et al. (2009) reported that the 2007 survey showed that 11.9% of the general Australian adult population made use of any service available for mental health problems in a 12-month period, and approximately one-third of people (34.9%) meeting criteria for a mental disorder did so. They also reported that those with affective disorders were most likely to make use of services (58.6%), followed by those with anxiety (37.8%). More females (40.7%) than males (27.5%) were likely to use services for mental health problems (Slade, Johnston, Teesson et al., 2009). Mental health hospitalisations were less common than consultations with community-based providers (2.6%), whereas 34.6% of participants had consulted a community-based provider, particularly general practitioners (24.7%), and 13.2% had consulted psychologists (Burgess et al., 2009). However, interestingly, Slade, Johnston, Teesson et al. (2009) note that not all people who accessed services were assessed as having a mental disorder. They state that many people had sought care for mental health problems, but were not sufficiently unwell to be diagnosed with a mental disorder.

2.3.1.3. South Africa.

Psychiatric epidemiology as a sub-discipline of psychiatry and epidemiology is relatively under-developed in South Africa and other low and middle income countries (Flisher, 2007). Ehrlich, Katzenellenbogen, Tollman and Gear (2007) substantiate this idea by arguing that until the 1950s to the mid-1970s, epidemiology did not feature prominently in South African health research. They state that information about the distribution, causation and control of many disorders was inadequate, with little useful baseline information available to assess the effectiveness of any intervention in South Africa. Parry (1996) adds that there are no studies focusing on a similar range of psychiatric disorders and also none

equivalent to the ECA study in scientific rigour and national representativeness that have been conducted in Africa. Nevertheless, available epidemiological and other studies that have been conducted in Africa suggest that while there are local variations in the nature and prevalence of psychiatric disorders across the continent, the burden of mental health problems and psychiatric disorders is similar to or greater than that reported in the ECA study in the United State of America (Kaliski, 2001).

According to Stein et al. (2008), no nationally representative household surveys were conducted prior to 2002 on the prevalence of mental disorders in South Africa. The first seems to be the South African Stress and Health Study (SASH) conducted as part of the WHO World Mental Health (WMH) Survey Initiative between January 2002 and June 2004 (Williams et al., 2008). A nationally representative household sample of 4351 adults of all racial groups aged 18 years and older participated in the SASH (Tomlinson, Grimsrud, Stein, Williams & Myer, 2009). Prevalence and severity of the DSM-IV disorders, treatment and sociodemographic correlates were assessed with Version 3.0 of the WHO Composite International Diagnostic Interview (CIDI 3.0) (Williams et al, 2008). The interviews were conducted face-to-face by extensively trained fieldworkers in seven different languages: English, Afrikaans, Zulu, Xhosa, Northern Sotho, Southern Sotho and Tswana (Seedat et al., 2008).

The SASH revealed prevalence lifetime estimates of 15.8% for anxiety disorders, as well as 9.8% and 13.4% for mood disorders and substance use disorders respectively and 30.3% for any disorder (Stein et al., 2008). For 12-month prevalence of any DSM-IV disorder, the most common disorders were agoraphobia (4.8%), major depressive disorder (4.9%) and alcohol abuse or dependence at 4.5% (Williams et al., 2008). Stein et al. (2008) reported that the median age at onset was earlier for substance use disorders (21 years) than for anxiety (32 years) or mood disorder (37 years). Regarding treatment, one-fourth (25.5%) of respondents with a disorder prevalent in the previous 12 month period had received treatment either from a psychiatrist (3.8%), non-psychiatrist mental health specialist (2.9%), general medical practitioner (16.6%), human services provider (6.6%), or complementary-alternative medical provider (5.9%) (Seedat et al., 2008). It is worth noting that treatment was mostly provided by general medical practitioners with few people receiving treatment from mental health providers. Blacks were significantly more likely than other racial groups to access the

complementary-alternative medical sector while Whites were more likely to have seen a psychiatrist (Seedat et al., 2008).

A number of other important small scale studies of the prevalence of mental disorders have also been conducted locally. For example, an epidemiological study conducted by Havenaar, Geerlings, Vivian, Collinson and Robertson (2008) in historically disadvantaged urban and rural communities in South Africa revealed a high prevalence of mental health and substance abuse problems. More than one-third (34.9%) of their community sample reported high levels of anxiety or depression symptoms. Other local researchers estimated that about 17% of the total population experienced a psychological disorder in 2007 (Lund et al., 2008). An important conclusion to note is that the high prevalence of psychiatric conditions in Africa is equivalent with that of international communities (Hugo et al., 2003; Kaliski, 2001; Williams et al., 2008).

High prevalence rates for mental illness reported in reviewed epidemiological studies should signify a need for the adequate distribution of knowledge and services pertaining to mental health. However, it is disconcerting that despite evidence of high prevalence of mental illness, the public still lacks mental health literacy and mental health services remain low on the priorities of most governments in low and middle income countries, South Africa included (Gureje & Alem, 2000; Mkhize & Kometsi, 2008). Moreover, while mental health literacy has been studied widely and comprehensively elsewhere (Bartlett, Travers, Cartwright & Smith, 2006; Jorm, 2000; Jorm, Barney, Christensen et al., 2006), it is a subject that has not received sufficient attention locally.

2.3.2. The burden of mental disorders.

A country's burden of disease assesses mortality, morbidity, injuries, disabilities and other risk factors specific to that country. Burden of disease estimates that highlight the extent of the burden and their causes are essential to assist policy makers in devising policies and implementing interventions to promote health, as well as interventions to prevent, treat or ameliorate disease (Norman, Bradshaw, Schneider, Pieterse & Groenewald, 2006). To assess a disease burden, the health impact of disease, injury and disability needs to be assessed quantitatively at population level. In order to quantify the disease burden in a way that is internationally comparable, the GBD study was introduced (Murray & Lopez, 1996). The initial GBD study was conducted in 1990 as a collaborative effort

between the Harvard School of Public Health, the WHO, and the World Bank (Lopez & Murray, 1998; Mathers, Lopez, & Murray, 2006; Murray & Lopez, 1996).

According to Murray and Lopez (1998), the main aims of the GBD studies were:

- 1) To systematically incorporate information on non-fatal outcomes into assessment of health status;
- 2) To ensure that all estimates and projections were derived on the basis of objective epidemiological and demographic methods; and
- 3) To measure the burden of disease using a metric that could also be used to assess the cost-effectiveness of interventions.

Pruss-Ustun, Mathers, Corvalan and Woodward (2003) also add that the GBD studies aimed to quantify the burden of premature mortality and disability for major diseases or disease groups. According to Mathers et al (2006), the WHO undertook an assessment of the second GBD study for the years 2000 to 2002, with consecutive revisions and updates published annually in the WHO's world health reports. These authors state that the second GBD study expanded the framework of the 1990 study to: 1) quantify the burden of premature mortality and disability by age, sex, and region for 136 causes; and 2) analyse the contribution of this burden of major physiological, behavioural and social risk factors by age, sex and region.

Through the GBD study, a new measure, the disability-adjusted life-year (DALY), was developed and applied to estimating the burden of disease for more than 100 causes (Murray, Lopez & Jamison, 1994). The DALY measures the future stream of healthy years of life lost due to each incident case of disease or injury by adding together years of life lost (YLLs) due to premature mortality, and years of life lived with disability (YLDs) weighted according to the severity of the disability (Bradshaw et al., 2003; Flisher, 2007; Pruss-Ustun et al., 2003). For example, disability caused by major depression is considered equivalent to that caused by blindness or paraplegia, and disability caused by active psychosis, as seen in schizophrenia, is estimated as somewhere between paraplegia and quadriplegia (Ustun, 1999).

Lopez, Mathers, Ezzati, Jamison and Murray (2006) state that the 1990 GBD study confirmed what many health workers had suspected for some time, namely, that non-communicable diseases and injuries were significant causes of the health burden in all regions. They add that neuropsychiatric disorders and injuries in particular were major causes of lost years of healthy life as measured by DALYs, and were vastly under-appreciated when measured by mortality alone. To

substantiate, Murray and Lopez (1996) report that of the ten leading causes of disability worldwide in the 1990 GBD study, measured in years lived with a disability, five were the following psychiatric conditions: unipolar depression, alcohol use, bipolar affective disorder, schizophrenia and obsessive-compulsive disorder. Unipolar depression alone accounts for more than 10% of the years of life lived with a disability worldwide (Jenkins, 1997; Vos et al., 2012). Table 2.1 below presents a comprehensive list of the world leading causes of disability. The original GBD study also estimated that non-communicable diseases, including neuropsychiatric disorders, caused 41 percent of the GBD in 1990, only slightly less than communicable, maternal, perinatal and nutritional conditions combined at 44 percent (Lopez et al., 2006). According to Jenkins (1997), psychiatric and neurological conditions combined account for 28% of years of life lived with disability in all regions except Sub-Saharan Africa where they account for 16% of total disability. This author adds that when years of life lived are combined with years of life lost and actual mortality rates into disability life years, then psychiatric and neurological conditions account for 10.5% of the GBD.

Table 2.1: World leading causes of disability, 1990

	Total (millions)	Per cent of total
All Causes	472.7	
1 Unipolar major depression	50.8	10.7
2 Iron-deficiency anaemia	22.0	4.7
3 Falls	22.0	4.6
4 Alcohol use	15.8	3.3
5 Chronic obstructive pulmonary disease	14.7	3.1
6 Bipolar disorder	14.1	3.0
7 Congenital anomalies	13.5	2.9
8 Osteoarthritis	13.3	2.8
9 Schizophrenia	12.1	2.6
10 Obsessive-compulsive disorders	10.2	2.2

Source: Murray & Lopez (1996, p.21)

A summary of the principal findings of the second GBD study is provided in Table 2.2 below. Regarding the leading causes of disability from the same study, Lopez et al. (2006) provide the following summary of key findings: 1) neuropsychiatric conditions, vision disorders, hearing loss and alcohol use disorders dominate the overall burden of non-fatal disabling conditions; 2) in all regions, neuropsychiatric conditions are the most important causes of disability, accounting for more than 37% of YLD among adults aged 15 years and older worldwide; 3) the disabling burden of neuropsychiatric conditions is almost the same for males and females, but major contributing causes are different; and 4) while depression is the leading cause of disability for both males and females, the burden of depression is 50% higher for females than males, and females also have higher burdens from anxiety disorders, migraine and senile dementia. Murray and Lopez (1996) add that alcohol use was found to be the leading cause of male disability, and the tenth largest in women, in the developed regions. Finally, more than 85% of disease burden from non-fatal health outcomes occurs in low- and middle-income countries, and South Asia and Sub-Saharan Africa account for 40% of all YLD.

Table 2.2: The findings of the second GBD study

Table 1.1 Deaths and Burden of Disease by Cause—Low- and Middle-Income Countries, High-Income Countries, and World, 2001

	Low- and middle-income		High-income		World	
	Deaths	DALYs(3,0) ^a	Deaths	DALYs(3,0) ^a	Deaths	DALYs(3,0) ^a
All causes						
Total number (thousands)	48,351	1,386,709	7,891	149,161	56,242	1,535,871
Rate per 1,000 population	9.3	265.7	8.5	160.6	9.1	249.8
Age-standardized rate per 1,000 ^b	11.4	281.7	5.0	128.2	10.0	256.5
Selected cause groups:						
<i>Number in thousands (percent)</i>						
I. COMMUNICABLE DISEASES, MATERNAL AND PERINATAL CONDITIONS AND NUTRITIONAL DEFICIENCIES	17,613 (36.4)	552,376 (39.8)	552 (7.0)	8,561 (5.7)	18,166 (32.3)	560,937 (36.5)
Tuberculosis	1,590 (3.3)	35,874 (2.6)	16 (0.2)	219 (0.1)	1,606 (2.9)	36,093 (2.3)
HIV/AIDS	2,552 (5.3)	70,796 (5.1)	22 (0.3)	665 (0.4)	2,574 (4.6)	71,461 (4.7)
Diarrheal diseases	1,777 (3.7)	58,697 (4.2)	6 (<.1)	444 (0.3)	1,783 (3.2)	59,141 (3.9)
Measles	762 (1.6)	23,091 (1.7)	1 (<.1)	23 (<.1)	763 (1.4)	23,113 (1.5)
Malaria	1,207 (2.5)	39,961 (2.9)	0 (0.0)	9 (<.1)	1,208 (2.1)	39,970 (2.6)
Lower respiratory infections	3,408 (7.0)	83,606 (6.0)	345 (4.4)	2,314 (1.6)	3,753 (6.7)	85,920 (5.6)
Perinatal conditions	2,489 (5.1)	89,068 (6.4)	32 (0.4)	1,408 (0.9)	2,522 (4.5)	90,477 (5.9)
Protein-energy malnutrition	241 (0.5)	15,449 (1.1)	9 (0.1)	130 (<.1)	250 (0.4)	15,578 (1.0)
II. NONCOMMUNICABLE CONDITIONS	26,023 (53.8)	678,483 (48.9)	6,868 (87.0)	129,356 (86.7)	32,891 (58.5)	807,839 (52.6)
Stomach cancers	696 (1.4)	9,616 (0.7)	146 (1.9)	1,628 (1.1)	842 (1.5)	11,244 (0.7)
Colon and rectum cancers	357 (0.7)	5,060 (0.4)	257 (3.3)	3,175 (2.1)	614 (1.1)	8,236 (0.5)
Liver cancer	505 (1.0)	7,945 (0.6)	102 (1.3)	1,223 (0.8)	607 (1.1)	9,169 (0.6)
Trachea, bronchus, and lung cancers	771 (1.6)	10,701 (0.8)	456 (5.8)	5,397 (3.6)	1,227 (2.2)	16,099 (1.0)
Diabetes mellitus	757 (1.6)	15,804 (1.1)	202 (2.6)	4,192 (2.8)	960 (1.7)	19,997 (1.3)
Unipolar depressive disorders	10 (<.1)	43,427 (3.1)	3 (<.1)	8,408 (5.6)	13 (<.1)	51,835 (3.4)
Alcohol use disorders	62 (0.1)	11,007 (0.8)	23 (0.3)	4,171 (2.8)	84 (0.2)	15,178 (1.0)
Cataracts	0 (0.0)	28,150 (2.0)	0 (0.0)	493 (0.3)	0 (0.0)	28,643 (1.9)
Vision disorders, age-related	0 (0.0)	15,364 (1.1)	0 (0.0)	1,525 (1.0)	0 (0.0)	16,889 (1.1)
Hearing loss, adult onset	0 (0.0)	24,607 (1.8)	0 (0.0)	5,387 (3.6)	0 (0.0)	29,994 (2.0)
Hypertensive heart disease	760 (1.6)	9,969 (0.7)	129 (1.6)	1,209 (0.8)	889 (1.6)	11,178 (0.7)
Ischemic heart disease	5,699 (11.8)	71,882 (5.2)	1,364 (17.3)	12,390 (8.3)	7,063 (12.6)	84,273 (5.5)
Cerebrovascular disease	4,608 (9.5)	62,669 (4.5)	781 (9.9)	9,354 (6.3)	5,390 (9.6)	72,024 (4.7)
Chronic obstructive pulmonary disease	2,378 (4.9)	33,453 (2.4)	297 (3.8)	5,282 (3.5)	2,676 (4.8)	38,736 (2.5)
Cirrhosis of the liver	654 (1.4)	13,633 (1.0)	118 (1.5)	2,146 (1.4)	771 (1.4)	15,778 (1.0)
Nephritis and nephrosis	552 (1.1)	9,076 (0.7)	111 (1.4)	929 (0.6)	663 (1.2)	10,005 (0.7)
Osteoarthritis	2 (<.1)	13,666 (1.0)	3 (<.1)	3,786 (2.5)	5 (<.1)	17,452 (1.1)
Congenital anomalies	477 (1.0)	23,533 (1.7)	30 (0.4)	1,420 (1.0)	507 (0.9)	24,952 (1.6)
Alzheimer and other dementias	173 (0.4)	9,640 (0.7)	207 (2.6)	7,468 (5.0)	380 (0.7)	17,108 (1.1)
III. INJURIES	4,715 (9.8)	155,850 (11.2)	471 (6.0)	11,244 (7.5)	5,186 (9.2)	167,094 (10.9)
Road traffic accidents	1,069 (2.2)	32,017 (2.3)	121 (1.5)	3,045 (2.0)	1,189 (2.1)	35,063 (2.3)
Falls	316 (0.7)	13,582 (1.0)	71 (0.9)	1,459 (1.0)	387 (0.7)	15,041 (1.0)
Self-inflicted injuries	749 (1.5)	17,674 (1.3)	126 (1.6)	2,581 (1.7)	875 (1.6)	20,255 (1.3)
Violence	532 (1.1)	18,132 (1.3)	24 (0.3)	765 (0.5)	556 (1.0)	18,897 (1.2)

Source: Chapter 3.

Notes: Numbers in parentheses indicate percentage of column total.

Broad group totals in bold are additive but should not be summed with all other conditions listed in table.

a. DALYs (3,0) refer to the version of the DALY based on a 3% annual discount rate and uniform age weights.

b. Age-standardized using the WHO World Standard Population.

c. Includes only causes responsible for more than 1% of global deaths or DALYs in 2001.

Source: Lopez et al. (2006, p.8)

Locally, although South Africa is one of the few countries in sub-Saharan Africa that produces national cause of death statistics, the country is considered deficient, with significant under-registration and misclassification (Bradshaw et al., 2003). With the lack of reliable data in South Africa, Bradshaw (1996) questions whether the DALY could be estimated for South Africa. Nevertheless, the first South African attempt to estimate DALYs was published by Bradshaw et al. (2003) in their study titled "Initial burden of disease estimates for South Africa, 2000". This was

followed by Norman, Bradshaw, Schneider, Pieterse and Groenewald's (2006) study titled "Revised burden of disease estimates for the comparative risk factor assessment, South Africa 2000". Despite uncertainty in the estimates, these studies provide important information to guide public health responses to improve the health of the nation (Bradshaw, Norman & Schneider, 2007).

The WHO's estimates place the burden from non-communicable diseases in South Africa as two to three times higher than that in developed countries (Mayosi et al., 2009). The key results of the initial South African DALY study provided by Bradshaw et al. (2003) are summarised as follows: 1) non-communicable diseases accounted for 37% of deaths, followed by HIV/AIDS, which accounted for 30%; 2) females have a higher proportion of HIV/AIDS and non-communicable diseases and a lower proportion of injury deaths than males; and 3) HIV/AIDS, homicide/violence, tuberculosis and road traffic accidents were leading the top 20 YLLs. Table 2.3 and Table 2.4 below show a clearer and more detailed presentation of these results.

Table 2.3: Results of the initial South African DALY study

Table I. Estimated cause-of-death and YLL profile by sex, South Africa, 2000

	Deaths			YLLs		
	Male N = 303 081 (%)	Female N = 253 504 (%)	Persons N = 556 585 (%)	Male N = 6 529 811 (%)	Female N = 5 438 011 (%)	Persons N = 11 967 822 (%)
HIV/AIDS	26	34	30	33	47	38
Other group I	21	20	21	25	24	25
Group II	36	40	37	20	21	21
Group III	17	6	12	22	8	16
Total	100	100	100	100	100	100

Group I = communicable/maternal conditions/perinatal conditions/nutritional deficiencies; Group II = non-communicable diseases; Group III = injuries.

Source: Bradshaw (2003, p.684)

Table 2.4: Causes of premature mortality in the South African DALY study

Table II. Top 20 specific causes of the premature mortality burden (YLLs) by sex, South Africa, 2000

Males				Females				Persons			
Rank	Cause of death (BOD list)	YLLs	%	Rank	Cause of death (BOD list)	YLLs	%	Rank	Cause of death (BOD list)	YLLs	%
1	HIV/AIDS	2 148 080	32.9	1	HIV/AIDS	2 517 330	46.3	1	HIV/AIDS	4 665 410	39.0
2	Homicide/violence	756 483	11.6	2	Diarrhoeal diseases	216 488	4.0	2	Homicide/violence	902 592	7.5
3	Tuberculosis	380 789	5.8	3	Tuberculosis	214 488	3.9	3	Tuberculosis	595 277	5.0
4	Road traffic accidents	344 868	5.3	4	Lower respiratory infections	209 240	3.8	4	Road traffic accidents	489 979	4.1
5	Lower respiratory infections	239 770	3.7	5	Low birth weight	180 274	3.3	5	Diarrhoeal diseases	452 827	3.8
6	Diarrhoeal diseases	236 339	3.6	6	Stroke	170 097	3.1	6	Lower respiratory infections	449 010	3.8
7	Low birth weight	213 489	3.3	7	Homicide/violence	146 109	2.7	7	Low birth weight	393 763	3.3
8	Ischaemic heart disease	175 906	2.7	8	Road traffic accidents	145 111	2.7	8	Stroke	318 083	2.7
9	Stroke	147 986	2.3	9	Ischaemic heart disease	108 531	2.0	9	Ischaemic heart disease	284 438	2.4
10	Suicide	123 822	1.9	10	Diabetes mellitus	86 154	1.6	10	Protein-energy malnutrition	171 433	1.4
11	Protein-energy malnutrition	93 556	1.4	11	Hypertensive heart disease	79 112	1.5	11	Suicide	163 544	1.4
12	COPD	74 459	1.1	12	Protein-energy malnutrition	77 877	1.4	12	Diabetes mellitus	145 421	1.2
13	Fires	70 535	1.1	13	Septicaemia	55 808	1.0	13	Hypertensive heart disease	127 066	1.1
14	Septicaemia	59 439	0.9	14	Fires	52 866	1.0	14	Fires	123 400	1.0
15	Diabetes mellitus	59 267	0.9	15	Cervix cancer	50 027	0.9	15	Septicaemia	115 247	1.0
16	Cirrhosis of liver	57 408	0.9	16	Neonatal infections	43 937	0.8	16	COPD	113 499	0.9
17	Trachea/bronchi/lung cancer	54 934	0.8	17	Asthma	43 037	0.8	17	Neonatal infections	96 819	0.8
18	Bacterial meningitis	54 876	0.8	18	Nephritis/nephrosis	43 025	0.8	18	Asthma	94 069	0.8
19	Neonatal infections	52 882	0.8	19	Suicide	39 721	0.7	19	Nephritis/nephrosis	93 973	0.8
20	Asthma	51 032	0.8	20	COPD	39 041	0.7	20	Bacterial meningitis	90 964	0.8
	All causes	6 529 811			All causes	5 438 011			All causes	11 967 822	

BOD = burden of disease; COPD = chronic obstruction pulmonary disease.

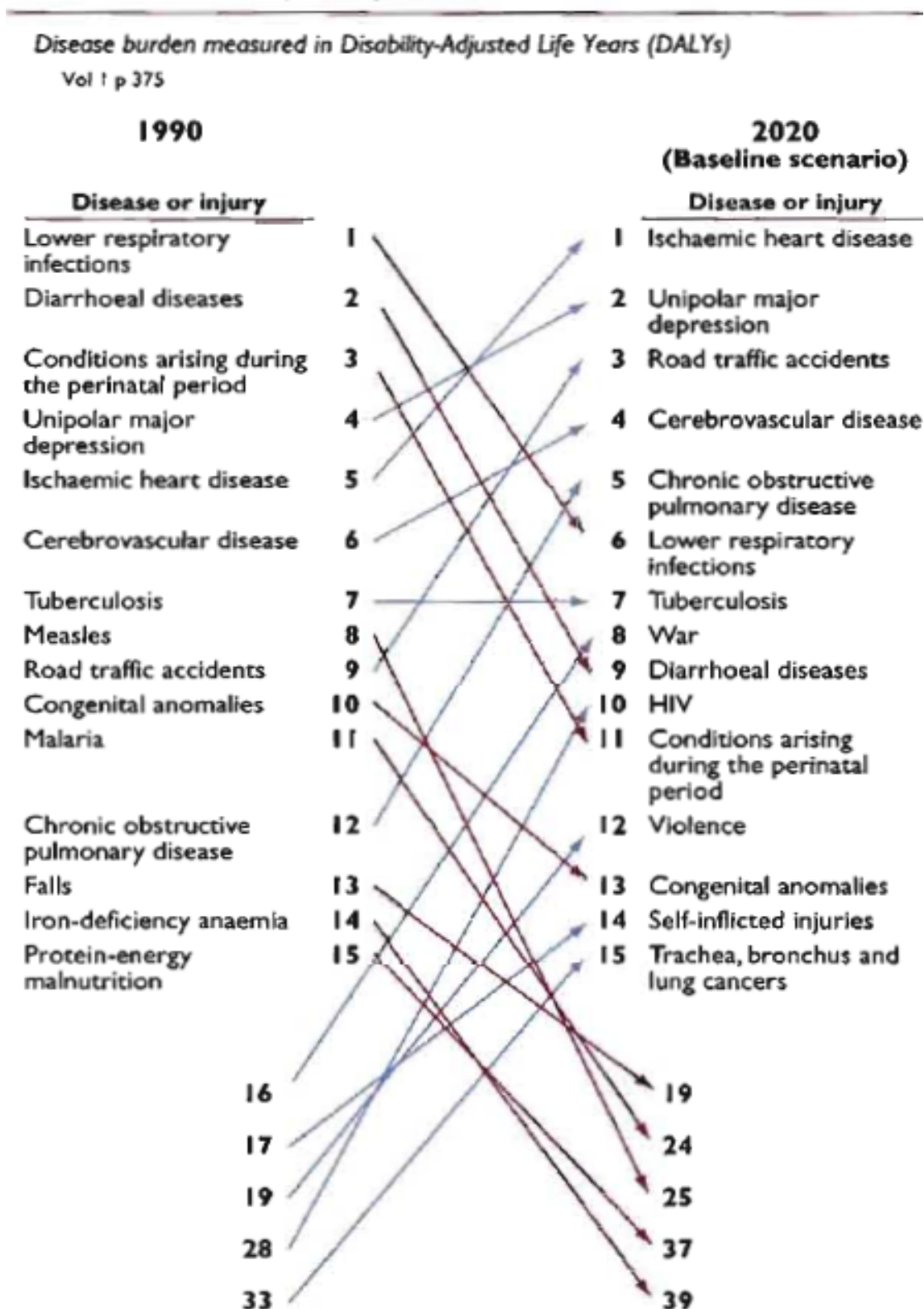
Source: Bradshaw (2003, p.685)

Following the initial national burden of disease study for South Africa, the second phase was revised to provide information for the Comparative Risk Factor Assessment which required DALY estimates for single causes (Norman et al., 2006). While the broad profile remained unchanged, the main differences between the initial and revised estimates, as reported by Norman et al. (2006), included the following: 1) the revised number of deaths was 520 000 compared with 550 000; 2) the revised proportion of deaths due to HIV/AIDS was 25.5% compared with 30%; and 3) the number of injury deaths was adjusted down by about 10 000 as a result of the decline observed in the more recent empirical data. The revised DALY estimates also highlighted the magnitude of neuropsychiatric problems, which ranked third as a category, following HIV/AIDS and other infectious disease categories (Bradshaw et al., 2007). Of significance was a warning by Abegunde, Mathers, Adam, Ortegón and Strong (2007) that the burden of disease related to non-communicable diseases was predicted to increase substantially in South Africa over the next decades if measures were not taken to combat the trend. In line with this prediction, diseases are on the increase in rural communities in South Africa, and they disproportionately affect poor people living in urban settings, and are driving a rise in the demand for chronic disease care (Mayosi et al., 2009).

When making projections into 2020 using data from the GBD studies, Murray and Lopez (1996) make the following two significant pronouncements relevant to mental health: 1) in the developing regions where four-fifths of the planet's people live, non-communicable diseases such as depression and heart diseases are fast replacing traditional illnesses, such as infectious diseases and malnutrition, as the

leading causes of disability and premature death; and 2) by the year 2020, non-communicable diseases are expected to account for seven out of every ten deaths in the developing regions, compared with less than half today. Table 2.5 below provides a graphical presentation of the projected in the rank order of disease burden for 15 leading causes, worldwide, 1990 and 2020. Of significance to note in Table 2.5, unipolar major depression was the fourth leading cause of disease burden in 1990 and is projected to move up to the second leading position in 2020. Within this overall picture, the contribution of psychiatric disorders to the global disease burden in 2020 is expected to be immense. The projections show that psychiatric and neurological conditions could increase their share of the total GBD from 10.5% to 15% in 2020 (Jenkins, 1997).

Table 2.5: Projected rank order change of disease burden in 1990 and 2020



Source: Murray and Lopez (1996, p.4)

Given the high prevalence of mental illness across the globe, it is likely that the emotional and financial burdens on patients, their family and society as a whole are enormous. The WHO (2003) report asserts that the economic impacts of mental illness affect personal income, the ability of the ill persons, and often their care givers, to work, productivity in the work place and contributions to the national economy, as well as utilisation of treatment and support services. Mental disorders are the second most common reason for medical boarding in South Africa (Singh & Mkhize, 2006). Costello et al. (2005) also add that in a world of scarce healthcare resources, it is important to understand the size of the burden to the community caused by these disorders. They emphasise that burden, in terms of numbers affected, has an impact on the individual, and cost to the community is a crucial factor in the battle for resources for treatment and prevention. Nevertheless, despite this evidence of the high burden of mental disorders, the overwhelming majority of people suffering from mental illness do not receive care, and many of those who do access care receive suboptimal care (Fisher, 2007). Where there are effective treatments, they are frequently not available to those in greatest need. Furthermore, while advances have been made in general health promotion and prevention, the same cannot be said for mental disability. This is because ignorance, prejudice and stigma are still very widespread (Burns, 2011).

In summary, the GBD studies have been eye-opening for public health in terms of mainstreaming mental health. They have highlighted the public health significance of mental disorders (Ustun, 1999), and have attracted the attention of policy makers and public health experts alike, because they provide a common metric for evaluating and priority-setting across a wide range of health problems (Ustun, Ayuso-Mateos, Chatterji, Mathers & Murray, 2004). These studies have also demonstrated that mental disorders are strongly related both to non-communicable diseases and other health challenges such as HIV, tuberculosis and injuries, and can increase the risk of these diseases, which in turn increases the risk for mental health disorders (Mayosi et al., 2009).

Jenkins (1997) adds that the GBD studies have provided an essential bedrock of data to demonstrate the cost of not taking proper action with regard to mental health. Mounting evidence of the massive global health burden of mental illness has also resulted in the launch of a United Nations collaborative initiative, led by the WHO, to improve the mental health of the world's underserved populations. This initiative seeks to raise the awareness of the world's policy makers,

to support countries to prepare and implement mental health policies, and to promote international collaboration and technical support for mental health programmes and services (Jenkins, 1997b). Ustun et al. (2004) conclude that it is imperative to investigate how these findings and initiatives can be applied to policy-making, planning and programme implementation for the benefit of improved world mental health. This expectation has direct implications for researchers of mental health literacy as the public's failure to recognise mental illness and professionals' misunderstanding of the way the public conceptualise mental illness may hinder any efforts to promote mental health in general.

2.4. Mental Healthcare in South Africa

Having discussed the epidemiology and burden of mental disorders, it is now pertinent to review mental healthcare practices in South Africa. This section examines South Africa's efforts to provide integrated health services delivery, not only in the effort to counter historical racial division, but also to align itself with international practices. Challenges related to these efforts will also be discussed. These are important issues for discussion in this study because mental health literacy is dependent upon the resolution of challenges linked to mental health service delivery.

Prior to the advent of a new democratic dispensation in 1994, South Africa was characterised by gross violation of human rights and a highly fragmented health system. There were 14 health departments in the country divided along racial and legislated 'ethnic' lines (Swartz & MacGregor, 2002). These departments provided services that were not only separate, but also grossly discriminatory on the basis of race. For example, in 1989, expenditure per capita on health services for whites was R596, and for Africans was R95 (Swartz & MacGregor, 2002). Not only were healthcare services segregated by race or ethnic group, they were also centralised, with the best-resourced facilities located in the urban areas while the rural areas were under-resourced (Lund & Flisher, 2006). Essential services, especially health, education, housing and sanitation were grossly underprovided in rural areas with mental health services, in particular, severely lacking in resources, including personnel (Pillay & Lockhat, 1997).

According to Swartz and MacGregor (2002), primary healthcare services were integrated and a range of fields (for example, tuberculosis and maternal health) were provided in dedicated clinics or in clinics on a particular day of the week. There was also a separate service offered for mental healthcare delivered by specialist mental healthcare nurses with back-up from psychiatrists and clinical psychologists. The focus of mental health services was on institutional care and psychopharmacological treatment of patients with psychiatric disorders (Petersen et al., 2009).

Post-1994, South Africa embarked on a major initiative to integrate health and other services, not only to counter the destructive divisions of the past, but also to align the country's health services with international trends such as the Alma Ata Declaration and WHO reports (Mkhize & Kometsi, 2008). In 1997, mental health was included in the White Paper for the Transformation of the Health System in South Africa (Lund, Petersen, Kleintjies & Bhana, 2012). The ruling political party, the African National Congress (ANC) adopted a district-based primary healthcare philosophy premised on community development and community participation in the planning, provision, control and monitoring of services (Ross & Deverell, 2010). It was envisaged that each health service user would be able to access one integrated service near to the place where the user lives, and, in a single visit to a clinic, would have all primary healthcare needs met (Swartz & MacGregor, 2002). This implied a comprehensive service, which included the integration of mental healthcare into the primary healthcare system (Petersen, 2000). The rationale for this approach was to make services accessible, affordable, and to provide minimal disruption to patients' lives. Further, it was considered that this move would have the benefit, not only of affording care to greater numbers of people, but also of reducing the stigma attached to receiving mental healthcare only in special psychiatric clinics and hospitals (Mkhize & Kometsi, 2008; Pillay & Lockhat, 1997). This meant that mental health services were to be integrated into primary healthcare.

Subsequently the Mental Health Care Act, No. 17 of 2002 was promulgated (Lund et al., 2012) aligning the provision of mental health services in South Africa with the country's constitution (Mkhize & Kometsi, 2008). Emerging from this Act has been the introduction of a legislated 72-hour emergency referral and observation period for mental healthcare users (MHCUs) in designated regional and district general hospitals before onward referral to tertiary hospitals, as well as Review Boards to protect the human rights of MHCUs (Petersen & Lund, 2011). If patients

are stabilised at regional and district general hospitals, they are discharged to the community and referred to primary care clinics, which they are expected to attend to receive medication and monitoring of their mental health status on an ongoing basis (Lund et al., 2012).

While South Africa has made significant strides at the level of policy and legislation of the Act for integrated primary mental healthcare (Mkhize & Kometsi, 2008), the implementation of this Act is confronted by challenges, and substantial gaps in service delivery nevertheless persist (Petersen & Lund, 2011). The mechanisms for monitoring service delivery remain weak and there is thus limited data on how successfully these policies have been implemented, and also limited data on whether access to or quality of mental healthcare at district level has improved (Petersen et al., 2009). Some authors report problems regarding shortage of infrastructure and specialist staff for the implementation of 72-hour referral and observation (Lund et al., 2012), and access to mental healthcare therefore remains a concern.

Poor infrastructure hinders the provision of mental health services at the primary level of care and this is particularly so in the rural areas (Mkhize & Kometsi, 2008). While rural contexts are encountered all over the world, the term 'rural' does not mean the same thing in all places. Unlike high-income countries, rural communities in low-income countries are generally characterised by severe infrastructural underdevelopment and poverty (Pillay & Kometsi, 2007). In South Africa, most mental health services are concentrated in urban settings, and virtually all specialised mental healthcare facilities and personnel are located in the major metropolitan areas. As a result, in excess of 20 million people, in the country's non-urban areas, have virtually no reasonable access to mental healthcare (Pillay et al., 2009). This suggests that many people with mental disorders are either not seeking help, or are making use of alternative services such as those of traditional healers (Emsley, 2001). Burns (2011) argues that traditional healers are more geographically accessible and more culturally accessible to many citizens, particularly in the largely rural province of KwaZulu-Natal in South Africa. To substantiate this argument, this author states that there is evidence that a significant proportion of individuals experiencing mental health problems in this region consult traditional healers as their first port of call. Therefore, equipping traditional healers to understand and effectively manage mental disorders in their

communities may contribute towards scaling up services because they are often consulted for mental healthcare (Sorsdahl, Stein & Lund, 2012).

The introduction of the 72-hour emergency management and observation period in designated regional and district hospitals in the absence of sufficient dedicated infrastructure and specialist staff, as well as inadequate training and support of general staff, has negatively affected the quality of care provided (Lund et al., 2012; Petersen & Lund, 2011). In a recent study conducted by Petersen et al. (2009) in northern KwaZulu-Natal, participants identified the following key reasons for the lack of attention paid to common mental health problems: 1) insufficient time to make a thorough assessment that would allow for the identification of common mental health problems; 2) insufficient time to manage these conditions; and 3) insufficient mental health specialists for referrals. The same study reported that the district as a whole had no psychiatrist and had only 0.2 psychologists per 100 000 population. Furthermore, most of these mental health professionals tend to be located within urban centres, leaving large rural regions of the country without such services. For example, of the 32 psychiatrists working in the public health sector in KwaZulu-Natal, only 6 are located outside of the major cities (Burns, 2011), despite the fact that many people in this province live in non-urban areas.

Furthermore, there is a gross inadequacy of beds in South Africa to accommodate those requiring hospitalisation for mental illness. A study by Lund et al. (2010) reported that per 100 000 population, there are 2.8 beds in psychiatric inpatient units in general hospitals, 18 beds in specialised mental health facilities, and 3.5 beds in forensic mental health facilities. In addition, there are 0.36 beds per 10 000 population located within 63 community residential facilities nationwide, and half of these are provided by a non-government organisation called the South African Federation of Mental Health (Burns, 2011). According to Lund et al. (2010), there are 3 460 outpatient facilities which offer mental health services in the country, although these are general health facilities, in which the provision of specific mental health services is not monitored. To reflect the seriousness of this problem, these authors report that of these outpatient facilities, only 1.4% provide services exclusively for children and adolescents. These findings appear to indicate that mental healthcare services in South Africa are not adequate.

Nevertheless, Petersen and Lund (2011) point out that on the positive side, there is relatively wide availability of psychotropic medication, and primary healthcare clinic nurses are generally comfortable with providing follow-up maintenance medication for patients with severe and chronic mental disorders.

Equipping these healthcare providers with basic skills to identify and manage certain common psychological problems, techniques of interviewing, counseling, and crisis intervention would go a long way to improving mental healthcare service delivery (Pillay & Lockhat, 1997). By so doing, nurses with mental health skills will be able to identify and intervene appropriately when a patient with a physical complaint is in fact mentally ill. Imbuing nurses with skills to promote mental health should also be an integral part of this process. Mental health promotion should be concerned with promoting optimal psycho-physiological development and mental health in people. Preventing the onset of mental disorders, early detection and treatment so as to reduce severity of mental disorders, and rehabilitation to prevent relapse should be the goals of primary, secondary, and tertiary prevention, respectively (Petersen, Bhana & Swartz, 2012).

According to Sorsdahl et al. (2012), one of the most significant barriers to accessing care for people with mental disorders in South Africa is low mental health literacy. These authors argue that most South Africans view common mental disorders as the result of everyday life challenges, rather than as treatable conditions. Petersen (2000) substantiates this viewpoint by suggesting that it is imperative, given South Africa's multicultural society, that the healthcare system accommodates multiple cultural formulations of illness and treatment modalities. This author argues that care informed by such a discourse demands a patient-centred approach which considers the subjectivity of the illness experience for the patient. Promoting culturally congruent services and mental health literacy will assist in improving help-seeking behaviour and in reducing stigma attached to mental health illnesses (Petersen & Lund, 2011). It is with this argument in mind that it becomes imperative to start first with the understanding of the public's notions of mental illness. Lund et al. (2012) affirm that the bulk of research in South Africa during the last 12 years provides information on burden of mental illness and the status of mental health services and there is a need to shift the research agenda to focus on intervention studies. However, South Africa's rich cultural diversity poses significant challenges when adapting Western diagnostic conventions, research tools and psychosocial interventions (Sorsdahl et al., 2012).

To conclude, in an effort to understand mental health literacy of indigenous South Africans, this literature review chapter began with a brief history of mental illness in order to demonstrate how the understanding and conceptualisation of mental illness has evolved over time. This history showed that what is considered to

be the cause of mental illness at a particular point in time or in different societies influences treatment approaches. Contemporary views of mental illness focusing on the history of classification and diagnostic systems were presented in this chapter. To highlight the significance of the topic considered in the current investigation, namely the prevalence of mental illness and mental health literacy, epidemiological studies and burden of mental disorders were discussed. This chapter concluded with a focus on mental healthcare in South Africa, reflecting on issues of integrated service delivery and their limitations. The following two important issues were highlighted in this chapter, which must be borne in mind in this study: 1) the conceptualisation of mental illness has evolved over the years and remains based on Western ideologies; and 2) the provision of integrated mental health services remains a challenge in South Africa. This chapter has established the background to the question that is central to this current study, that is, if notions of mental illness are still largely based on Western ideologies and the provision of integrated mental health services remains a challenge, what would be considered to be the level of mental health literacy of indigenous South Africans who are likely to view mental illness from their cultural perspectives? It is for this reason that it becomes important to consider cultural views and understandings of mental illness, thus a review of these understandings and conceptualisations will follow in the next chapter.

Chapter 3

Culture and Mental Illness

In an endeavour to understand the conceptualisation of mental illness in a society, it becomes important to first examine culture and its influence on the construction of mental illness. This constitutes a background to support the theories chosen to underpin this study by demonstrating that notions of and attitudes toward mental illness are generally informed by the worldviews within a particular society. This chapter presents the hypothesis that mental illness cannot be understood without considering culture; the argument is that culture influences what could be considered as normal or abnormal behaviour. The debate of cultural universalism versus cultural relativism is used as a prelude to this hypothesis. This initial discussion focuses on the extent to which mental disorders are considered common to humankind (i.e. universalism) and the extent to which they are considered as unique to specific cultural groups (i.e. relativism) (Sam & Moreira, 2012). Central to this discussion are questions related to whether, on the one hand, in explaining mental illness, assumptions can be made regarding the existence of commonalities in the psychological make-up of human beings, and commonalities in human experience and behaviour. On the other hand, the argument that studying mental illness outside the social and cultural context in which it occurs is impossible, and behaviour can best be understood in the context in which it occurs (Sam & Moreira, 2012), will be considered.

This chapter then discusses indigenous African views of illness, with a particular focus on mental illness. A review of the relationship between aetiological and treatment beliefs forms part of this section of the chapter. This discussion is based on Honwana's (1998) idea that the manner in which people understand their afflictions is undoubtedly connected to beliefs about the origins of such afflictions, and such beliefs are central in devising appropriate therapeutic strategies for their alleviation and elimination. The chapter concludes with the proposition that an integration of both the Western and African paradigms provides the best solution to a better understanding of the culture and mental illness conundrum.

3.1. Problematising Culture

It is imperative to highlight that the literature considered in this chapter shows that indigenous African views on health and illness are based on a social and clinical reality that is remarkably different from Western beliefs or those of Euro-Americans. It is, however, not the intention of this chapter to provide a comparison between African and Western perspectives, as this is likely to create an impression that one is superior over the other or that they are two competing perspectives. A number of authors (Herselman, 2004; Menkiti, 1984; Mkhize, 2006; Nwoye, 2006; Ramose, 2005; Verhoef & Michel, 1997) have written about the contrast between Western and African views, and this falls beyond the scope of this current research. The decision to focus only on an African perspective of health and illness is based on the rationale that this perspective is at the centre of the current study. The aim of this chapter is to examine alternative ways in which mental illness and illness in general can be viewed from a cultural perspective outside the framework of Western biological and sociocultural paradigms. A thorough discussion of culture and mental illness requires a great deal more than is possible in a single chapter. Therefore, this chapter will focus on those aspects of culture and mental illness that are most germane to the research problem.

It is helpful to point out that while a number of cultural practices are shared amongst sub-Saharan African peoples, the ideas presented in the sections to follow do not necessarily imply that African culture or traditional practices are homogeneous. Multiculturalism is certainly acknowledged as characteristic of people of African descent. Matoane (2012) writes, for instance, that while the different ethnic groups may share common traditions with respect to *lobola* (dowry), bereavement rituals, rites and so forth, the actual processes and practices of these traditions differ widely. This author adds that, similarly, not all Black South Africans believe in African indigenous practices due to colonisation, Christianity and apartheid, each of which have contributed to viewing everything that is traditionally African as inferior and uncivilised. For example, traditional healing was regarded by the missionaries of the nineteenth century as a manifestation of heathen culture and, as such, a convert to Christianity was required to renounce these practices (Peu, Troskie & Hattingh, 2001). It is due to such influences that Pretorius (1995) postulates that three broad cultures can now be differentiated in South Africa: a) Westernised people; b) traditional people; and c) 'inbetweeners'. While many Africans found much value in religion and Western practices, Peu et

al. (2001) argue that most found it impossible to forget the ways of their ancestors and would, for example, consult traditional healers when they felt that Western-style medicine was not able to help them. Solomon and Wane (2005) maintain that many indigenes have a growing interest in returning to their sacred cultural teachings and ceremonies and will continue to follow their traditions to sustain themselves and to help the generations to come. It is their assertion that many people are beginning to more fully recognise that the traditional ways of their ancestors are valuable, reliable and more sustainable than the present-day methods of living in the universe.

3.2. Culture and Mental Illness

South Africa is characterised by a multiplicity of cultures, and its people embrace various cultural practices which define who they are as individuals and as a collective (Matoane, 2012). In order to plan and provide culturally-sensitive and appropriate mental healthcare services for all, health professionals need to be aware of and be able to identify cross-cultural issues. Mental health practitioners need to be cognisant of how notions of culture and mental illness are based on taken-for-granted assumptions about African culture or the 'African mentality' (Yen & Wilbraham, 2003). Honwana (1998) argues that it is essential to study and understand local knowledge about mental illness because this knowledge informs specific cultural understandings about the causes of ill-health, including psychological distress, and about the effect that traumatic experiences and events might have on individuals and groups. According to this author, only through an understanding of local notions of mental illness will it be possible to devise appropriate intervention programmes to deal with mental health issues. Failure to do so is likely to result in inadequate understanding of the local people, with the possible consequence of misinterpretation of patients presenting mental health problems (Matoane, 2012) and inappropriate intervention attempts.

3.2.1. What is culture?

Culture, according to Chu (1998), refers to a shared system of meanings; the shared beliefs, knowledge, values, symbols, and ways of life that emerge in the course of group experience which are transmitted from one generation to another. Culture allows groups to define who they are, to establish what is

meaningful, to communicate with others, and to manage their physical and social environments (Kim, 2000). It offers a framework within which people can relate to one another and co-exist. Fabrega (1992) posits that culture provides people with a distinctive sense of reality and helps shape behaviour and affective responses. Significant to note is Honwana's (1998) assertion that culture plays a crucial role in issues of health and well-being, since the process through which people manage their afflictions is built on cultural perceptions. According to this author, mental health is closely linked to culture because the ways in which people express, experience, and give meaning to their illnesses are tied to specific social and cultural contexts. These arise out of moral, religious, judicial and social injunctions which dictate how people should behave and express themselves (Drennan, 2001).

Thakker and Ward (1998) caution that when people study another culture it is perhaps always, although often unintentionally, in comparison to their own. They use their own culture implicitly as the standard by which other cultures are judged (Kim, 2000). Chu (1998) advises that it is therefore imperative to note that since people from different cultures have different beliefs, values and practices, it cannot be assumed that the way things are done in one culture is the only or the best way to do them. According to this author, cross-cultural studies should promote the view that all cultures have equal standing, that all are correct, normal and valuable to those making them up, and that cultures cannot be ranked better or worse. Kim (2000) postulates that each culture should be understood from its own frame of reference, including its own ecological, historical, philosophical and religious context. These arguments have fuelled what is generally known as the universalism-relativism debate.

3.2.1.1. Cultural universalism.

It is clear from the discussion presented in the first few opening paragraphs on culture and mental illness in this chapter that a multiplicity of cultures exist between and within a group. Therefore, differences between the ways of life of people are inevitable. However, according to Herselman and Parry (2004), it is apparent that underlying the differences in beliefs and behaviour of people is their common human heritage, which is regarded as a primary source of the so-called cultural universals. Universalism assumes that basic human characteristics are common to all members of the species (constituting a set of biological givens), and

that culture influences the development and display of human processes (Sam & Moreira, 2012). Cultural universalism contends that culture is a pattern of stable meanings and symbolic systems that are common to all groups (Moleko, 2012).

Regarding mental health, the fundamental assumption of universalism, according to Swartz (1998), is that mental illness is universal. This view uses the Western bio-medical framework to find similarities across cultures and explicit standard diagnostic criteria to interpret and classify mental disorders in diverse populations (Thakker & Ward, 1998), and has therefore gained more credibility especially from cross-cultural psychological perspectives (Sam & Moreira, 2012). The basic premise of the universalist view is that psychiatric disorders and syndromes are universal and have core symptoms that cluster into universal syndromal patterns (Canino & Alegria, 2008). According to Thakker and Ward (1998), the central claim of universalism is that mental disorders, as defined in Western taxonomies, will have similar, if not identical, manifestations in all cultures because they are the result of physiological dysfunction and human beings share a common physiology. To advance this view, the bio-medical approach would argue, for example, that regardless of the cultural context, the disorder exists if individuals report having the symptoms associated with that particular disorder (Tsai & Chentsova-Dutton, 2009).

Universalism, however, does acknowledge that symptomatic manifestation of a disorder could vary across cultures. According to Canino and Alegria (2008), this means that the same disorder could be manifested differently in different cultures but the underlying psychopathology would remain the same across cultures. As a result, Swartz (2007) argues that within the view of universalism, the task in dealing with people from different backgrounds should be to look beyond the obvious ways in which people communicate and behave to find common factors under the surface. This author offers the example of some people who do not use the word 'depressed' to describe what psychiatrists would call depression, but instead complain of a range of body aches and pains which cannot be explained by obvious physical causes (Swartz, 2007). To illustrate this further, the same author states that universalists would therefore try to show, for instance, that a person in Harare complaining of thinking too much or shoulder pain, with no obvious organic cause, and who does not complain about psychological problems, may be just as depressed as someone in London who complains of depression (Swartz, 1998).

The limitation of universalism as practiced in Western psychiatry, according to Swartz (1998), is that it does not give careful attention to the notions that people's ways of seeing the world, and their assumptions, help shape how the world is perceived. Universalists are more interested in their own culture than those of others, adds Winders (2013). To cast Western knowledge as universal and indigenous knowledge as merely local and possibly ignorable, is to propagate a new imperialism, argues Summerfield (2014). Clearly universalism does not accord a fair weight and value to other ways of seeing or explaining things. This is particularly relevant to the South African context where people with different cultural frames of reference are in close contact with one another (Herselman & Parry, 2004). Furthermore, although the principle of universalism makes it possible for research to be conducted by providing a common disease classification, it is criticised for considering the Western diagnostic system to be standard for all people across the globe. To assume that Western psychiatric categories like depression are universal, according to Summerfield (2014), is to commit what Kleinman has called 'category fallacy', which questions the issue of validity of a universalist approach in psychiatric research and practice. This conceptualisation of the universality of psychopathology, according to Thakker and Ward (1988), arguably stems from the biological model.

3.2.1.2. Cultural relativism.

Opponents of universalism, relativists, incorporate the view that when moving across different cultural dimensions, many differences (such as language and how it refers to meanings, values, beliefs and religion) can be found that make people unique (Moleko, 2012). Relativism contends that any two beliefs on a given question arising from two different cultures are equally valid and neither of them is wrong, even though they may literally contradict each other (Dell'Utri, 2009). The principle of relativism, therefore, informs people that they should refrain from judging the way of life of others against the principles and values of their own culture, but should rather develop an understanding in terms of the culture of the persons concerned (Herselman & Parry, 2004). Central to the relativist viewpoint, according to Dell'Utri (2009), is the basic understanding that beliefs and values stemming from different cultures are exclusively relative to a culture, and this means that no belief and no value can acquire an absolute and universal validity. The principle of relativism, therefore, seeks to avoid all forms of ethnocentrism by

suggesting that people should be understood in their own terms without any value judgements being made, and without preconceived ideas being used (Sam & Moreira, 2012). For mental health literacy research, this would mean that although the public and professionals' understandings of mental illness may differ depending on cultural and training differences, these differences must be treated with the same amount of respect. In short, cultural relativism maintains the view that all cultures are equal in value and therefore should not be judged on the basis of other cultural perspectives (Chowdhury, 2012).

In opposing the universalist view regarding mental illness, relativists argue that Western diagnostic categories are limited in their capacity to explain mental illness in diverse settings and question the merit of using classification systems devised in one culture for understanding psychopathology in substantially different cultures (Thakker & Ward, 1998). The relativistic point of view claims that culture shapes the individual's development and cultural settings shape definitions of normality and pathology (Canino & Alegria, 2008). To advance this argument, Spiro (2001) provides a summary of three basic assumptions of relativism which can be expressed in the following three propositions: 1) a particular mental disorder may be present in some social groups, while it may be absent in another; 2) even when mental disorder is found in more than one group, its symptoms may be variable; and 3) a psychological condition that is regarded as pathological by the cultural standards of some social groups may not be regarded as such by the cultural standards of other groups. For example, with regard to the first and second propositions, respectively, anorexia nervosa was first described in the West and was reported as particularly rare or absent in Eastern cultures (Iancu, Spivak, Ratzoni, Apter & Weizman, 1994), and it is well-documented that symptoms of depression may vary considerably across various cultures (Tsai & Chentsova-Dutton, 2009). Therefore, Jenkins, Kleinman and Good (1991) contend that culture is of profound importance to the experience of depression, the construction of meaning and social response to depressive illness, the course and outcome of the disorder, and thus to the very constitution of depressive illness. To lend support to the third proposition, Spiro (2001) cites the example of possession trance, which is considered as pathological by the cultural standards of the contemporary Western world but not by those of much of the indigenous world. In fact, relativists support the belief that mental health should be understood through the context of normative behaviour within a specific culture (Chowdhury, 2012).

In clinical practice, relativists assert that clinicians should not merely endeavour to uncover commonalities across groups but should also aim to understand the particular meaning of expressions of distress within particular groups (Swartz, 2007). This implies that, according to relativists, it is not sufficient for clinicians just to understand the physical disease of any person, but what is equally important is to understand the person's experience of illness and distress, as it is this experience which will determine how the person behaves, the treatment sought, and the reaction to treatment (Swartz, 1998).

Critics of the relativist point of view do not believe that a strongly relativist perspective is internally coherent. They argue that if cultural relativists make a claim that norms are specific to cultures and there cannot be one set of universal norms (Nayak, 2013), this would mean that communication among mental health professionals across the globe would be virtually impossible. The claim that there is no unitary set of universal norms suggests that globally acceptable standardised assessment tools would be unattainable. To support this critique, Jefferson (2014) contends that cultural relativists would then have to concede that what is considered a disorder in their own society may not be considered so in another, and it does not seem credible that anyone would actually concede this degree of relativity for their own ascription of 'disorderedness'. The main criticism here is that if relativists do not detect a disorder correctly, this may result in the wrongful labelling of some ailment as a disorder. To illustrate this point, Jefferson (2014) offers the example of homosexuality, which could change from being viewed as healthy to being considered a disorder simply by moving from a culture where homosexuality is seen as not constituting a mental disorder to a culture where it is.

To problematise relativism further, Hyder and Morrow (2006) pose the question of whether the behaviour in question is considered 'wrong' from an epidemiologic perspective. They ask how, from a relativist point of view, a distinction could be made between dangerous behaviours (such as using an HIV-contaminated needle) and behaviours that are merely different and therefore seem odd. This is problematic because diagnosing someone with mental illness has far-reaching practical consequences. Investigating the notions of mental illness amongst people of African descent, therefore, becomes an essential step toward building culturally informed models of mental health practice. However, it is apparent that strong forms of relativism (the claim that one and the same belief

may be true in one context and false in another) may, on the one hand, present a problem. On the other hand, weak forms of relativism, such as versions that claim that there may be beliefs that are true in one framework but not true in a second simply because they are not available in the second (Baghramian & Carter, 2015), may also not solve the problem between these extreme forms of relativism. It would appear that clinicians and researchers from both extreme forms of relativism may need to find a common understanding through open discussions. With this in mind, a discussion of African views of illness and mental illness will be presented in the sections to follow, to ground the topic under consideration in this study, that is, the mental health literacy of indigenous people in KwaZulu-Natal in South Africa.

3.3. African Indigenous Views of Illness and Mental Illness

It is apparent from the discussion presented in the early parts of the previous chapter that conceptualisations of mental illness have evolved over time. Undoubtedly, the modern world is characterised by rapid changes. Mkhize (2004) states that cross-pollination of ideas between cultures occurs more rapidly in the current era, compared to the past. As a result, he argues that Western psychology and medicine cannot afford to ignore African worldviews and it would be short-sighted of Western practitioners to remain insulated in one conceptual framework. Pretorius (1995) has long cautioned that Western views of illness and mental illness cannot summarily be applied to a culture with a different view of life, different value system, and different perception of psychiatric illness. Human societies in various parts of the world have developed different ways of living, and have complex systems of thinking about the world and a person's place within it (Semenya & Mokwena, 2012). In Africa too, other forms of understanding the origins, manifestations and treatment of mental illnesses, based on African indigenous worldviews, have evolved. In order to understand African indigenous perspectives towards illness and mental illness, it is necessary to first critically explore the notion of a worldview and its bearing on how people conceptualise the world and their place in it.

3.3.1. Worldviews: an Africentric perspective.

A worldview is defined by Mkhize (2004) as a set of basic assumptions that a group of people develops in order to explain reality and their place and purpose in the world. According to Karanja (2010), a worldview refers to a cultural group's understanding of universe (cosmology), being (ontology), values (axiology) and knowledge (epistemology), which all contribute to the ways in which a people make sense of their lived reality. Grills (2006) contends that people's values, language, shared history and experience all affect how they view things, how they feel, and what matters to them. It is important to note that different terms are used, such as African or European, to refer to the concept of the worldview. To illustrate this, Karanja (2010) posits that the African worldview is complementary to what others may call Afrocentric, African-centered or Africentric worldviews and the European worldview is complementary to Eurocentric, European-centered, Euro-American worldviews. This clearly demonstrates that a number of different worldviews exist. These worldviews are not necessarily based on research or verified knowledge, but rather on the assumptions people make about the nature of the world (Semenya & Mokwena, 2012). They are usually unconsciously or uncritically taken for granted as merely the way things are. This essentially implies that there is an acquired communal ideology and unique worldview among African people that is passed down from elder members of the community and is valued (Ayuya et al., 2015).

Although Ivey and Myers (2008) state that this acquired and passed on knowledge and experience is adhered to and treated as the norm by many, it is important to note that not all Africans view the world according to one uniform African worldview. The African continent comprises thousands of indigenous groups living in diverse geographical areas, and it would be erroneous to assume that all of these communities operate and experience the world in an indistinguishable manner (Obasi, 2002). This means that alternative worldviews exist, however Hart (2010) argues that these views are not usually held by the majority of the society. It is in this regard that Kanu (2013) cautions that:

the idea of African worldview must be understood in a general sense and in restricted sense, because what we call African Worldview is not shared by all Africans in its totality but rather some characteristic features of the common elements among African worldview (p. 534).

For example, Myers (1993), Nobels (1990) as well as Wallace and Constantine (2005) have argued that African Americans' values today can be considered a mixture of African traditionalism and philosophies and the values that come from the historical experience of living in the United States. It is also pertinent to mention that individuals from different cultural groups from other continents who subscribe to alternative worldviews may share some worldviews that are similar to those of Africans. Sue and Sue (2003) concur that individuals can adapt and use behaviours associated with another worldview. This shows that the way in which people of African descent come to acquire knowledge and information is fluid and inclusive, posits Grills (2003).

The influence of colonisation and the vilification of Africa by Europeans regarding the philosophical integrity of traditions in Africa cannot be ignored (Thabede, 2008). This influence may have caused some Africans to view their own traditional practices as inferior and shameful, and may have led to them abandoning their value systems by trying to embrace a European worldview. Also blaming colonisation for the hindrance of the development of African traditions, Ngwabi Bhebe in Viriri and Mungwini (2010) argues that political subjugation by Europe traumatised Africans to the extent that many of them lost confidence in and looked down upon their own cultures, forcing some of them to view and embrace Christianity and Islam as progressive. Nevertheless, literature shows that the indigenous African worldview has survived and even spread, and is also adhered to by a number of indigenous communities in other continents (Mbiti, 2015; Mkhize, 2004). Reference in this chapter will be made to dominant themes, in the sense of those that are common within the African culture. Furthermore, ideas put forth regarding the African worldview are presented from the researcher's own positionality and situatedness as an African in South Africa. It is with reference to this positionality as an African that the researcher has come to understand this African worldview. The African worldview in this study is therefore defined as the way in which Africans perceive their world which, in turn, influences their way of life (Matoane, 2012). The worldview prevalent in a society provides an

insight into the way its members think and behave, the way in which they conceptualise the existential problems of their lives, and ultimately their views of what it takes to be human (de Villiers & Herselman, 2004). The following four dimensions that conceptualise the worldview of African people will be discussed to complement the overview of an African belief system (Baloyi & Makobe-Rabothata, 2013; Karanja, 2010; Mkhize, 2004; Myers, 1987): a) epistemology, b) cosmology, c) ontology, and d) axiology. These dimensions provide the basic themes in African worldview about the structure of the world, the nature of being and the intrinsic values which are the imperatives for a good life.

3.3.1.1. Epistemology.

Epistemology is generally concerned with the matter of what constitutes knowledge. Indigenous epistemology, therefore, refers to a cultural group's way of theorising knowledge (Gegeo & Watson-Gegeo, 2001). The epistemological relevance to the current research is based on the position that a society's conceptualisation of mental illness is grounded in an acquired, preserved and lived knowledge. The African epistemological position asserts that there are different ways of viewing reality and that knowledge is acquired through everyday experiences (Njoki, 2005). Unlike Western epistemologies which posit that knowledge stems from science and books, Absolon (2010) argues that indigenous epistemology emerges from ancestral teachings that are spiritual and exist in the visions, dream ceremonies, songs, dances and prayers of indigenous people. This implies that indigenous knowledge is lived, experiential and enacted knowledge.

Despite the marginalisation that has forced indigenous knowledge to the periphery of mainstream society, Diale and Fritz (2007) argue that indigenous communities have managed to sustain their culturally rich histories and knowledge. In a similar fashion to how it is acquired, traditional knowledge is stored and also passed on by elders from one generation to another by learning through various modes, which include language, music, dance, oral traditions, proverbs, myths, stories and religion (Omolewa, 2007). Absolon (2010) adds that traditional knowledge is also transmitted and passed on at ceremonies and that it is in this setting where important protocols are learned. According to Diale and Fritz (2007), initiation schools in the African context are considered as important sites of learning and transmission of indigenous knowledge. In these schools, elders or respected members of the community train young people in the African traditional

philosophies and way of life. To signify the position and role played by elders in this regard, Absolon (2010) states that elders are another cornerstone of indigenous knowledge and are essential to learning and teaching, and the passing on of teachings.

Njoki (2005) argues that instead of relying on explicit hypotheses, theories and laws, indigenous knowledge is spiritual, cumulative and collective, and is constantly reviewed. To clarify this position, Njoki (2005) further states that indigenous knowledge is the product of people's direct experience with nature and its symbiotic relationship with the social world, and is very crucial for community survival. The discussion of other dimensions of African worldview to follow in the subsequent sections will show that spirituality is inherent in indigenous epistemology which, according to Absolon (2010), sees everything in relation to creation and the earth, and recognises that all life has spirit and is sacred. While not denying the material aspect of life, Mazama (2001) posits that the essence of life and of human beings from the indigenous epistemology is therefore spiritual. This refers to the fundamental interconnectedness of all things in the universe (cosmology), which is discussed next.

3.3.1.2. Cosmology.

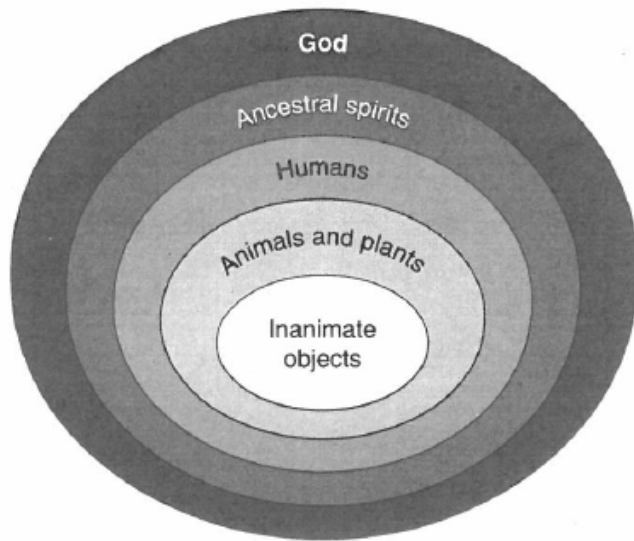
The term cosmology, according to Kanu (2013), is derived from the Greek words *cosmos* and *logos* meaning *universe* and *science*, and refers to the 'science of the universe'. To add clarity to this definition, Udefi (2012) elaborates that the meaning of cosmology refers to the study of the origin, structure and development of the world or universe in its totality. A discussion of the actual origin of the universe is beyond the scope of this research and it would not do justice to the magnitude of the topic to cover it briefly in this thesis. Therefore, only ideas related to the beliefs of the African people about the universe, humans and existence in their totality will be discussed. Udefi (2012) posits that in African traditional societies, there is a belief that the universe is bifurcated into two, namely the sky and the earth. This author further states that the spirits or supernatural entities occupy the sky while the land is occupied by human beings and other entities like animals, plants, water and so forth.

According to Mkhize (2004), traditionally, Africans believe that all these entities in the universe are connected to one another. He states that in an African

belief system, it is thought that intricate webs of relationships exist between organisms and objects in a system where each organism is capable of influencing and being influenced by others. Some scholars perceive the arrangement of, and relations between, this complex system in terms of hierarchies (Semenya & Mokwena, 2012). Regarding the ordering of the universe, Mkhize (2004) and Kanu (2013) state that inanimate objects and plants occupy the lowest level of hierarchy, animals occupy the next level, followed by ancestral spirits and human beings in the level above that, while God is at the apex of the hierarchy. God is referred to by different names in the different cultures. Mkhize (2008) as well as Semanya and Mokwena (2012) state that in South Africa God is called *uMvelinqangi* (the originator of all life) by the amaZulu, *uQamatha* (the omnipresent who lives in everything) by the amaXhosa, and *Modimo* (the one who dwells in the highest place) by the Basotho.

In an African worldview God is believed to have created everything, resides everywhere (omnipresent) and is all powerful (omnipotent). However, Mkhize (2008) cautions that it should be noted that in African mythology, God does not exist in complete isolation from the rest of creation; instead, a hierarchy of beings is assumed. Figure 3.1 below shows this hierarchical ordering of the world in African worldview. This African worldview is similar to a systemic viewpoint where the different parts of the system are believed to function together, and life is perceived to be in harmonious unity. In other words, within this hierarchy the different levels have an interdependent relationship, where each is influenced by the other (Semenya & Mokwena, 2012). This shows that the African worldview consists of both the spiritual and physical realms, which are separate but which maintain harmonious interaction. Being in harmony with the universe is explained as the principle of cosmic unity. According to Mkhize (2008), cosmic unity means that everything is perpetually in motion, influencing and being influenced by other factors. Therefore cosmology, from an African worldview, shows that harmony with nature, group orientation and interpersonal relationships are of prime importance and are highly valued among traditional Africans (Jackson & Sears, 1992).

Figure 3.1: A hierarchical ordering of the world in African cosmology



Source: Semenya and Mokwena (2012, p. 75)

3.3.1.3. Ontology.

Ontology refers to the study of the meaning and nature of being (Udefi, 2012). In Western cultures, the person is defined with reference to internal psychological attributes, such as thoughts and emotions, and the individual is thought to exist independently of the social order (Mkhize, 2006). However, the African worldview refutes the idea that persons can be defined by focusing only on certain physical or psychological characteristics of the lone individual (Menkiti, 1984). From an indigenous African perspective, a different conception of the self, and of the relationship between self and others, both the living and the dead, exists: the self is not understood in isolation from the collective (Honwana, 1998). African indigenous thought defines personhood in terms of wholeness (Ramosé, 2005). The concept of the self is based on the development of an individual's personality in the relational and contextual setting of his or her community. This opposes Western orientations, which isolate the individual from his or her social setting in understanding a person's sense of an individualised self (Semenya & Mokwena, 2012).

It is apparent that in an African worldview, individuals cannot exist alone, but owe their existence to the ancestors, the entire community, and all of nature (Jackson & Sears, 1992). Ramosé (2005) argues, however, that the African concept of person as wholeness does not deny human individuality as an ontological fact, but ascribes ontological primacy to the community through which the human

individuals come to know themselves and the world around them. According to this author, the human individual is therefore inextricably linked to the encompassing universe, and thus, the person in African traditional thought is regarded simultaneously as a physical and a metaphysical being. The person, in Mkhize's (2006) view, is thus extended in space and time and is embedded in social and communal relationships. An indigenous African view of the person can be summed up in the statement: I am because we are, and since we are, therefore I am (Menkiti, 1984). The African proverb *Umntu ngumuntu ngabantu*, literally meaning 'a person is a person because of another person', reflects the emphasis that is placed on the close relationship between the individual and the community (Berg, 2003b). As a result, some authors conclude that in African cultures, without relationships with the wider community one is not a person (Verhoef & Michel, 1997).

3.3.1.4. Axiology.

Axiology stems from the Greek words *axios* meaning worth and *logos* which means science (Obasi, 2002). Axiology is therefore defined as the science of *values*, that is, the study of what people value or what their values consist of (Karanja, 2008). According to Obasi (2002), axiology describes a fundamental value system that defines the relationship between humans and their environment. Axiology is concerned with ideas about what a good life looks like and what is valued in life, both in moral terms as well as in terms of quality of life (de Witt, de Boer & Boersema, 2014). Every culture has its own sets of ethical customs, rules, taboos and morals. African societies believe that their morals originated with, or are tied to, God (Mbiti, 1969).

The fundamental axiological principle of *being*, communalism and harmony-with-nature are also central to the African worldview (Karanja, 2008). The discussion of ontology in the preceding paragraph shows that African values emphasise connectedness and interdependence over individualism. Myers (1987) notes that, in terms of axiology, Africans place the highest value on interpersonal relationships among people. Rather than the survival of the fittest, African axiology reflects values based on the general guiding principle of the survival of the entire community and a sense of cooperation, interdependence and collective responsibility (Cobbah, 1987). Indigenous Africans believe that the Supreme Being (God) created the cosmos. Although God is also believed to be everywhere,

Olumbe (2008) suggests that there is a strong belief among Africans that God is far removed from human beings and the earth, and resides away in the farthest heavens. According to African traditions, one can gain access to the Supreme Being through intermediaries such as the spirits or the ancestors (Ross & Deverell, 2010). Spiritualism, in terms of Hadebe's (1986) thought regarding the African worldview, refers to the belief that there is life after death where the person continues to live as an ancestral spirit, the living-dead. It is thus understood, as Ramose (2005) argues, that death discontinues the existence of those beings departed from the world of the living only with regard to the concrete, bodily and everyday life as people know it, but death does not totally discontinue the life of these departed beings. Baloyi and Makobe-Rabothata (2013) further argue that from an African perspective death is seen as a natural transition from the visible to the invisible spiritual ontology where the spirit, the essence of the person, is not destroyed but moves to live in the spirit world as an ancestor. Ancestors are guardians of the traditions and intermediaries between God and the community (Schmidt, 2005). This shows the value of the belief in the existence of a connection between the living and the living dead, and there are a series of rituals that are performed in traditional African societies to establish this connection.

It is worth noting that some spirits, in an African worldview, are considered good and are therefore honoured while others are evil and are to be avoided (Olumbe 2008). Explaining how some spirits end up being good and others evil, Kanu (2013) states that people who are considered to have lived their lives in good moral standing are believed to go to the spirit land to become ancestors when they die, on the one hand. On the other hand, those who lived bad lives and died before they reached a ripe old age are sent to an intermediate state, which is thought to be between the spirit-land and the land of the living, where they live as frustrated, restless and evil spirits (Kanu, 2013).

3.3.2. Personhood in African-view.

It is important to begin with the acknowledgement that there are a number of conceptions of the person found in Western thought. These views are based on the premise that a person is a biological organism with psychological characteristics, who has a soul, rationality, will or memory. This section, however, does not aim to provide a comparison between the African and Western views of the person, but instead focuses on the African indigenous conception of the

person. The goal is to articulate the view that in African cultures personhood is achieved and can be lost based on an individual's engagement or relationship with his or her community. In the African view, according to Menkiti (1984), it is the community which defines the person as a person, and persons become persons only after a process of incorporation. Of significance is that full personhood, in an ethical-moral sense in an African view, is not bestowed on the individual at birth. It is a process that is attained as one participates in communal life through the discharge of various obligations defined by a person's community (Menkiti, 1984). Becoming a person is seen developmentally as a state that is progressively achieved through stages (De Craemer, 1983). In order to be considered a person (*umuntu*, or *motho*) the human individual must, according to indigenous African thought, go through various community-prescribed stages and be part of certain ceremonies and rituals (Menkiti, 1984; Ramose, 2005). For example, the birth of a child is often followed by a naming ceremony. In the Xhosa culture the *imbeleko*, a sacrificial offering, is performed to welcome the child as a member of the clan and links the child in the clan to its ancestors and heritage (Berg, 2003b) and, by extension, to God (Mkhize, 2006). Similar offerings are performed during various stages of a person's life. For instance, full personhood for a boy is only achieved after an initiation ceremony.

Meissner and Buso (2007) state that initiation confers a socially approved adult status, and with it marriageability. According to these authors, an uncircumcised male is not allowed access to family inheritance and is treated as a minor, regardless of his age. It is therefore possible that some individuals could fail to meet the accepted standards of full personhood. To support this view, Menkiti (1984) opines that personhood in African societies is something at which individuals could fail, at which they could be competent or ineffective, or better or worse. For example, according to Mkhize (2006), a number of sayings in some African societies such as *ga e se motho* (Tswana) or *a ku si muntu* (Nguni), literally meaning 'he or she is not a person', exist. This author also writes that personhood could be regarded as *becoming* and is an unpredictable, open-ended process during which personhood could be achieved, lost and regained, depending on the person's circumstances. This is perhaps why Menkiti (1984) states that Africans emphasise the rituals of incorporation and the overarching necessity of learning the social rules by which the community lives so that personhood can ultimately be attained.

It is apparent that African personhood as a process of becoming may, once achieved, also be lost given that the relationship between individuals and the community may not always be a harmonious one. The self-in-communal belief system implies that one is considered a person in a robust sense, only when one consistently acts or behaves in ways that are considered morally acceptable (Ikuenobe, 2016). When writing about '*Ubuntu and harmony*', Mkhize (2008) states that to be a human being (*ukuba ngumuntu*) is therefore a social practice that requires one to co-operate with others by doing good, thereby promoting the balance that is thought to characterise the universe. The same author elsewhere provides a number of sayings used in some African societies that refer to people who have failed to meet the standards expected of a fully human person. These are sayings such as '*a ku si muntu*' (Nguni) or '*ga se motho*' (Tswana), literally meaning 'he or she is not a person' (Mkhize, 2004). Significant to note and of pertinence to this review is Kometsi's (2004) caution that these conceptions of personhood carry with them practices that have the potential to ostracise and render an individual as *persona non grata* were the person to spurn these cultural practices. It is clear that to be a human being from the African perspective, as Mkhize (2008) states, is a social practice that requires a person to cooperate with others by doing good, thereby promoting the balance that characterises the universe. However, if an individual has transgressed the social rules of communal harmony and is ostracised, or communal harmony is disrupted, there are certain traditional rehabilitative practices that may be performed to restore the person to the realm of humanity or to restore harmony. For example, at the end of the civil war in Southern Sudan in 2005, according to Kamwaria and Katola (2012), healing and ceremonies for cleansing of evils caused by the war were viewed by community members as imperative for peaceful and harmonious coexistence to continue in the community.

3.3.3. African worldview: implications for health and illness.

Prior to a consideration of the influence of the African worldview on key conceptualisation issues of health, such as aetiology, diagnosis and treatment, it is imperative to examine how health and illness are defined in both the Western and African perspectives. Truter (2007) argues that Western medicine is often contrasted with the approach taken by traditional medicine because the former

is usually associated with diseases of the physical body and is based on principles of science, yet traditional medicine has its roots in ancient traditions of healing that are still relevant and complementary to modern medical practice. It remains important to pay attention to the influence of culture in constructing an identity of health and illness because this in turn affects people's health and illness behaviours. According to Corbin (2003), the construction of health or illness refers to the means that people use to arrive at conceptions of self as either well or ill, based on a particular worldview. Ross and Devereil (2010) argue that in terms of worldviews, there are two main types of constructions of health and illness, namely the traditional approach, which is based on indigenous belief systems, and the so-called modern approach that is located within a Western medical paradigm. Both the cultural and medical conceptualisations of health and illness differ, even though similarities may be detected. Cultural conceptions of health are more holistic than the biomedical models.

3.3.3.1. Western and African models' definition of health.

Western or biomedical models, according to Piko and Bak (2006), define health as the lack of disease or illness. Boddington and Raisanen (2009) argue that defining health as lack of disease or illness tunnels the vision too much to the physical body, leaving out reference to other dimensions of health such as mental, emotional and social aspects. A much more inclusive definition of health that might be considered 'holistic' is provided by the WHO. According to the WHO (2001), health can be defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (p. 1). This definition indicates that health is considered to be multidimensional, and encompasses both biomedical and psychosocial aspects of health. Although this definition of health by the WHO is not far off from the African conception of health, what is missing, from this definition is the spiritual aspect, which is vital and relevant to the African conception of health.

What is apparent from the WHO's definition of health is that it focuses mainly on the individual. The African notion of health expands on that of the WHO and yet differs in some ways. Indigenous African perceptions of health encompass both the individual and his or her society, the environment as a whole, as well as the spiritual world. The fact that, according to an African worldview, the individual is

surrounded by members of the family and clan, both the *living* and the *living-dead* community, and that their personhood is anchored in such a network of relationships is a primordial source of that person's physical, psychic and spiritual security and well-being (De Craemer, 1983). Good health means much more than just a healthy body. Just like with personhood, health in an African context is viewed not only as a bodily process, but is also viewed in terms of life processes. This shows the artificial divisions of 'physical health' from 'mental health' common in the Western developed world, which is not shared by traditional cultures (Sturgeon, 2007). According to Nelms and Gorski (2006), Africans view health as transcending the mere absence of a disease, and recognise that the body and the mind must be in a harmonious state of wellness that is recognised and accepted by the individual and society. However, the spiritual component is missing in this model. Nevertheless, this is in harmony with the biopsychosocial model, as stated by Sturgeon (2007), which suggests that mental well-being, social support and social networks are protective factors for physical health. The opposite would also be true, which is to say, that physical health impacts positively on mental health. Health in the African worldview is also defined and influenced by the harmonious relationships between human beings and their environment (surroundings), between human beings and the spiritual world, and between human beings and their communities (Honwana, 2001). Although the term *illness* refers to the experience of a sick person, according to Peu et al. (2001), all diseases, from a traditional view, are determined by how a particular society defines them. This will be shown in the definitions of illness below.

3.3.3.2. Western and African models' definition of illness.

The concept of an illness is the subject of vast debate that taps into complex cultural and philosophical issues and does not lend itself to a simplistic definition. This concept, when examined from the Western perspective, is further problematised by the evolution of medicine throughout human history. For the purpose of the current study, although the concepts *illness*, *sickness* and *disease* could be defined differently, they will be used interchangeably. To show the differences between these concepts, Boyd (2000) defines disease as a pathological process that deviates from a biological norm, while illness is an experience of being unhealthy, and sickness is an external and public mode of being unhealthy. To sum up these differences, disease reflects a malfunctioning of

biological and/or psychological processes, while illness is the psychosocial experience and meaning of perceived disease (Kleinman, 1980). However, these concepts will be used interchangeably because they usually occur together. For an example, Ross and Devereil (2010) write that people are ill because they have a disease and are labelled as sick. Many patients, in most instances, are probably classified as having a disease, or feeling ill, or recognised as sick (Boyd, 2000). According to Hofmann (2001), ancient medicine defined disease as the disturbance of humoral homeostasis, and medicine of the third millennium seeks to define disease in the language of microscopic or radiographic morphology, biochemistry and molecular biology. From the Western biomedical perspective, Nordenfelt (2006) defines disease as a type of internal state which is either an impairment of normal functioning ability or a limitation of functional ability. Lester King (as cited in Hofmann, 2001) provides a more holistic Western approach that acknowledges a cultural imperative and defines a disease as "the aggregate of those conditions which, judged by the prevailing culture, are deemed painful, or disabling, and which, at the same time, deviate from either the statistical norm or from some idealized status" (p. 220). Although this definition acknowledges cultural imperatives, similar to the Western definition of health, the Western definition of a disease is largely focused on the individual, where the term disease is used to refer to a particular physical experience of the body.

It is clear that African culture is not homogeneous. It would therefore be expected that different African cultures would have different beliefs about causation and treatment of ill-health and that there would be differences in the way in which illnesses are conceptualised and dealt with (Honwana, 2001). Thus, illness or disease would be defined differently in different contexts, by placing varying emphases on various aspects of cultural understanding. For example, on the one hand, Kamsu-Foguem, Diallo and Foguem (2013) define disease or illness in an African tradition as a failure of complex physical, social and spiritual relationships. On the other hand, according to Kale (1995) and Truter (2007), disease, in some African cultures, is considered a supernatural phenomenon governed by a hierarchy of powers beginning with the most powerful deity followed by lesser spiritual entities, ancestral spirits, living persons, animals, plants and other objects. According to Botha and Moletsane (2012), if one or more, or indeed all, of these levels is or are not held firmly, then the person comes to exist in a state of disequilibrium. As it has already been stated, harmonious relationships

within this hierarchy are important for good health. Some authors (Edwards, 2011; Mkhize, 2013; Ross & Deverell, 2010) also agree that should this harmonious relationship be interrupted or thrown into a state of imbalance or disequilibrium, from an African point of view, illness would befall an individual.

From an African perspective, Semenya and Mokwena (2012) assert that illness can occur as a result of upsetting the interdependence of things or people; the balance is upset and things fall out of harmony. While in a state of disequilibrium, the person becomes unhappy and gets sick often because the relationship or bond between the levels is weak (Botha & Moletsane, 2012). For example, ailments could be due to the ancestors' withdrawal of their protection because they are angry that the person concerned did not perform certain rituals. Semenya and Mokwena (2012) state, for instance, that if a person dies, relatives of the deceased need to perform specific rituals and if these rituals are not performed, the flow of the relationship between the family, ancestors and God is broken. It is commonly believed, in African cultures, that when ancestors withdraw their protection, a space for vulnerability is created for misfortune or illness to occur. Mkhize (2013) also argues that it is possible for unknown forces to intervene without people's awareness and to cause disequilibrium, and thus an illness. This stems from the belief that the creative life force may be manipulated for sinister purposes (Mkhize, 2004). An example of this would be an illness caused by witchcraft.

3.3.4. Views on aetiology.

The review of the African worldview presented above in this chapter has demonstrated a few points to consider as a foundation for discussion regarding the indigenous views on aetiology of illness. These points can be summed up as follows: a) all things in the universe are connected to one another; b) different parts of the life forces are perceived to exist in harmonious unity and these forces influence each other; c) however, unknown forces such as witchcraft may interfere with this harmonious unity; and d) this may lead to a disequilibrium of the life forces which may manifest in a variety of ways. This is probably why Mkhize (2004) contends that Africans deny the possibility of events happening by accident. He argues that, for example, in the event of a personal tragedy, Africans would seek to investigate the cause as to how an individual, the family or a sinister force might have brought about the undesired consequence. Elsewhere, the same author (Mkhize, 2013) contends that this tendency among Africans to prefer teleologically

inclined explanations stems from the view that life force can be manipulated. Eagle (2005) agrees and writes that in most African societies, if misfortune befalls an individual the search for causality generally excludes the possibility of such an act being random or fortuitous. To substantiate this view, Nwoye (2015) also asserts that when a sudden or strange illness befalls a family member, the tendency within the Afrocentric paradigm is to see such an illness as carrying a hidden message or meaning that must first be decoded before a decisive solution to achieving a cure can be found. This desire for explanations in the African worldview forms a fundamental human drive.

The African conceptualisation of sickness is generally attributed to causes beyond the parameters of the patient's illness and is either not or very rarely considered to be simply due to some physical disorder or malfunctioning of the body (Seape & Drennan, 2007). It is important to state that this does not by any means imply that the African worldview denies psychosocial causal explanation. Nwoye (2015) makes it clear that, instead, the African worldview recognises the possibility of the origin of an illness arising *not only* from the illness of the body, or that of the mind, or social context, but also, at times, originating from the spiritual or other life forces. Disease causation is often understood by Africans through the holistic explanatory model based on the belief that harmony must exist within the body and between people and the physical environment (Tjale, 2004). In line with Honwana's (2001) definition of health, as previously stated, Matoane (2012) posits that from an indigenous African perspective, illness hinges on the interrelational element between different parts of the life forces. According to this author, a harmonious relationship between and within these forces signifies a state of wholeness and good health, while disharmony between any of the three levels leads to a state of disintegration, either within the individual or between individuals.

Consistent with teleological orientations, Peu et al. (2001) state that African people who view illness from an indigenous point of view believe that illness can be intentionally caused by a malevolent agency which has control over supernatural (mystical) forces. A cause is described as a thing, person or set of circumstances that give rise to a condition of ill-health (Herselman, 2004). The aetiology of the disease is also considered a supernatural phenomenon governed by a hierarchy of vital powers beginning with a most powerful deity followed by lesser spiritual entities, ancestral spirits, living persons, animals, plants and other objects, and disharmony between these vital powers can cause illness (Kale, 1995).

When an illness strikes, it also prompts the search for causality, including why the person has been affected in a particular way at a particular time (Eagle, 2005). Illness and sickness is often attributed to three major influences on the human condition, namely: a supreme being (God); the ancestors (spirits of the dead); and witches (Shizha & Charema, 2011). The underlying idea, according to Ramose (2005), is that there must be a correlation between the illness experienced in the body and the disturbance of harmony and balance between the body and the ancestors and/or God.

There is literature to support the notion that Africans traditionally believe that practitioners of witchcraft and sorcery can also cause certain kinds of illness (Peu et al., 2001). For example, the Shona and the Zulu people believe that *varoyi* and *abathakathi* (wizards and witches, respectively), may cause an illness through the use of their destructive and evil spirits (Shizha & Charema, 2011). Sorcery is believed to occur through procedures such as uttering spells, manipulating medicines to poison people, or by obtaining body parts such as nail parings and hair clippings, and mixing them with medicines and administering them to victims to harm them (de Villiers & Herselman, 2004). Furthermore, Straker's (1994) writing adds that, traditionally, Africans believed that illness and distress may also be caused not only by persons in this world but also by those in the world beyond. As previously stated, the ancestors may withdraw their protection should they not be attended to (Berg, 2003a), or if the patient or his/her family members have committed an immoral act such as incest (Mzimkulu & Simbayi, 2006). To support this view, Buhrmann and Gqomfa (1981) state that it is believed that the ancestors usually express their displeasure by withdrawing their protection, thus exposing the living kin to the powers of evil which can then cause misfortune, unhappiness, sickness and even death. Therefore, according to these authors, if disturbing, puzzling, painful events or illness occur in the life of an individual or a family, it is regarded as an indication that the equilibrium between the living and the deceased has been disturbed. Aetiology, from traditional views, therefore, helps people 'make sense' of what is happening to themselves or to others (Herselman, 2004).

Regarding mental illness, firstly, it is important to note that it should always be borne in mind that in terms of worldviews, there are two main types of health conventions or social constructions of illness. These are: 1) the holistic approach

based on indigenous belief systems; and 2) the so-called modern approach that is located within a Western medical paradigm (Ross & Deverell, 2010). However, it has already been stated that the review presented here will be limited to the focus of this chapter, which is the cultural or traditional perspective. According to indigenous African beliefs, mental illness can be caused by conflict between an individual and the ancestors or by God, a witch, spirit or sorcerer (Ross & Deverell, 2010). To be more specific, Sow (1977, cited in Botha & Moletsane, 2012) provides the following examples of illnesses cause by different conflicts: a conflict between individuals and their ancestors which leads to serious chronic psychotic states; conflict between the person and the family which leads to organic illness and conflict between the person and the community which leads to more benign organic and psychosomatic illnesses, as well as neurotic states. Herselman (2004) also reports that the possibility of inflicting mental illness upon oneself is also recognised in an African worldview. According to this author, from an indigenous African view, sleeplessness, depression, irrational behaviour or mental distress are possibly caused by a guilty conscience about harm caused to others. For example, an individual may experience guilt for a prolonged period for causing someone, intentionally or unintentionally, physical or psychological pain.

Abbo (2011) reports that a few studies have shown that some traditional healers in Africa, for example the Yoruba native leaders, use both aetiological and symptom logical concepts, mostly interchangeably, to describe psychotic illness. According to this author, the most common diagnostic label is referred to as 'were', which refers to a person who is chronically psychotic, careless in dressing, vagrant in behaviour, talks irrationally, and suffers from auditory and visual hallucinations. While 'were' denotes chronic psychosis in Yoruba, in South Africa the equivalence seems to be *amafufunyana*. It is interesting to note that, according to Mzimkulu and Simbayi (2006), similar traditional conceptualisations and beliefs about causes of psychosis exist in cultures found in other African countries. These authors report that the most common types of spirits that are thought to cause psychosis are known as 'ngozi'. This clearly shows that mental illness is a socially constructed phenomenon in an African context.

3.3.5. Views on diagnosis.

Indigenous people consult traditional healers for various reasons, including, but not limited to, treatment of diseases. Kale (1995) cites diseases or reasons such as sexually transmitted diseases, divulgence of secrets, immunisation against witchcraft, prophecies of future events, and annual check-up as the most common reasons for consulting a traditional healer. Traditional diagnosis is a system that is both an art and a method of seeking to discover the origins and nature of the disease (Pretorius, 2001). According to Prinsloo (2001), a *sangoma* does not only associate disease with specific parts of the body by starting to diagnose an illness through a physical examination of the patient's body, as it happens in the Western society. Patients are seldom diagnosed as having, for example, schizophrenia or major depression, and no distinction is made between physical and psychological illness (Pretorius, 1995). Instead, traditional healing is primarily concerned with the patient's background in socio-cultural and in divine or supernatural relations (Prinsloo, 2001). In fact, people who consult traditional healers do not tell them what the problem is; rather the healer tells the person or the family what he or she believes to be the problem (Ross & Deverell, 2010).

3.3.5.1. Traditional diagnostic process.

As in Western medicine and psychiatry, Sodi (1998) writes that an indigenous African healer has two critical functions to perform when consulted: 1) he or she must attempt to identify and diagnose the particular phenomenon experienced by the patient; and 2) must also link the patient's idiosyncratic experience with a culturally meaningful explanation. A diagnosis, according to Honwana (2001), is achieved through a careful examination of the state of the patient's social relationships in the community (relationships with the living, with the spiritual world and with nature). Attention is focused on some person or object or on the appeasement of the ancestors (Seape & Drennan, 2007). Ramose (2005) concurs that the aim would be for the traditional healer to discover whether the patient's ancestors are displeased and what remedy would be required for their appeasement. Therefore, a diagnosis, according to Kamsu-Foguem et al. (2013), starts with an examination of both human and supernatural interactions.

The diagnostic process in traditional healing not only seeks answers to the question of how the disease originated (immediate causes), but also to who or

what caused the disease (Pretorius, 2001) and why the person has been chosen for affliction (Starker, 1994). Complete diagnosis takes into consideration the ecological complex of the total environmental setting of people, and biological, social, psychological, cultural, spiritual and supernatural causal evidences are usually involved (Prinsloo, 2001). Diagnosis comprises a combination of information, namely observation, patient self-diagnosis and divination (Pretorius, 2001). In diagnosing illness, the traditional healer will point out the agent or the agency responsible for the illness and will also refer to an event in the visible or palpable world which caused such an agency to intervene (Seape & Drennan, 2007).

To conduct the actual diagnostic procedure, according to Sodi (1998), with little or no history of the problem given by the patient, the indigenous healer will use assessment devices to reveal the nature and extent of the patient's problem. Bone-throwing is a popular diagnostic technique that traditional healers employ (Mufamadi, 2001). The traditional healer is able to interpret the patient's symptoms through the use of divination bones. Sodi and Bojuwoye (2011) provide an example where a traditional healer that was consulted threw the divination bones on a mat and declared that the patient suffers from a condition called *senyama* (bad luck). In this case, the traditional healer went on to provide an explanation for this condition and suggested that the *senyama* was visited on the patient by angry family ancestors who felt that the patient's parents had turned their backs on them. According to Truter (2007), other methods of divination include mediumistic ability (clairvoyance or telepathy) or dreams and visions.

3.3.5.2. Traditional diagnostic labels.

Since traditional healers are more concerned with the aetiology of the disease than with symptom grouping when making a diagnosis, Ramgoon, Dalasile, Paruk and Patel (2011) state that it is possible that patients presenting with widely differing symptoms may be given the same diagnosis. Drennan (2001) concurs and adds that traditional labels for illnesses are often applied on the basis of the cause of the misfortune and classification is based on meaning rather than symptoms, unlike Western diagnostic systems such as the DSM or ICD. Seape and Drennan (2007) provide the following examples of diagnoses a Zulu traditional healer is likely to make following a consultation: 1) *spirit possession* - this condition is attributed to possession by alien spirits and makes the person agitated, tense or anxious and causes them to experience altered perceptions; 2) *sorcery* - this may

be considered to cause a variety of symptoms and is often referred to as *ukuloyiwa*; 3) *poisoning* - this is similar to sorcery but presents only with somatic complaints; 4) *pollution* - this may be caused by a mystical force, resulting in weakness in patients and making them accident-prone; and 5) *environmental hazards* - this affects people when they step over tracks which are dangerous (referred to as *umeqo*) and causes painful, swollen legs and joints and may lead to paralysis. In addition, there is also *amafufunyana* – a condition caused by possession by evil spirits, usually contracted when soil and ants from graves are mixed together and ingested, and *ukuphambana*, which is considered to be a generic term for madness, sometimes due to possession by evil spirits (Drennan, 2001). The symptoms of *amafufunyana* and *ukuphambana* are similar to those of schizophrenia (Ramgoon et al., 2011). These conditions, according to Washington (2010), are sometimes referred to as 'African illnesses' or *ukufa kwabantu* in isiZulu.

Another category worth adding to the list of these traditional diagnostic labels is *umkhuhlane* (illnesses of a natural cause). According to Washington (2010), included under this category are *isithuthwane* (epilepsy), *isifuba somoya* (asthma), and *ufuzo* (familial/genetic disorders) such as *isidalwa* (intellectual disability). It is apparent from the examples of diagnoses employed in traditional healing presented here that many illnesses that meet DSM criteria are also understood within cultural paradigms in African traditional communities (Ramgoon et al., 2011).

3.3.6. Views on treatment.

It is apparent that cultural factors not only influence the meanings attached to different health conditions and beliefs regarding causation, but are also likely to determine the persons who are consulted to restore health and well-being (Ross & Deverell, 2010). In African traditional cultures, one of the most respected health components is the significant role played by traditional healers and the use of African traditional medicine in matters of health and wellness. The WHO (2004) defines traditional medicine as:

the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health and in the prevention, diagnosis, improvement or treatment of physical and mental illness (p. 6).

Traditional healers are established healthcare workers within their communities and are widely consulted by people who may be in search of causes and cures for various ailments, illnesses and misfortune (Shizha & Charema, 2011). Traditional healers are respected members of the community and they function in multiple capacities. They provide healthcare by using methods based on social, cultural and religious backgrounds, as well as prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community (Pretorius, 2001). This implies that traditional healers deal with the complete person and provide treatment for physical, psychological, spiritual and social symptoms (Truter, 2007). They do not separate the natural from the spiritual, or the physical from the supernatural, because these dimensions are viewed as intertwined.

Traditional healers interact very differently with their clients, when compared to their Western counterparts, and employ a more client-centred approach. They are regarded as interdimensional interceders who carry the responsibility and directions to intervene on people's behalf, to help bring healing, balance, peace and harmony in the present, with the ancestors, and also for future generations (Solomon & Wane, 2005). Apart from their role in health-related issues, traditional healers' leadership and services play a major role in the areas of governance, family disputes, marriages and divorce, sexuality and infertility, and guidance of children (Shizha & Charema, 2011). According to Ross and Deverell (2010), traditional healers' skills are acquired by apprenticeship to an older healer, experience of certain techniques or conditions, or by a *calling* from the spirits or the ancestors. The calling, according to these authors, can take the form of a dream, a passion or a passing, or sometimes a condition which makes the person feel sick or brings him or her ill-fortune, so that he or she consults with a traditional healer who would then inform the person that he or she has been called. This process of a calling to become a traditional healer is referred to as *ukuthwasa* in isiZulu. Although the initiate must undergo training once being called to become a healer, *ukuthwasa* could be averted through animal sacrifices to the ancestors (O'Connell, 1982).

3.3.6.1. Categories of traditional healers.

Traditional healers, just like medical doctors, are not a homogenous group; they do not all perform similar functions or fall in the same category. The term 'traditional healer', according to Mokgobi (2014), is an umbrella concept that encompasses different types of healers with different types of training. Each of them has their own field of expertise and their own ways of working using their own particular treatment regimen (Truter, 2007). What follows in the subsequent sections is an identification and description of different types of South African traditional healers, namely, *izinyanga*, *izangoma*, *abathandazi*, and *traditional birth attendants*.

3.3.6.1.1. *Izinyanga*.

Izinyanga are herbalists who possess extensive knowledge about curative herbs and medicines of animal origin. According to Kale (1995), they do not need to have a calling to be herbalists, but may have acquired competency through working closely with a herbalist, perhaps as an assistant, and are allowed to practice on their own once the herbalist feels that they are competent enough. They are expected to diagnose and prescribe herbal medicines for everyday ailments and illnesses, to prevent and to alleviate misfortune or evil, to provide protection against witchcraft and misfortune, and to bring prosperity and happiness. The term *ubulawu* is widely used to refer to the roots of varieties of herbs and creepers used by *izinyanga*, but is also sometimes used to refer to the stems or bark of certain plants utilised to facilitate treatment among Xhosa indigenous healers (Sobiecki, 2008). These herbal medicines contain ingredients obtained from animals, plants, and other objects that have medicinal properties and can restore the decreased power in a sick person (Kale, 1995). However, if the patient's illness does not respond to these medicines, the herbalist concludes that there is something else present in the sickness, a diviner is called, and causation is sought in a wider context (Nelms & Gorski, 2006).

3.3.6.1.2. *Izangoma*.

Izangoma are diviners and are the most senior of traditional healers. Although they are mostly referred to as *izangoma* (isiZulu word), diviners are known by different names in South African cultures, such as *amagqira* in isiXhosa, *ngaka* in Setswana, *selaoli* in Sesotho, and *mungome* in Venda and Tsonga (Truter, 2007). Diviners, according to Sobiecki (2012), are considered to be spiritual specialists, and use divination to communicate with ancestral spirits to diagnose their patients' misfortunes or medical conditions. They tend to concentrate on diagnosing and interpreting unexplainable illnesses, and are therefore regarded as the most important intermediaries between humans and the supernatural (Kale, 1995). They are called by ancestors to training to become diviners where they learn to throw the bones, and control trance-like states where communication with the spirits takes place (Truter, 2007). Diviners make use of dreams during divination as a medium through which they establish contact with the ancestors and also consider these dreams to have ritual and medicinal significance in healing. In addition, it is common for diviners, after dreaming about a medicinal plant (*iyeza* or *umuthi*) in the bush to go and collect it from the place in which it was seen in the dream and to use it to treat patients (Hirst, 2005). Although both the herbalists and diviners prescribe and utilise herbs in their treatment, Sobiecki (2012) points out that the diviner has a specialised knowledge regarding particular species of *ubulawu* that are used for various purposes such as cleaning the body through vomiting and to bring good luck. According to Hirst (2005), diviners or initiates (*abakhwetha* in isiXhosa) also ingest *ubulawu* to enhance dreaming.

3.3.6.1.3. *Abathandazi* or *abaprofiti*.

Abathandazi or *abaprofiti* are faith healers or prophets, respectively. They are professed Christians who usually belong to one of the independent African churches and heal through prayer, by using holy water or ash, or by touching the patient (Kale 1995). *Abaprofiti*, in particular, are individuals who are possessed by the Holy Spirit and are able to foretell the future and advise on how to avert an undesirable event (Mokgobi, 2014). According to Hirst (2005), Christianity and traditional religion are considered to be related systems of thought and practice, and connections are drawn between Satan (*uSathane*) and witches or sorcerers. Truter (2007) states that *abathandazi* or *abaprofiti* believe that their healing power

comes from God through ecstatic states and trance-contact with a spirit (*umoya*), or sometimes a combination of both Christian holy spirit and ancestral spirit. The treatment that they prescribe therefore usually involves a combination of prayers, herbs, remedies and holy water.

3.3.6.1.4. *Traditional birth attendants.*

Traditional birth attendants are described by Pretorius (2001) as traditional midwives. According to this author, they often serve communities located in very isolated and remote areas where they are consulted as a matter of necessity due to the unavailability of Western healthcare services. Traditional birth attendants are usually older women who have perfected the skill of midwifery over the years through experiencing, witnessing and assisting in many births throughout their adult lives (Mokgobi, 2014). They are responsible for duties such as the teaching of behavioural avoidance among pregnant women, ritual bathing of the mother, ritual disposal of the placenta, provision of healing medicine and traditional massage after delivery (Truter, 2007). Mokgobi (2014) is concerned about the survival of this important category of traditional healers as more African people now prefer to give birth in hospitals and not at home as was previously the case.

While it is apparent that traditional healers do not all perform the same functions and each of them has their own field of expertise, it is not unusual for healers to integrate aspects of more than one orientation into their practice (Ensink & Robertson, 1999). Figure 3.2 below provides a summary of each of these healers with regard to the skills, method of services, nature of services offered and their accessibility. However, the generic term 'traditional healer' is commonly used to refer to all types of healers considered above (Kahn & Kelly, 2001).

Figure 3.2: Some of the traditional healers and the methods of their services

Agent	Skills	Method of service	Nature of service	Accessibility
Isangoma:				
High grade	1 Lower and middle grade qualifications a prerequisite 2 "Call" by spirits 3 Apprenticed to an expert 4 Medical skills acquired as in inyanga	1 Essentially diagnostic 2 Contact with patient not needed for diagnosis 3 History, symptoms, and nature of problem not revealed by patients	1 Conflict resolution 2 Revelation of misfortune and illness 3 Recommends solution 4 Provides expertise and leadership	Access given to relatively few
Middle grade	1 Lower grade qualification a prerequisite 2, 3, and 4 as above	1 As above 2 Throws and reads "bones" 3 As above	1, 2, 3, and 4 as above	Relatively accessible compared with above
Lower grade	1 First entry point to divination 2, 3, and 4 as above	1 As above 2 Divination through trance 3 As above 4 Cooperation of clients sought	Confirms patient's beliefs	Much more accessible
Inyanga	1 Individual choice to become one 2 Apprenticed to an expert	1 Knowledge of symptoms and patient's history necessary 2 Contact with patient necessary	Comprehensive, curative, prophylactic, ritualistic, and symbolic	Freely accessible
Specialist	Usual family prerogative	Essentially curative	Consultant, special skills	Fewer in number
Spiritual healer	Trances and contact with spirits	Essentially diagnostic	Lays on hands, prays, provides holy water and other symbols	Freely accessible

Source: Kale (1995, p. 1182)

Each traditional healing practice is unique and healing takes different forms depending on a person's individual situation (Solomon & Wane, 2005). For example, it is possible, on the one hand, for two people to receive the same diagnosis (e.g. bewitchment), but with quite different symptom patterns (Swartz, 1998). On the other hand, different people with the same illness may get different treatments because healing focuses on the person, not the illness (Shizha & Charema, 2011). Traditional healing is holistic, which means illness and healing cannot be dealt with without taking into account the actual context in which they occur (Herselman, 2004). Healing seeks to restore harmony, balance and equilibrium, not only through alleviating physical and psychological symptoms, but also through reintegrating the person with his or her community, the earth and the spiritual world (Ross & Deverell, 2010). In practice, traditional healers treat mental disorders with various methods that include herbs, appeasing the spirits and divination, depending on the perceived cause (Abbo, 2011). According to Solomon and Wane (2005), some healers might prescribe a spiritual bath, which is a formal acknowledgement that something needs to be done about the physical, mental and emotional well-being. They add that sometimes songs, dances, ceremonies and sacred medicines could be used and these serve as the vehicle and tools of the healer. Such treatments often include rituals performed in the patient's home while evocating evil spirits, which culminates with a feast involving the sacrifice of an animal to appease the spirits and drinking of traditional beer (Mzimkulu & Simbayi, 2006).

Furthermore, Shizha and Charema (2011) state that those who experience psychosocial disorders resulting from problems of unemployment, inability to find a spouse, infertility, bad luck and many others, may resort to faith healing and prayer. According to these authors, where illness is attributed to spirit attack or possession, rituals involving dancing, incantations and prayer, induction of trances and exorcism are performed. In some cases, the spirits of the dead (ancestors) are called upon for protection or discipline. The ancestors are believed to work together with *Unkulunkulu* (God) and the healing is made possible through spiritual agents (Shizha & Charema, 2011). Ross and Deverell (2010) state that traditional healing has been shown to have several benefits including psychological relief from ailments and reduced anxiety through a shared, unquestionable belief in the powers of the healer. They emphasise that healing may be promoted by the personal meaning the patient derives from treatment, as well as the connection between the person seeking healing and the healer.

Consistent with the holistic conception of the person and illness, indigenous healing practices are directed at the whole person (Seape & Drennan, 2007) and embrace both the physical as well as the psychosocial aspects of disease (Pretorius, 2001). Illnesses perceived to be of supernatural origin are managed together with their physical manifestations so that the patient feels as if they have been treated holistically (Puckree, Mkhize, Mgobhozi & Lin, 2002). Abbo (2011) adds that the emphasis is on the need to look at the whole person, which includes an analysis of their physical, environmental, emotional, social and spiritual lifestyle values. According to this author health, from this holistic point of view, cannot be achieved without achieving a balance in life with others and with the environment.

A traditional healer never considers the patient as an isolated individual but as an integral component of a family and a community, and members of the patient's family must therefore also participate in the treatment process (Kale, 1995). As a result, a consultation with a traditional healer is never conducted with the patient alone (Berg, 2003a). Instead, family members, relatives or people who know the patient well are called in to provide information regarding the patient's illness. Rituals are always performed with members of the affected individual's family and people from the community who are actively involved in the life of the person for whom the ritual is being performed (Berg, 2003a). Pretorius (2001) states that satisfactory healing involves not merely the recovery from bodily symptoms, but also the social and psychological reintegration of patients into their communities. To affirm this view, Berg (2003a) states that through rituals

connectedness is re-established, and links are concretely and actively made between the individual, the family and the community, between the body and mind, and between the conscious and unconscious dimensions of the psyche.

The African healing system sometimes requires the afflicted person to live at the healer's home for months or even years (Pretorius, 1995). Although this could be equated to an inpatient hospital admission in Western healing, it raises serious ethical concerns regarding patient safety and healer-patient professional relational issues. For example, Ensink and Robertson (1999) report that allegations of sexual and physical abuse of patients by some indigenous healers were made by families interviewed during an exploratory study undertaken in Cape Town during 1993. In spite of traditional healers reportedly subscribing to a code of ethics, unfortunately there are no mechanisms to enforce this code (Pretorius, 2001) and this leaves open an opportunity for abuse, either intentional or unintentional.

3.3.7. Relationship between aetiological and treatment beliefs.

Pathways to healthcare are essentially determined by knowledge and belief systems about the cause of illness (van Rensburg, 2009). In addition, Abbo (2011) asserts that when people require psychological help, they look for it wherever it can be found and easily accessed. According to Swartz (2007), when faced with bad experiences or sicknesses, people often turn for advice to their neighbours, relatives and others in their communities who may not necessarily be 'healers' but are trusted and are close by. Peu et al. (2001) argue that traditional Africans in the North West Province and other provinces of South Africa consult traditional healers because they know from experience that their interpretation of health and illness is often different from the interpretation that would be given by a Western practitioner. Western views of illness are often interpretations that people from traditional African cultures find difficult to identify or relate with. As a result, any form of healing process that ignores these patient's beliefs about the cause of illness is considered psychologically unsatisfactory and, in some cases, regarded with suspicion (Pretorius, 1995). It is for this reason that most traditional Africans are less likely to consult with a doctor at a hospital in cases of illness or conditions in which they suspect bewitchment and vengeance of the spirits or gods (Shizha & Charema, 2011). Of significant note, traditional healers are perceived as easily accessible because they often live in the same community, and share the same culture, beliefs and values as their patients (Puckree et al., 2002).

It is also important to note that costs and accessibility also play a significant role in influencing the choice which patients make when they wish to consult a healthcare provider (Peu et al., 2001). The number of Western-trained doctors and healthcare personnel in the province of Kwa-Zulu Natal and in South Africa as a whole is too small to meet the actual healthcare needs of the province and country (Puckree et al., 2002). About 200 000 traditional healers practice in South Africa compared with 25 000 doctors of modern medicine (Kale, 1995; Pretorius, 2001). According to Shizha and Charema (2011), in Venda (Limpopo province), there is one traditional practitioner for every 700 to 1 200 people, compared to one physician for every 17 400 people. These authors argue that this comparison between numbers of traditional healers and medical doctors evidently demonstrates the importance of this healing modality in Africa. To add, the comparison also shows that traditional healers are more easily accessible than medical doctors. Involving traditional practitioners in the care of common mental health problems could help narrow the current treatment gap for common these forms of mental disorder in South Africa (Campbell-Hall et al., 2010).

Although all traditional healers in South Africa are technically in private practice, they are found in places that are convenient, have flexible working hours and are ready to be consulted at any time, which is an advantage in terms of satisfying the great need for healthcare, (Puckree et al., 2002). In essence, they are a major source of health services for the majority of people, especially in rural areas (Shizha & Charema, 2011). Furthermore, traditional healers treat all age groups and all problems, their treatment is comprehensive, curative and protective, and they use and administer medicines that are readily available and affordable (Pretorius, 2001). It is apparent that traditional healers play a significant role in the promotion of health and the prevention of diseases. To substantiate this point, Swartz (2007) argues that while it is important not to romanticise the role played by traditional healers and what they are capable of, it is also crucial not to ignore the role they play in people's lives and in their pathways of management of illness.

3.4. Integration of Western and Indigenous African Practices

Previously, efforts to promote interdisciplinary work between Western and indigenous African practices were discouraged by research which indicated that such collaboration might have unintended detrimental impacts (White, 2013).

Indigenous practices were not respected for the integrity inherent in them and scientific paradigms were often used to deny their time-tested, reliable and successful practices (Solomon & Wane, 2005). It is, however, becoming evident in the current era of rapid globalisation, that mental health practitioners, social scientists and anthropologists need to collaborate and engage in constructive dialogue aimed at developing cross-cultural understanding of how best to meet the mental health needs of people across the globe (White, 2013).

During the apartheid era, the Health Professions Act, No. 56 of 1974 and its 1982 amendments restricted traditional healers' performance of any acts related to medical practice (Ross & Deverell, 2010). However, even though South Africa at that time promoted Westernised medical practices as the norm, there is evidence to suggest that, despite these laws, traditional healing practices remained resilient and have always formed a component of the healthcare system (Koen, Niehaus, & Muller, 2003; Puckree et al., 2002). Patel (2011) argues that in spite of considerable growth in the awareness of biomedical perspectives on mental illness and the evidence base on the effectiveness of biomedical treatments, substantial numbers of people with mental illness continue to seek help from the traditional sector. Studying the profiles and outcome of traditional healing practices for severe mental illness in Uganda, Abbo (2011) reports that over 80% of patients from their sample suffering with psychosis used both biomedical and traditional healing systems. Similar trends have been recorded in South Africa by Mzimkulu and Simbayi (2006) and in other parts of the African continent by Kamsu-Foguen et al. (2013). Abbo's (2011) study revealed that those who combined the biomedical and traditional healing systems seemed to have better outcomes. In South Africa, Ross and Deverell (2010) found that when people were asked about their reasons for consulting traditional healers, a common response was dissatisfaction with treatment received from or negative experiences with Western medical practitioners. Other common themes, according to these authors, are: 1) the holistic focus of traditional healing; 2) traditional healers' close association with cultural and religious beliefs and practices of their patients; and 3) the fact that these healers speak the patients' language, spend time with them and provide explanations for their health conditions. Kamsu et al. (2013) as well as King (2000) make some of the following points in favour of collaboration between Western and traditional healers:

- Traditional healers often considerably outnumber Western-trained doctors, and they therefore provide a large, easily accessible and affordable human resource pool;
- Traditional healers provide client-centred, personalised healthcare that is culturally appropriate, holistic and tailored to meet the needs and expectations of the patient;
- Traditional healers are culturally close to clients, which facilitates communication about diseases and related social issues;
- Traditional healers use traditional medicines that are more affordable and less expensive than pharmaceutical drugs; and
- Traditional healers often see their clients in the presence of other family members, which sheds light on the family's role in promoting social stability and counselling.

From the preceding paragraphs, it is evident that there is increasing recognition by modern Western-trained mental health professionals of the need to take cultural factors into account in the diagnosis and treatment of traditionally-oriented patients (Edwards et al., 1983). According to Honwana (1998), it is now common to see people consulting both the hospital and the traditional healer, or even the prophet of a religious healer, simultaneously, and in some cases people start with one and move on to another. Therefore, an integration of Western and African practices in the approach to healing should be considered without any one practice imposing superiority over the other. An atmosphere of understanding, trust and respect should be created between Western-trained health professionals, traditional healers and the communities they serve (Hoff, 1992). In clinical practice, this is likely to increase clinician-patient (Western or traditional) rapport and the effectiveness of treatment (Edwards et al., 1983).

The obvious question that emerges, according to Patel (2011), is whether traditional healers may play a role in the formal mental healthcare system alongside biomedical providers. Koen et al. (2003) suggest that a more proactive stance needs to be taken to ensure co-operation with traditional healers in order to ensure a more integrated Westernised-traditional approach which promotes health for all. This can only happen if alternative healthcare methods are recognised and accommodated on an official level and if traditional healers and Western-trained healthcare workers are officially regarded as being of equal

importance in status in spite of the diversity and differences in methods, techniques, treatments and worldview (Peu et al., 2001).

A slow move in this direction is noted in an article by van Rensburg (2009), which states that traditional African healing practice was mainstreamed in South Africa through the promulgation of the Traditional Health Practitioners Act, No. 35 of 2004. According to van Rensburg (2009), this Act has significant importance in the mental healthcare scenario considering its emphasis on mental health in the definition of traditional health practice, namely:

“the performance of a function, activity, process or service that includes the utilization of a traditional medicine or practice with the object: (a) to maintain or restore physical or mental health or function; (b) to diagnose, treat and prevent physical or mental illness; (c) to rehabilitate a person to resume normal functions; and (d) to physically and mentally prepare a person for phase of life changes (puberty, adulthood, pregnancy, childbirth and death)” (p. 158).

Prior to the instatement of the Traditional Health Practitioners Act, Puckree et al. (2002) suggest that there was legislation in place allowing traditional healers to apply for licenses and to call themselves 'doctors'.

There are many organisations that can register traditional healers in South Africa, and these healers are licensed in terms of the Companies Act (Pretorius, 2001). These organisations include the Southern African Traditional Healers Council, the Congress of Traditional Healers of South Africa, and the African Dingaka Association, to mention a few (Kale, 1995). During 1997 public hearings were conducted into the legitimisation of traditional healers, which resulted in a proposal for the creation of an Interim Co-ordinating Committee whose task was to establish a statutory Council for Traditional Healers (Pretorius, 2001). However, not all traditional healers have registered with these organisations.

Even though traditional healers in South Africa can now obtain licences to practice, very little formal assessment has been done on the extent of their contribution to healthcare (Koen et al., 2003). Although traditional remedies are believed to be effective in treating diarrhoea, headaches and other pains, as well as psychological problems, unfortunately there have been no studies on their efficacy (Kale, 1995). To compound the picture, the actual contribution of

traditional healers to healthcare in the province of KwaZulu-Natal or South Africa is not known (Puckree et al., 2002). Bhugra and Bhui (1997) recommend that research needs to be conducted in which a clinician identifies whether a specific cluster of symptoms, signs and behavioural changes demonstrated by the patient are interpreted consistently by the patient and their relatives, and how the personalised diagnostic model offered by the traditional healer fits in with the psychiatric model.

Even if traditional healing is found to be effective, the challenge, as documented by van Rensburg (2009), is that the inclusion of traditional healers into the formal health and mental health system may still prove to be too costly to implement, especially within the current context where resources are generally strained by characteristically low priority allocated to mental health services. This author also adds that as traditional health practice may over time become more integrated with public health services, some concern from a health system perspective can be raised relating to the practical challenges of the employment of different categories of spiritual and traditional health workers in the formal health and hospital environment.

The considerable diversity of traditional healers, encompassing a wide range of practitioners including herbalists, spirit mediums, diviners and faith healers is a major barrier to their integration into the formal health environment (Patel, 2011). Added to this is Pretorius' (2001) view that the testing and certifying of traditional remedies, as well as the licensing and monitoring of traditional healers, could also prove to be costly and difficult to implement. According to this author, the most important constraint could prove to be the lack of funds required to monitor registered traditional healers, to measure their knowledge and to evaluate any modification in their practices according to desired standards. In order to overcome these barriers, Puckree et al. (2002) suggest that the first step is for Western-trained healthcare professionals to acquaint themselves with knowledge regarding the exact role of the traditional healer in the provision of healthcare. Without this knowledge it would be difficult for healthcare professionals to know whether it is advisable to refer patients to traditional healers in certain instances. It is important to note that, similarly, traditional healers may also want to know whether Western healthcare facilities contribute anything that service users value and regard as useful, before referring patients (Ensink & Robertson, 1999).

3.5. Conclusion

To conclude, this chapter argued that while African culture is diverse, in all African societies an orientation exists towards a communal way of life, an understanding which is grounded in the belief that an individual is naturally connected to, as opposed to separate from, others and the universe (Verhoef & Michel, 1997). It was also demonstrated that health and illness are socially constructed phenomena, and whether patients consult a Western healthcare professional or an African traditional healer, in turn, depends on their worldview of health (Ross & Deverell, 2010). This shows that an individual's mental health literacy may be relative to their worldviews, and that no one health perspective should dominate others. Instead, an interest in building culturally-informed models of health that seek to find a common understanding would be useful to drive both mental healthcare and literacy research. It is, therefore, apparent that an active effort to transform mental healthcare in South Africa to ensure collaboration between Western and African healing practices is long overdue. In order to make this a reality, such effort, according to Patel (2011), should be guided by evidence and common sense to enable a mutually rewarding partnership between biomedical and traditional healthcare providers. This must be characterised by the institutionalisation of more standardised training of traditional healers, and the authority and mechanisms to oust quacks and charlatans who run the risk of tarnishing the image of this kind of healthcare (Pretorius, 2001). The ultimate goal should be to use all the available diagnostic and treatment modalities to optimise the health of the person on all levels of well-being, without doing harm (Abbo, 2011). The successful incorporation and integration of traditional healers into the healthcare system will inevitably contribute to a better quality of life for all South Africans (Peu et al., 2001).

Chapter 4

Theoretical Framework

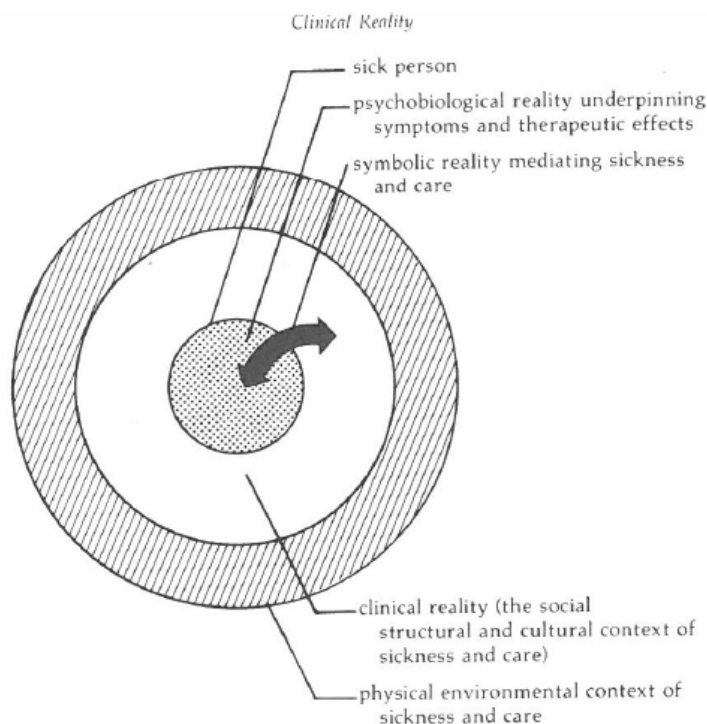
This current study aims to explore the notions of and attitudes toward mental health disorders and beliefs about treatment amongst African residents of Sisonke District in KwaZulu-Natal. The theoretical framework chosen to underpin the study therefore draws on ideas from a number of theories or models of healthcare, beginning with the explanatory models of mental illness, followed by contact theory, as well as the health belief model. The explanatory model will be used to demonstrate that meanings attached to mental illness are important in shaping how mental illness is experienced, expressed and dealt with. Contact theory will be used to argue that contact and interaction with the mentally ill may lead to decreased stigma of mental illness. The health belief model is presented to demonstrate how psychosocial constructs explain the individual's decision-making with regard to health-related behaviours.

4.1. Explanatory Models of (Mental) Illness

Social construction theories, in particular the explanatory models of mental illness, are very relevant for this study to broaden an understanding of the public's awareness of and beliefs about mental illnesses, including mental health services and their willingness to use them. Explanatory models were developed by Arthur Kleinman out of a criticism of the Western diagnostic categories, which he coined 'category fallacy'; Kleinman refutes the idea that these categories are themselves culture-free entities (Littlewood, 1990). Rather, Kleinman argues, these diagnostic categories are explanatory models specific to the Western context and culture, and shaped an already existing natural phenomenon based on the context in which ideas of illness were conceived (Littlewood, 1990). In this way, illness is seen as socially and culturally constructed. Considering that social realities differ between different societies, social groups, professionals and even individuals, Kleinman (1980) argues that these differences may affect the way in which individuals think about and react to sickness and choose among and evaluate the effectiveness of the healthcare practices available to them.

Kleinman coined the term 'explanatory models of illness' to denote a person's ideas about the nature of their illness, its causes, the onset of symptoms, severity, prognosis and treatment preferences (Kleinman, 1978; 1980). Stated differently, according to Kleinman, Eisenberg and Good (2006), as well as Pelto and Pelto (1997), explanatory models for any particular illness episode include: 1) aetiology; 2) onset of symptoms; 3) pathophysiology; 4) course of illness; and 5) treatment. Fox, Ward and O'Rourke (2005) state that explanatory models emerge as people ask questions such as: what is the nature of the problem, why has it affected me, why now, what course will it follow? This shows that explanatory models of illness generally help people to cope with and make sense of an illness as a social reality construct. Kleinman (1980) calls these health-related aspects of social reality the *clinical reality* to show that clinical phenomena are socially constituted and that the social world can be clinically constructed. Kleinman (1980) developed a model in which he illustrates how the socially constituted contexts influence illness and clinical care. He describes this model as consisting of social and symbolic reality, but relating as well to psychobiological and physical realities. Figure 4.1 below provides a graphical presentation of this clinical reality model.

Figure: 4.1: Kleinman's clinical reality model



Source: Kleinman (1980, p.42)

In addition, help-seeking, treatment compliance, patient satisfaction and coping are considered by Nambi et al. (2002) as other aspects of human behaviour that are also influenced by explanatory models. In essence, explanatory models explain and influence the meaning and expectations that people have about a particular illness. According to Bussing, Gary, Mills and Garvan (2003), explanatory models were developed also to compare the perspectives of clinicians and patients. This is based on the premise that it is important to examine relationships and consequences of interactions between patients' ideas about their health problems and those of clinicians who are responsible for their care (Weiss & Somma, 2007). The implication is that patients' views are seen as complementary to clinicians' assessments. By asking patients about the nature and origin of their health condition, Kleinman, according to Rich, Patashnick and Chalfen (2002), discovered that patients understood and explained their illness to themselves using different conceptual models than those used by their healthcare providers. This led to a distinction being made between *etic* and *emic* perspectives of illness.

On the one hand, *etic* models of illness provide perspectives usually based outside of the patient's culture and seek patterns of behaviour as defined by the observer (Nambi et al., 2002). According to Jacob, Bhugra, Lloyd and Mann (1998), they employ doctors' perspectives and are based on scientific explanations. On the other hand, *emic* models elicit patients' perspectives and conceptualisations of the sickness, roles and expectations (Jacob et al., 1998). Included in the *emic* models, according to Nambi et al. (2002), are patients' perspectives regarding beliefs and behaviours concerning aetiology, course, timing of symptoms, meaning of sickness, diagnosis and treatment. Whilst the concept of an explanatory model is broad and encompasses several features of illness related to behaviour and ideas (Patel, 1995), focus in this review will be limited to the explanatory models of mental illness. Moreover, to avoid creating a skewed impression slanted toward cultural explanations, it is also acknowledged that the differences between illness explanatory models are often discussed in relation to those that attribute illness to physical causes and those that attribute it to psychosocial causes. According to Fox et al. (2005), as well as Lynch and Medin (2006), the dominating explanatory model in Western healthcare is the biomedical model, which attributes illness to a disruption of bodily and physiological processes.

Lynch and Medin (2006) state further that psychosocial explanatory models attribute illness to thoughts or emotions which usually result from social factors.

According to Pelto and Pelto (1997), all people, whether biologically-trained healthcare professionals or rural villagers, have cultural belief systems about the causes of sickness and possible remedial measures. Explanatory models of mental illness acknowledge that people explain their distress in a multitude of ways (Bhui & Bhugra, 2002) and that culture plays a large role in shaping health-related values, beliefs, and behaviour (Betancourt, 2004; Kleinman, 1978). According to McSweeney, Allan and Mayo (1997), as well as Meeto and Meeto (2005), explanatory models of an illness are subjectively and personally constructed to reflect the culturally situated meaning of an illness. This is based on the premise that the meaning of illness for an individual is grounded in the network of meanings that the illness has in a particular culture (Littlewood, 1990). To illustrate this, the African worldview, explained in the previous chapter, subscribes to the idea that mental illness (like all other illnesses) is caused by supernatural powers, such as witchcraft, by a failure to connect spiritually with the ancestors, God and/or with other members of the community, or by the removal of the ancestors' protection over the person (Loveday, 2001; Mzimkulu & Simbayi, 2006; Patel, 1995). Various studies attesting to this have been documented both locally (Campbell-Hall et al., 2010; Mzimkulu & Simbayi, 2006) and elsewhere in the world (McCabe & Priebe, 2004; Patel, Gwanzura, Simunyu, Lloyd & Mann, 1995). What these studies have in common is the assumption, as stated by Lynch and Medin (2006), that illness originates from some psychological state which is usually triggered by a change in a person's relationship to the social world.

Locally, Campbell-Hall et al. (2010) report that people of the rural areas of KwaZulu-Natal hold a widespread belief that mental illness is caused by witchcraft or the ancestors. In a study conducted in Cape Town, Ensink and Robertson (1999) found that some of their respondents dismissed information provided by psychiatric services about their illness on the basis that the hospital did not understand the illnesses of 'Black' people. Their respondents explained the causes of mental illness in terms of failure to perform Xhosa rituals, stepping over a dangerous track, evil spirits, being poisoned with soil and ants from the grave, and a variety of 'witch familiars' such as the snake of the river, or *tikoloshe* (dwarf-like creature with baboon features). Regarding treatment, biomedical doctors are thought to be capable of understanding and treating conditions classified as *umkhuhlane*, whilst

those illnesses seen as specific to the African people, referred to as *ukufa kwabantu*, are thought to be understandable only within the African concepts of illness and are therefore only recognised and treated by traditional healers (Crawford & Lipsedge, 2004).

Further afield, a study of subjective accounts of the causes of mental illness in the United States of America suggested that patients who are acutely ill with mental illness, regardless of their professional diagnosis, are far more likely to mention challenging life experiences than biological or psychological factors as causally responsible for their condition (Elliott, Maitoza & Schwinger, 2011). In Africa, a study of explanatory models of mental health problems amongst low-income women in Lusaka, Zambia, by Aidoo and Harpham (2001), revealed that the phrase used by their respondents to define and explain the mental problems of women, in particular depression, was 'problems of the mind'. The same study also found that mental illness implied 'madness', and this attitude inhibited the women from seeking psychiatric services, as such experiences were not considered to fit the spectrum of health disorders. In their study of explanatory models and help-seeking behaviour in Kampala, Uganda, Okello and Neema (2007) reported that although their respondents occasionally mentioned witchcraft in reference to the aetiology of depression, psychosocial problems and poor relations between the living and the dead also seemed to be important in the aetiology of non-psychotic and psychotic depression, respectively. The following extract is a narrative provided by one of Okello and Neema's (2007) participants as an explanation for his depression:

"People may not be very happy about my progress. They become jealous because I am successful, I think they are bewitching me" (p.19).

In Zimbabwe, Patel et al. (1995) also found that the causes of mental illness were mainly attributed to spiritual factors such as being bewitched and *mamhepo* ('bad airs'). The same was also found in South Africa in a study by Mkhize and Uys (2004). In addition, Okello and Neema (2007) noted that their participants sought help depending on the interpretation of their illness, and when no improvement was registered, new explanations were developed and new help was sought. Their participants described an admission to a psychiatric hospital as an end to a long pathway that had taken the patient and significant others a substantial amount of resources to accomplish. Some participants in the same

study indicated that at times there were disagreements within their families regarding symptom definition and the appropriate help that should be sought (Okello & Neema, 2007). The idea that explanatory models of individuals may differ from those of the family or ethnic group had earlier been written about by McSweeney et al. (1997).

It is important to note that apart from being culturally determined, explanatory models of illness are also influenced by other social factors such as socioeconomic status, ethnicity and education (Carrillo, Green & Betancourt, 1999; Meeto & Meeto, 2005) as well as occupation, religious affiliation, and past experience with illness and healthcare (Kleinman et al., 2006). Although it is apparent that explanatory models are constructed through interaction with the sociocultural environment, McSweeney et al. (1997) argue that much of their content is integrated into beliefs and value systems of an individual in the form of common sense understandings of the body's functions. Therefore, an individual's explanatory models may change due to ongoing experience with a specific illness or acquisition of new knowledge (McSweeney et al., 1997).

Kleinman (1978) cautions that, not infrequently, explanatory models conflict and when they do and are not responded to, this could lead to substantial problems in terms of patient care. Disease explanations that are inconsistent with a preferred explanatory model, according to Lynch and Medin (2006): 1) may not be considered; 2) may seem implausible; and 3) may be seen as less satisfactory than those which are consistent with the preferred explanatory model. To substantiate this view, evidence suggests that health professionals and lay people frequently have different explanatory models and their differing views often result in conflicting expectations of treatment and outcomes (McSweeney et al., 1997; Meeto & Meeto, 2005). This is because both clinicians and patients are influenced by culture in presenting and understanding the diverse experiences of distress (Bhugra & Gupta, 2010). Therefore, elicitation of explanatory models becomes very important, more so, when the patient and physician come from different cultural backgrounds. Kleinman and Benson (2006) support this idea and suggest that this could be used to encourage clinicians to be more open to human communication and to set their expert knowledge alongside (not over and above) the patient's own explanation and viewpoint. In this way, on the one hand, the clinician would attempt to understand the illness as it is understood by the patient from their own cultural perspective through open communication. On the other

hand, the patient may realise that doctors do not fit certain stereotypes any more than they themselves do (Kleinman & Benson, 2006). In this way, explanatory models would provide a means of bridging cultural differences between patients and clinicians with different backgrounds, and would also provide a means of bridging conceptual differences and promoting empathy and a therapeutic alliance (Weiss & Somma, 2007). This is particularly relevant in the South African context where the majority of patients come from diverse cultural backgrounds yet mental illness and its categorisation, in formal healthcare, has a Western basis.

It is also important to bear in mind the point made by Carrillo et al. (1999) that even when the patient's and doctor's sociocultural backgrounds are similar, substantial differences may exist because the doctor serves as the expert on the disease whereas the patient experiences and expresses an illness. Kleinman et al. (2006) provide this set of questions as a guideline for eliciting the patient's EM: (a) what do you think has caused your problems? (b) why do you think it started when it did? (c) what do you think your sickness does to you or how does it work? (d) how severe is your illness? (e) what kind of a treatment do you think you should receive? Although patients may initially be hesitant to reveal their beliefs about an illness, according to Carrillo et al. (1999), focusing on what others may believe or on hypothetical situations may take some of the pressure off the patient. In this way, the patient is most likely to relax and provide relevant answers to their own explanatory model of the disease. Kleinman et al. (2006) also add that the clinician needs to be persistent in order to show patients that their ideas are of genuine interest and importance for clinical management. Meetoo and Meetoo (2005) state that once the clinician has validated the patient's EM, it would then be possible to negotiate a treatment plan that meets the patient's expressed healthcare needs.

Explanatory models influence many aspects of illness, including compliance with treatment and patient satisfaction (Jacob et al., 1998). Thus, what people believe about their illness influences their experience of and potential benefit from mental health services. Nambi et al. (2002) highlight the significance of explanatory models in relation to treatment and argue, therefore, that a detailed understanding of the patient's perspective, health beliefs, fears and treatment expectations is a prerequisite in managing every patient. In their study of explanatory models of illness in schizophrenia, McCabe and Priene (2004) found that the type of explanatory model, independent of ethnicity, was related to

satisfaction with treatment. They reported that people with a 'biological' explanatory model more often said that they were receiving the right treatment for them, were more satisfied with the treatment and had better therapeutic relationships than those with a 'social' explanatory model. An even more interesting finding was reported by Ensink and Robertson (1999) in their study of patient and family experiences of psychiatric services and African indigenous healers. These authors found that although indigenous names were used as explanatory categories for mental illness, which included the consideration of psychosocial and other explanations, the use of indigenous names did not preclude satisfaction with conventional psychiatric services.

It is not uncommon today to find patients receiving both Western and traditional treatments simultaneously in many Western-type medical settings in Africa and elsewhere (Mzimkulu & Simbayi, 2006). This is consistent with Ensink and Robertson's (1999) finding that the majority of African patients and their families attribute mental-health problems to a combination of indigenous, biological, psychosocial and other causes. Kleinman (1978) offers an explanation which suggests that although the explanatory models of biomedicine may structure a view of clinical reality in which the sickness is located within the body of the sick person, and care is viewed as treatment of the diseased organ by the doctor, the explanatory models employed in a particular culture may locate the problem in the family and may label the entire family as sick. In this case, the target of treatment could be seen as involving considerably more than just the patient's body, and the doctor could be viewed as only one, and perhaps not even the most important agent of the treatment. The family-patient relationship or family-doctor relationship could be regarded as the 'real' therapeutic relationship (Kleinman, 1978), treatment could be concerned with the total person and could often include both close and distant relationships (Mzimkulu & Simbayi, 2006).

Given the possibility of such a wide array of explanatory models, it is apparent that it would be difficult for clinicians to distil a single set of causal explanations that might relate to mental illness, diagnosis or adherence to medication (Bhui & Bhugra, 2002). Nambi et al. (2002) caution that outright rejection of the patient's beliefs about their illness early in the consultation could prove disastrous. Eliciting a patient's explanatory models could provide the clinician with knowledge of the beliefs a patient holds about their illness, the personal and social meaning they attach to the disorder, their expectations about

what will happen to them and what the doctor will do, and their own therapeutic goals (Kleinman et al., 2006). Clinicians could use this to promote collaboration and improve clinical outcomes and patient satisfaction (Bhui & Bhugra, 2002). Otherwise, conflicting explanatory models between patients and clinicians may result in undesirable outcomes.

Explanatory models become the bridge between what patients believe about an illness and what is seen as a reasonable and appropriate treatment. The basic premise, as stated by Rich et al. (2002), is that if the clinician can understand what illness means to the patient and the tacit beliefs and assumptions that the patient brings to the clinical interaction, the illness could be treated more effectively. As soon as the practitioner understands the patient's explanatory models, then alternative medical or psychological explanations about their illness could be offered. Thereafter the patient and the practitioner may negotiate a treatment plan that meets the patient's expressed health needs (McSweeney et al., 1997). This could sometimes be achieved through negotiations which may entail acknowledgement of differences in beliefs between the patient and the clinician. Carrillo et al. (1999) suggest that a compromise can often be reached by presenting the problem in terms and concepts that reflect the patient's explanatory model. For example, according to these authors, a patient who believes strongly that her hypertension is episodic and stress-related and does not see the importance of taking daily antihypertensive medication could be told that her blood pressure goes up when she becomes stressed, which puts her arteries under stress all the time, and taking medication would help to relieve this stress; however, it cannot eliminate all stress in her life (Carrillo et al., 1999). Providing alternative explanations for the symptoms within the supportive context, according to Nambi et al. (2002), would help change knowledge and attitudes related to illness and treatment. When dealing with patients' explanatory models, it is important to bear in mind the claim made by Weiss and Somma (2007), that illness explanatory models of patients and clinicians do not necessarily refer to research findings derived from empirical study, even though they might be influenced by them. Instead, they argue that these explanatory models are representations of illness, described with reference to a set of cognitive explanations, emotional and social experiences, as well as personal history that collectively characterise the illness at a particular point of inquiry (Weiss & Somma, 2007).

Originally, according to Bussing et al. (2003), explanatory models were developed to investigate cross-cultural differences and did not focus on sub-cultural distinctions. Moreover, these authors state that explanatory model approaches have not typically been used to examine gender issues related to help-seeking across sub-cultures. In the current study, explanatory models of illness are used to provide a framework for understanding demographic and cultural variations in participants' conceptualisations of mental illness across the two municipalities of the Sisonke District in KwaZulu-Natal. Other researchers abroad have studied explanatory models of various mental disorders such as attention deficit hyperactivity disorder (Bussing et al., 2003), alcohol dependence (Kendler, 2008), depression (Lynch & Medin, 2006), and anorexia nervosa (Fox et al., 2005). Locally, a number of studies have been conducted on explanatory models, focusing on the areas of school dysfunctions (Bergman, Bergman & Gravett, 2011), mental disorders and treatment practices among traditional healers (Sorsdahl, Flisher, Wilson & Stein, 2010), general practitioners (Mash, 2000), and schizophrenia in Xhosa families (Mbanga, Niehaus, Mzamo, Wessels, Allen, Emsley & Stein, 2002), to mention a few. However, studies of explanatory models related to mental health are scant in the province of KwaZulu-Natal. Some studies that have been conducted were related to traditional practitioners and primary healthcare staff (Campbell-Hall et al., 2010), sexual issues (Leclerc-Madlala, 2002), and childhood diarrhoea (Kauchali, Rollins & Van Der Broeck, 2004). The scarcity of studies addressing the public's mental health literacy using explanatory models in this province is even worse. Specifically, no such studies were found that have been conducted in Sisonke District in the of province KwaZulu-Natal.

To conclude, understanding the public's explanatory models in relation to mental health literacy can be useful in enhancing better mental healthcare outcomes. It is apparent that mental health literacy is a relative concept and is influenced by conceptions of illness, including patients' and healers', or clinicians', explanatory models. Exploring patients' explanatory models would be useful, according to McSweeney et al. (1997), as it may lead to the development of culturally appropriate treatment plans that address illness concerns and priorities in the cultural context of patients' daily lives. Apart from these clinical benefits, greater awareness of explanatory models in relation to mental health literacy may have beneficial effects on mental health policy makers, training of healthcare practitioners and public awareness campaigns.

4.2. Contact Theory

The theoretical framework for this study is further informed by Allport's (1954) contact theory, also known as intergroup contact theory. Using contact theory's main hypothesis that contact decreases prejudice (Barlow et al., 2012), this section will argue that contact, which will be equated to familiarity, leads to decreased stigma and positive attitudes. Thus, familiarity with mental illness leads to more accepting and favourable behaviours towards both psychiatric patients and/or mental health interventions. Although research testing the contact hypothesis on mental illness has been conducted in various countries such as Germany (Angermeyer & Matschinger, 1997), the United States of America (Phelan & Link, 2004), China (Callaghan, Shan, Yu, Ching & Kwan, 1997), Canada (Ng & Lindsay, 1994) and Nigeria (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley & Kola, 2005), fewer, if any studies, have been conducted using a South African population. An extensive search for literature using search engines such as SABINET, Medline, Ebscohost, Google Scholar, Academic Search Complete, and so forth, yielded no results of such studies conducted using participants from the province of KwaZulu-Natal.

Contact theory postulates that positive interaction between groups erodes various kinds of prejudiced attitudes (Dixon, Durrheim & Tredoux, 2007). According to Shook and Fazio (2008), the underlying assumption of this theory is that prejudice stems from lack of knowledge and exposure. These authors argue that increased interaction with members of different groups should allow individuals to gain information about other groups and should therefore lead to a reduction in hostility and prejudice. Contact theory suggests, as stated by Dixon et al. (2007), that even deep-seated antipathies toward another group may be improved by regular interactions with members of that group.

The contact hypothesis, however, proposes that simple contact between groups is not automatically sufficient to improve intergroup relations (Dovidio, Gaertner & Kawakami, 2003). Proponents of the contact hypothesis argue that only under certain conditions will interaction between in-group members and out-group members cause prejudice towards the out-group to decline (Bowyer, 2009). Allport specified the following four conditions deemed optimal for successful intergroup contact and prejudice reduction: 1) equal group status within the

situation; 2) common goals; 3) intergroup cooperation; and 4) authority support (Pettigrew, 1998). Two additional factors for successful intergroup contact and prejudice reduction, according to Shook and Fazio (2008), have been added more recently; these are intimacy and friendship. There is also a strong argument from Dovidio et al. (2003) that the nature of the relationships among contact, cross-group friendships and intergroup attitudes are of crucial importance. Shelton, Trail, West and Bergsieker (2010), as well as Shook and Fazio (2008), argue that personal, intimate interaction between individual group members allows for self-disclosure and the formation of friendships, and contributes to the positive change in prejudice that emerges from intergroup contact. In addition to that, it is important to note that optimal intergroup contact requires time for cross-group friendships to develop (Pettigrew, 1998). Shook and Fazio (2008) conclude that providing a situation in which interaction is intimate and friendship can easily form should increase the effectiveness of intergroup contact and should result in a reduction of prejudice. To compound the picture, Bowyer (2009) states that only prolonged, personal contacts that bring knowledge and familiarity serve to reduce prejudice.

Studies that directly tested the contact hypothesis originate mostly from social psychology (Callaghan et al., 1997), and most of these studies were used to address attitudinal problems resulting from racial segregation (Pettigrew & Tropp, 2006). The contact theory, according to Jackman and Crane (1986), holds that the sharp rupture between the social lives of whites and blacks promoted whites' ignorance about Blacks, and this ignorance fed negative beliefs about blacks, which in turn engendered feelings of hostility and discriminatory social and political predispositions towards blacks. There are, however, studies (Bowyer, 2009; Pettigrew & Tropp, 2005; Shook & Fazio, 2008; Stephan & Finlay, 1999) that reported evidence to suggest that contacts with a particular racial group lead to more positive attitudes towards that group. Of particular importance, and yet to be established in this study, is the relationship between contact theory and mental health literacy. It is therefore important to review in this literature the process through which contact effects change, particularly with regard to attitudes towards certain groups.

4.2.1. Processes of change through intergroup contact.

Over time, researchers altered their focus in identifying the underlying process by which intergroup contact brings positive attitudes. Pettigrew (1998) suggests that the following four interrelated processes operate through contact and mediate change: a) learning about the out-group; b) changing behaviour; c) generating affective ties; and d) in-group reappraisal. First, there are a number of studies that support the notion that learning about an out-group can improve intergroup attitudes and reduce stereotypes (Kawakami, Dovidio, Moll, Hermsen & Russin, 2000; Stephan & Finlay, 1999). With access to more information about others, people are likely to see others in more personalised ways, and greater knowledge of others may reduce uncertainty about how to interact with them (Dovidio et al., 2003). This is likely to stimulate more curiosity in people while increasing contact and consequently improving positive attitudes. Second, with regard to changing behaviour, Pettigrew (1998) argues that optimal intergroup contact acts as a benign form of behaviour modification, and considers behavioural change to be a precursor to attitude change. According to this author, since new situations require conforming to new expectations, if these expectations include acceptance of out-group members, this behaviour has the potential to produce attitude change.

Third, generating affective ties suggests that emotions, especially when positive, can mediate the effects of intergroup contact. To substantiate this, Pettigrew (1998) states that although anxiety is common in initial encounters between groups, continued contact generally reduces anxiety. In a study of the contextual determinants of whites' racial attitudes in England, Bowyer (2009) discovered findings that support this hypothesis. This author concluded that an increased likelihood of residential contact with blacks appeared to be associated with lower hostility among whites. Empathy also plays a role in such situations. This idea, that intergroup contact reduces bias by enhancing empathy toward members of the out-group, has further been supported by various authors such as Dovidio et al. (2003), who argue that empathy influences people's motivations to behave in a more supportive way toward others, independent of how much they like them. Consistent with this view, Stephan and Finlay (1999) suggest that empathising with a member of an out-group, toward which people had previously held negative attitudes, may create dissonance due to the discrepancy between

people's current empathic concern and their prior negative attitudes. As a means of reducing this dissonance, these authors add that people may change their attitudes toward the previously disliked out-group. Fourth, in-group reappraisal, according to Pettigrew (1998), is based on the notion that optimal intergroup contact provides insight about in-groups as well as out-groups. This author states that this new perspective can reshape views of the in-group and lead to a less provincial view of the out-group in general.

4.2.2. Intergroup contact and mental illness.

The contact hypothesis has also been extended to mental health studies, and there is evidence of the importance of appropriate intergroup contact for reducing negative attitudes or stigma towards people with mental illness. Using contact theory, authors such as Angermeyer, Matschinger and Corrigan (2004), as well as Corrigan, Green, Lundin, Kubiak and Penn (2001), hypothesised that attitudes and stigma about mental illness in general are influenced by an individual's degree of familiarity or contact with mental illness. Familiarity or contact could range from seeing a television portrayal of mental illness, to having a friend or co-worker who has a mental illness, to having a family member who has a mental illness, to having a mental illness oneself (Corrigan, Green et al., 2001). In brief, according to the contact hypothesis, members of the public who have contact with people with mental illness would have more positive attitudes toward that group, including less desire for social distance (Phelan & Link, 2004).

Empirical support for contact theory is evident from a series of studies that have been conducted in which vignettes or real patients have been used to measure the public's stigmatising attitudes and social distance in relation to mental illness. Unfortunately, stigma is not a rare phenomenon and stigmas about mental illness are widely endorsed by the general public (Corrigan, Edwards, Green, Diwan & Penn, 2001). Stigma is a negative evaluation of a person who has been tainted or discredited on the basis of attributes such as race, ethnicity, illness, religion or culture (Adhikari, 2007). In their review of literature, Angermeyer and Matschinger (2003) provide the following three components of stigma as summarised from the work of Corrigan and Watson (2002), namely stereotype, prejudice and discrimination. They write that: a) stereotypes represent notions of groups or a person (*the mentally ill*), b) people who are prejudiced endorse these

negative stereotypes and, as a result, generate emotional responses; and c) prejudice then leads to social discrimination. Consequently, people with mental illness are robbed of the opportunities that define a decent quality of life such as good jobs, safe housing, satisfactory healthcare and affiliation with a diverse group of people (Corrigan & Watson, 2002). Negative views such as those implying that people with mental illness are irresponsible and therefore incapable of making their own decisions, or are dangerous and are to be feared, are widespread (Gureje et al., 2005).

While using derogatory terminology and making jokes about marginal groups has become socially unacceptable, it is still commonplace to draw on stereotypical images and stigma of mental illness in media and everyday language (Schulze, Richter-Werling, Matschinger & Angermeyer, 2003). The media perpetuate stigma, giving the public narrowly-focused stories about people with mental illness based around stereotypes. In cinema and television, according to Byrne (2000), mental disorders are substrate for comedy, and are also conferred with highly charged negative connotations of self-infliction, an excuse for laziness and criminality. Such depictions elicit fear and apprehension from the public and lead to stigmatisation of and distancing from mentally ill patients. To show support for this, in a study investigating the relationship between people's television watching and the desire for social distance from people with schizophrenia, Angermeyer, Dietrich, Pott and Matschinger (2005) found that the desire for social distance increases almost continuously with the amount of television watched.

It is also important to note that, not only do people with mental illness suffer from the public's stigmatising attitudes, they also suffer from self-stigma. Self-stigma has been shown to yield deleterious effects on the lives of people with mental illness (Corrigan, Watson & Barr, 2006). Numerous studies conducted on patients with mental illness indicate that self-stigma is a serious problem that leads to diminished self-esteem (Estroff, 1989; Link, Struening, Nesse-Todd, Asmussen & Phelan, 2001; Ritsher, Otilingam & Grajales, 2003). According to Corrigan and Watson (2002), when living in a society that widely endorses stigmatising ideas, people with mental illness are likely to internalise these ideas and believe that they are less valued because of their illness. Corrigan et al. (2006) argue that the effects of such self-stigma on self-esteem, psychological well-being, and self-efficacy may impact on behavioural goals. They claim that self-stigma could consequently interfere with

the pursuit of rehabilitation goals in terms of living independently and obtaining competitive work.

Corrigan, Edwards et al. (2001) suggest that individuals who perpetuate stigma are likely to distance themselves socially from persons with mental illness. Stereotypes about mentally ill people make it easier to dismiss these ill people, and in so doing, the stigmatiser maintains social distance (Byrne, 2000). Social distance is likely to manifest itself in such discriminatory practices as being less likely to hire persons who are labelled mentally ill, being unwilling to lease apartments to them, or being reluctant to freely interact with them (Corrigan, Green et al., 2001). The negative views or stigmatising attitudes held tend to be indicative of the degree of tolerance individuals might have about people with mental illness (Gureje et al., 2005). Link et al. (1999) reported in their study that 90% and 47% of their participants were unwilling to interact with people who were considered 'troubled' or 'depressed', respectively. Their participants desired the most social distance from the person described through vignettes as having cocaine dependence followed, in order, by those with alcohol dependence, schizophrenia and major depression. In a similar study, Stuart and Arboleda-Florez (2001) reported that one in five of their participants stated that they would be unable to share a room with, and three-quarters of participants would be unable to marry, someone with schizophrenia. This clearly supports an assertion made by Gureje et al. (2005) that attitudes to mental illness are characterised by intolerance of even basic social contact with people known to have such illness.

Phelan and Link (2004) raise a concern that where perception of danger is present, it may increase rejection and avoidance of people with mental illness. This means that people with mental illness are, therefore, likely to be feared if perceived as dangerous. It is of concern to note that the 'dangerousness' stereotype has endured and has probably increased over the past 50 years, even though there have been large-scale public education efforts focused on the nature, causes and treatment of mental illness in the United States (Link et al., 1999). Fear generally yields avoidant behaviours, or a strong preference for social distance from the feared person or object (Angermeyer et al., 2004). Link et al. (1999) found, from their study, a correlation of 0.432 ($P < .001$) between perceptions of violence and social distance towards people with mental illness. They, therefore, concluded that there was a significant association between the belief that a

mentally ill person is likely to be violent and the desire to maintain social distance from that person. In Africa, a Nigerian study conducted by Gureje et al. (2005) recorded findings that support this conclusion. Their results showed that most respondents would be afraid to have a conversation with and would be disturbed to work with a person with mental illness. Arvaniti et al. (2009) argue, however, that familiarity with patients with mental health problems should imply less fear of dangerousness and more positive attitudes, in general, towards them.

Consistent with this familiarity argument, in their study of familiarity with mental illness and social distance from people with schizophrenia and depression, Angermeyer et al. (2004) found that respondents in Germany who were familiar with mental illness were less likely to believe that people with mental disorders are dangerous. They also reported that weaker perceptions of dangerousness corresponded closely with less fear of such people, which in turn was associated with less social distance. There is also evidence from other literature (Angermeyer & Matschinger, 1997; Corrigan & Watson, 2002; Stuart & Arboleda-Florez, 2001) supporting the postulation that there is a strong relation between social distance and knowledge of mental illness. Most of these studies contend that people with the highest and most accurate knowledge of mental illness are the least socially distancing. Stated another way, Stuart and Arboleda-Florez (2001) concluded from their study that people with the greatest knowledge of mental illness were ten times more likely to express highly tolerant attitudes, compared with those with the least amount of knowledge. Angermeyer and Matschinger (1997) went beyond investigating only the knowledge of mental illness and concluded that increased educational level, referring to formal schooling education, increased the desire for social distance to people with mental illness. Education provides information so that the public can make more informed decisions about mental illness (Corrigan & Watson, 2002). Stuart and Arboleda-Florez's (2001) study also revealed that older respondents were significantly less knowledgeable about mental illness and were thus more distancing than their younger counterparts. Similar findings have also been recorded in studies conducted by Angermeyer and Matschinger (1997), as well as Wolff, Pathare, Craig and Leff (1996).

In general, the current review of the existing literature generally supports the basic premise of the contact hypothesis, that is, that contact with the mentally ill can help to reduce stigma and social distance, and increase their acceptance.

When summarising 3651 articles reviewing population-based attitude research studies in psychiatry covering a period of over 15 years, Angermeyer and Dietrich (2006) concluded that, if indeed any relationship exists, there is a positive association between familiarity with mental illness and acceptance of people with mental disorders. They add that it becomes evident from these numerous studies that facilitation of contact with people with mental disorders may prove effective in reducing negative attitudes.

Phelan and Link (2004) offer an interesting critique to consider when applying the contact hypothesis to studies of mental illness. Taking into account the fact that positive effects of intergroup contact occur under optimal conditions (equal status, sharing common goals, etc.), as stated earlier in this chapter, they argue that the kind of contact the general public often has with mentally ill patients is often quite impersonal, for example, the general public may only see a television portrayal of a person with mental illness, or may experience having a person with mental illness in the neighbourhood. According to Phelan and Link (2004), since this kind of contact is so impersonal and does not meet the optimal criteria, it is possible that this contact could be associated with more negative attitudes, even though personal contact is generally associated with more positive ones. It would be significant to test this critique in the present study.

The contact hypothesis could also be extended to the public's familiarity with services that provide treatment of mental health illnesses. For this current research, it is hypothesised that people who may have had contact with mental illness, as described above, will show high levels of mental health literacy. Numerous studies such as those conducted by Anderson (1995), Phelan and Link (2004), as well as Callaghan et al. (1997), have recorded findings that support this hypothesis.

Based on the contact theory hypothesis as presented here, it would be expected in the current study that members of the public who have contact with people suffering from mental illness, and/or contact with mental health treatment facilities would have higher levels of mental health literacy. Conversely, those individuals with a greater social distance are likely to have more stigmatising attitudes and less mental health literacy. Other hypotheses originating from contact theory to be tested in this study include the effect of age and level of education in terms of social distance towards the mentally ill.

4.3. The Health Belief Model

The development of the health belief model grew out of concerns with the limited success achieved by various programmes of the Public Health Service in the 1950s in the United States of America (Rosenstock, Stretcher & Becker, 1994). Social psychologists sought, in particular, to understand the infrequent acceptance of preventive practices and pre-illness screening tests (Prentice-Dunn & Rogers, 1986). Effective health education was required to target potentially modifiable individual characteristics which predicted preventive behaviour and health service usage and which, ideally, reflected differences in socialisation histories, indexed by demographic variables (Abraham & Sheeran, 2005). Researchers in the 1950s therefore began their pioneering work in order to understand why individuals did not participate in preventive health programmes and why they used or failed to use health services (Austin, Ahmad, McNally & Stewart, 2002; Rimer, 2008). Their studies led to the development of the health belief model. The health belief model was first proposed and developed by Godfrey Hochbaum, Stephan Kegels and Irwin Rosenstock (Jahanlou, Loffizade & Karami, 2013; Mikhail & Petro-Nustas, 2001). This model was then expressed more formally by Rosenstock, and is considered by Champion and Skinner (2008) as one of the most widely used conceptual frameworks in health behaviour research to explain change and maintenance of health-related behaviours. The health belief model continues to be a major organising framework for explaining and predicting acceptance of health and medical care recommendations (Janz & Becker, 1984). This model is relevant to the current study because it uses psychosocial constructs to explain the decision-making behind individual health-related behaviours (Harrison, Mullen & Green, 1992; Vandiver, 2009). According to Rosenstock (2005), the health belief model's core objective is the explanation of behaviour in terms of the psychological state of readiness to take specific action and the extent to which a particular course of action is believed, on the whole, to be beneficial in reducing the threat. For mental health literacy research, investigating the relationship between the willingness to seek help and attitudes toward mental illness is very crucial and is thus relevant to the current study.

The term *belief*, according to Vandiver (2009), is used in the health belief model to refer to a conviction that a phenomenon or object is true or real. For

example, a mental health orientated belief statement would be 'mental illness is infectious' or 'mental illness is not a real illness'. According to Cerkoney and Hart (1980), the health belief model is based on the value-expectancy theories of social psychology. In brief, this model links individuals' beliefs about illness and treatment with health actions such as the use of preventive health measures, sick-role behaviours and service use (Sirey et al., 2001). The six principal constructs of the health belief model were initially derived from the two value-expectancy concepts, which are: 1) the value placed by an individual on a particular goal; and 2) the individual's estimate of the likelihood that a given action will achieve that goal (Janz & Becker, 1984). According to Rosenstock et al. (1994), when value-expectancy concepts were gradually reformulated in the context of health-related behaviour, the translations pertinent to the health belief model made were as follows: 1) the desire to avoid illness or to get well (value); and 2) the belief that specific health action available to a person would prevent (or ameliorate) illness (expectation). In other words, according to Brewer and Rimer (2008), people are more inclined to engage in a health behaviour when they think that doing so can reduce a threat that is likely and which would have severe consequences if it occurred. Summed up differently, in their review of literature, Cerkoney and Hart (1980) state that this model hypothesises that behaviour is determined by the subjective value attached to an outcome and the perceived likelihood that certain actions will result in that outcome. This makes the health belief theory relevant to this study because it remains to be seen what kinds of attitudes people in the Sisonke District of KwaZulu-Natal have towards mental illness, and whether these attitudes, if rejecting, are related to the person seeking treatment, and if so, are related to the kind of treatment sought for mental illness.

According to Lennon (2005), Moodi, Razaiean, Mostafavi, and Sharifirad (2012), Orji, Vassileva and Mandryk (2012), as well as Prentice-Dunn and Rogers (1986), the health belief model consists of the following six principal constructs: (i) *perceived susceptibility* (the subjective perception of risk or vulnerability to a health threat or contracting a disease); (ii) *perceived severity* (a person's belief that contracting the disease may result in harsh health consequences); (iii) *perceived benefits* (the beliefs of individuals in the value of adhering to health-related measures to prevent or reduce the threat of illness or disease); (iv) *perceived barriers* (the negative consequences that might limit a person from carrying out the necessary health-related measures, such as side effects or inconvenience); (v) *cue to action* (exposure to factors that prompt action); and (vi) *self-efficacy*

(confidence in one's ability to perform the new health behaviour. Individuals' perception of these constructs, according to Hayden (2009) as well as Orji et al. (2012), individually or in combination, can be used to postulate their likelihood of engaging in a health-related behaviour. More importantly, in terms of Henshaw and Freedman-Doan's (2009) thought, these constructs are thought to be influenced by demographic variables such as race, age and socioeconomic status.

In an attempt to make sense of these constructs, Lennon (2005) argues that perceived susceptibility and perceived severity taken together form the perceived threat to health. Personal risk or susceptibility is one of the more powerful perceptions in prompting people to adopt healthier behaviours (Hayden, 2009). This implies that the more the risk is perceived to be higher, the greater the chances of a person engaging in behaviours to decrease that risk. Conner and Norman (2005) are also of the opinion that threat perceptions are dependent upon the perceived susceptibility to an illness and the perceived severity of the consequences of the illness. Naturally, when people are threatened they are most likely to evaluate various behaviours to counteract this threat. According to Rosenstock (2005), as well as Prentice-Dunn and Rogers (1986), the two principal dimensions that define whether a state of readiness to act in relation to a perceived health threat are the degree to which individuals feel vulnerable or susceptible to a particular health condition and the extent to which they feel that contracting that condition would have serious consequences for their health. Rosenstock (2005) goes on to say that readiness to act is defined in terms of the individual's point of view about susceptibility and seriousness rather than the health professional's view of reality.

The health belief model hypothesises, according to Rosenstock et al. (1998), that health-related action depends upon the simultaneous occurrence of three classes of factors, namely: a) the existence of sufficient motivation to make health issues salient; b) the belief that one is susceptible to a serious health problem (perceived threat); and c) the belief that following a particular health recommendation would be beneficial in reducing the perceived threat, at a subjectively acceptable cost. Thus, for behavioural change to succeed, people must have an incentive to take action, must feel threatened by their current behavioural patterns and must also believe that change of a specific kind would

be beneficial by resulting in a valued outcome at acceptable cost (Rosenstock et al., 1998). Thus, individuals are likely to follow a particular health action if they believe themselves to be susceptible to a particular condition which they consider to be serious, and believe that the benefits of the action taken to counteract the health threat outweigh the costs (Conner & Norman, 2005; Lennon, 2005). People may, according to Rosenstock (2005), see a health problem as serious in terms of its medical or clinical consequences and would thus be concerned with questions concerning whether a disease could lead to their death, or to reduced mental or physical functioning or permanent disability. Accepting susceptibility to a disease that is believed to be serious would thus provide a motivation leading to treatment action.

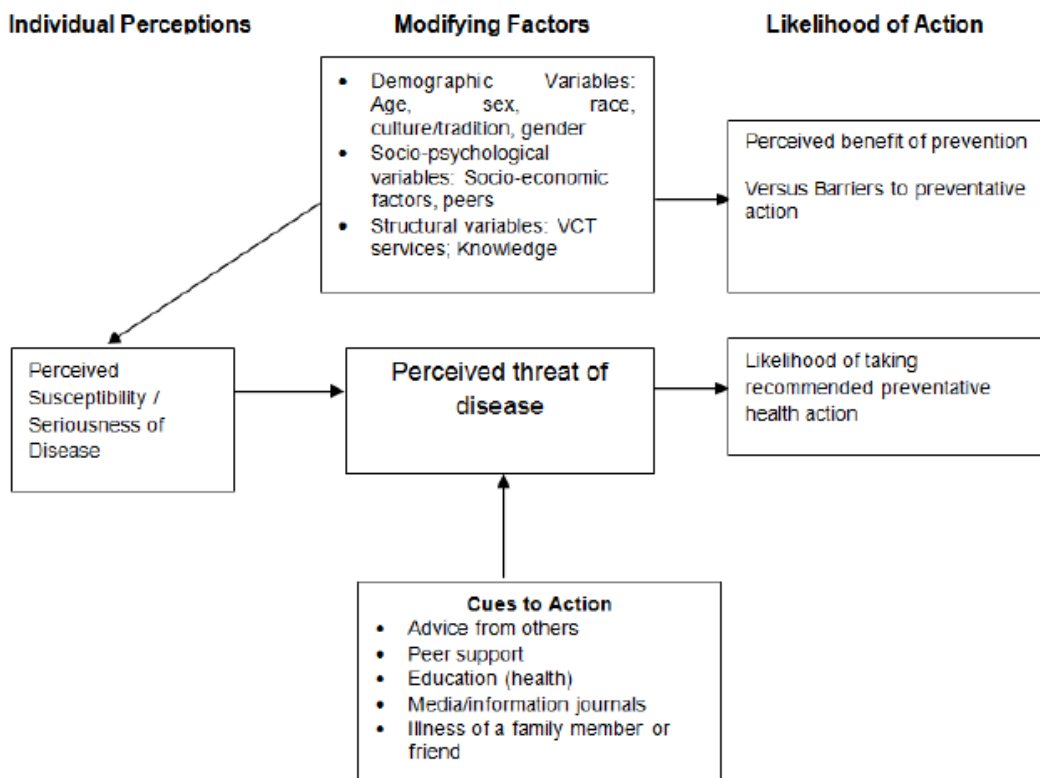
The health belief model is cognisant that change does not come easily to most people and that there may be perceived barriers to change. Barriers to change in this regard, according to Hayden (2009), refers to an individual's own evaluation of the obstacles that may stand in the way of adopting a new health-related behaviour. In terms of Janz and Becker's (1984) thought, the potential negative aspects of a particular health action may act as barriers to undertaking the newly recommended health behaviour. This implies, according to these authors, a form of cost-benefit analysis in which the individual weighs the action's effectiveness against perceptions that it may be expensive or dangerous (side effects), unpleasant (painful, upsetting), or time-consuming and inconvenient (Janz & Becker, 1984). Believing that the benefits of the new behaviour outweigh the consequences of maintaining the old behaviour would, according to Hayden (2009), enable barriers to be overcome and new behaviour to be adopted.

It is important to note that it is possible that a person could have a high level of readiness to take a health-related action in terms of susceptibility, severity and benefits related to taking such an action, and yet, would not take any action. According to the health belief model, a variable that would be considered missing in terms of instigating an action in such a situation is a cue to take action (Elder, Ayala & Harris, 1999). The cue to take an action could be anything that may heighten awareness or trigger interest in performing the necessary health-related activity to prevent, control, treat or elevate the health problem (Lennon, 2005). The cues to action can either be internal (i.e. symptoms) or external (e.g. mass media health messages or interpersonal interactions), according to Janz and Becker (1984). Lennon (2005) states that health messages presented through media, such

as television, radio and newspapers based on the health belief model, may be powerful means to present cues to action.

Although cues to action may be strong enough to prompt an individual to act on a particular health behaviour, self-efficacy may also be a mediating variable. The construct of self-efficacy, according to Lennon (2005), refers to a person's confidence to perform the necessary health-related action. Hayden (2009) argues that people generally do not try to engage in something new unless they think they can actually do it. Hayden (2009) goes on to say that if people believe that a new behaviour is useful (perceived benefit), but do not think they are capable of doing it, the chances are that they will not try it. Figure 4.2 below is a diagram which presents the health belief model.

Figure 4.2: The health belief model



Source: Tarkang and Zotor (2015, p.4)

The health belief model is used in this study as another framework to understand whether the notions of mental illness held by the public (participants) are related to attitudes and help-seeking behaviour. Anderson (1995) supports the notion that attitudes and knowledge that people have about health or *mental illness* and health services are related to their perceptions of the need and use of health services. Adams and Scott (2000), as well as Hayden (2009), support the idea that a relationship exists between constructs of the health belief model and variables like demographic and psychosocial factors such as culture, education level and past experiences. These are individual characteristics that influence personal perceptions. For example, someone with a close family member who was diagnosed with depression and treated successfully may have heightened perception of susceptibility and may be careful of monitoring exposure to stress. However, Hayden (2009) warns that this past experience might also diminish the person's perception of seriousness. In the example provided, the person's perception of seriousness could be diminished because depression was treated early and the family member was compliant with treatment.

When applying the health belief model to mental health treatment seeking behaviours, there are four main beliefs that must be taken into account. These beliefs, according to Adams and Scott (2000), relate to perceived benefits of adherence (e.g. being symptom free), perceived barriers to adherence (e.g. stigma of taking medication), perceived susceptibility (belief that they are likely to experience relapse), and perceived severity of the outcome (e.g. belief that relapse would have negative consequences). It is possible that, given the role of culture in understanding mental illness, the decision to make use of mental health services will be influenced by the need to recover from mental illness and its associated debilitating symptoms, as well as the need to avoid the public's stigmatising attitudes.

Moreover, the model is relevant for this study because it deals with the individual's subjective beliefs about illness and its treatment. It is used to understand why people may accept preventative health services and why they may or may not adhere to other kinds of healthcare regimens (Adams & Scott, 2000; Rimer, 2008). Samouilhan and Seabi (2010) argue that this model might be able to account for the pattern of utilisation of mental health services by identifying which core beliefs influence mental health treatment. The health belief model holds that health behaviour is a function of the perceptions an individual has of vulnerability to an illness and the perceived potential effectiveness of treatment with respect to deciding whether to seek medical attention (Elder et al., 1999). To strengthen their argument, Samouilhan and Seabi (2010) provide the example that if people adhered to the African worldview and believed that their depression was as a result of ancestral discord, they might seek traditional help rather than formal psychological treatment. It thus becomes clear, as Vandiver (2009) states, that the health belief model is also useful to practitioners because it can be used to understand health perceptions of their patients and what motivates them to seek care, including from whom care is sought.

Applying the afore-mentioned four principles of health belief model, Elder et al. (1999) maintain that health related behaviours are, therefore, determined by whether individuals: 1) perceive themselves to be susceptible to a particular health problem; 2) see this problem as serious; 3) are convinced that treatment or prevention activities are effective yet not overly costly in terms of money, effort, or pain; and 4) are exposed to a cue to take a health action.

Interesting points based on the literature reviewed in the previous chapters (including the two theories reviewed above) are noted. While acknowledging that individuals vary widely in the acceptance of personal susceptibility to a particular illness (Rosenstock, 2005), from an indigenous African perspective, it could be argued that failure to perform certain rituals, which symbolises to the whole community the acceptance of an individual by the ancestors, could be regarded as making an individual susceptible to mental illness. Apart from the symptoms of mental illness, the seriousness of the problem may be ascertained by stigma and its resultant social distance experienced by an individual suffering from mental illness. If people consider these problems serious enough, depending on the notions of the illness and its causes, it would be expected in this study that such judgment and notions of mental illness would influence help-seeking behaviours. Furthermore since, the person's belief about the availability and effectiveness of various courses of action, according to the health belief model, and not the objective facts about the effectiveness of action, determines what course of action they will take (Rosenstock, 2005) this renders the theory suitable to study attitudes towards help-seeking and interventions for mental health.

Although the health belief model is by far the most commonly used theory to design health-education behavioural change interventions (Hayden, 2009; Lennon, 2005) and has received substantial support for its ability to predict behaviour (Brewer & Rimer, 2008), it is not without criticisms. Orji et al. (2012) state that there is evidence to suggest that the health belief model's determinants are insufficient predictors of behaviour. They base this criticism on two main limitations of this model. Firstly, according to Orji et al. (2012), the health belief model has a low predictive capability of the determinants and this is compounded by a lack of clear rules for combination of the variables and relationship between them. A low predictive capability of this model, as stated by Sirey et al. (2001), is also due to its lack of attention to social context of the health actions. These authors argue, for example, that perceived social barriers may be very important in predicting treatment behaviours, such as taking an antidepressant medication, to remedy an illness whose victims may experience social stigma (Sirey et al., 2001). According to Orji et al. (2012), the health belief model's determinants predict approximately only 20% of variance in healthy behaviour on average, thus leaving 80% of the variance unaccounted for. The second limitation of the health belief model is based on its assumption that the individual determinants are only directly

related with healthy behaviour and no indirect or mediating effects exist between these variables (Orji et al., 2012).

Another criticism of the health belief model relates to the question of whether it can explain behaviour in a variety of cultural settings. According to Poss (2001), the health belief model does not account for normative or cultural factors that may be important in explaining health-seeking behaviour. It lacks a culturally specific concept. To substantiate this limitation, Poss (2001) argues that culturally related factors influencing the individual, such as demographic variables, social support or previous health experiences may play a role in prompting behaviour are not an explicit part of the health belief model; instead, they are only thought to influence the major variables in the model. When concluding their comprehensive review of the health belief model, Janz and Becker (1984) provide a cautionary statement that the health belief model is a psychosocial model and therefore much of the variance in individuals' health-related behaviours can be explained by their attitudes and beliefs.

In conclusion, this chapter presented the theoretical framework that serves as a guide on which to build and support this study, drawing ideas from three theories. These are the explanatory model, the contact theory as well as the health belief model. The explanatory model was used in this chapter to demonstrate that illness is culturally constructed, and people have their own ideas about the nature of illness, its causes, prognosis and treatment preferences (Kleinmann 1978; 1980). This model also demonstrates that patients understand and explain illness using different conceptual models than those used by their healthcare professionals. This supports the need to undertake a study of mental health literacy to investigate how people conceptualise mental illness and what their attitudes are towards mental illness and treatment preferences, especially since literature of this nature is scant in South Africa.

Another theoretical framework discussed in this chapter is the contact theory of Allport (1954). Its main hypothesis is that contact reduces prejudice. The underlying assumption of this theory is that prejudice stems from lack of knowledge and exposure (Shook & Fazio, 2008). Consequently, the central argument of this theory is was presented: that increased interaction with members of different groups would enable individuals to gain information about other groups and should therefore lead to a reduction in prejudice. To support this view, in relation to mental illness, the hypothesis that attitudes and stigma about mental illness are

influenced by an individual's degree of familiarity or contact with mental illness (Angermeyer et al., 2004; Corrigan, Edwards et al. 2001; Corrigan, Green et al., 2001) was presented. However, it was also noted that stigmatising people with mental illness is likely to perpetuate social distance from them. For example, the mentally ill are likely to be feared and ostracised if they are stigmatised as dangerous. The theoretical ideas presented in this chapter provide the base from which this study seeks to investigate the issue of mental health literacy, with specific reference to the relationship between contact with the mentally ill or understanding of mental illness and attitudes toward the mentally ill.

Lastly, the health belief model was presented in this chapter. This model is used as a framework to understand factors influencing the acceptance of health and medical care recommendations (Janz & Becker, 1984). The argument that it is crucial to investigate the relationship between willingness to seek help and attitudes toward mental illness was highlighted. The view that a relationship exists between constructs of the health belief model and variables such as demographic and psychosocial factors, including culture (Adams & Scott, 2000; Hayden, 2009), was presented to support this argument. Therefore, the health belief model is used in this study of mental health literacy as a framework to guide this investigation of factors that are related to help-seeking.

Chapter 5

Methodology

This chapter presents the overall design of the study and the research methods that were followed. It begins with an overview of the study location, which is Sisonke District, and the two municipalities within this district where data was collected. This is followed by a discussion of the selected research design to present an understanding of why and how the researcher decided on the methodological approaches of this study. In particular, the quantitative approach in terms of a cross-sectional design, correlational design and survey are discussed, and the strengths and limitations of each form part of this discussion. Thereafter, the research instrument used to collect data, namely a self-administered questionnaire, is presented in this chapter. The adaptation of this instrument, its translation, pre-testing and piloting are presented together with issues of reliability and validity. What follows next is an outline of the actual process of data gathering of the main study, starting with the sample and sampling technique used, followed by an account of the process of data collection. The method of data analysis used to interpret the data gathered and the ethical issues taken into consideration in the course of the study are presented last in the final section of the chapter.

5.1. Study Location

5.1.1. Sisonke District.

This study was conducted at the district previously known as Sisonke District Municipality (DC43) in KwaZulu-Natal. This district has recently undergone a name change and is now called Harry Gwala District. The Provincial Gazette publishing this name change was made available on the 19th September 2013 (Department of Co-operative Governance and Traditional Affairs, 2013). However, for the purpose of this study, the former name (Sisonke District) will be used because this was the name used at the inception of the current research and it is still a name commonly used by and known to many people. According to Statistics South Africa (2011a), Sisonke District is one of the 11 districts of the province of KwaZulu-Natal, is located at the extreme south of this province, and has a population of approximately 461 420 inhabitants. Table 5.1 provides a breakdown of Sisonke

District population by municipality. This district comprises the following five local municipalities: Ingwe, Ubuhlebezwe, Greater Kokstad, Kwa Sani and Umzimkhulu. Figure 5.1 below provides a visual map of Sisonke District. The majority of this district's population, about 96.7%, using classification according to historical population group, are black Africans. Table 5.1 provides a detailed population breakdown of this district, by municipality, as adapted from Statistics South Africa (2011b). Statistics further indicate that 62.7% of Sisonke District's population speaks isiZulu as their first language, followed by those who speak isiXhosa (28.6%), English (3.2%), Afrikaans (1.3%) and *Other* (4.8%) (Statistics South Africa, 2011a).

Table 5.1: Population estimates of Sisonke District by municipalities

Municipalities	Population Estimate	%
1. Umzimkhulu	180 302	39.1%
2. Ingwe	100 548	21.8%
3. Ubuhlebezwe	101 691	22.0%
4. Greater Kokstad	65 981	14.3%
5. Kwa Sani	12 898	2.8%
Total	461 420	100%

Source: Harry Gwala District Municipality (2016)

Figure 5.1: A map of Sisonke District



Source: Harry Gwala District Municipality (2016)

Sisonke District is predominantly a rural area characterised by a high unemployment rate, agriculture forms the bedrock of its economy, and the most prominent employment sectors are agriculture, construction and small-scale farming (The Local Government Handbook, 2015). The district's Health Development Plan states that the unemployment rate, in 2014, was at 36% and the majority of people earned below R283 per month (Harry Gwala Health District Plan, 2014). The unemployment rate in this district is particularly high among youth (those between the ages of 15 – 34). However, the Sisonke District Municipality (2014) reports that the district has embarked on a number of programmes to alleviate this situation. For example, the district has offered bursaries to needy students for them to be able to attend tertiary institutions and has encouraged learners to pay more attention to scarce skills like engineering. In 2013 a significant number of students from the district were sent to Cuba to study medicine. According to the Harry Gwala Health District Plan (2014), the majority of those people who are employed in Sisonke District are employed in farms, sugar plantations and supermarkets, and those who qualify for social grants are able to complement their low wages. A large number of the district's settlements have no adequate access to basic services. There are only two general hospitals in Sisonke District situated at Greater Kokstad (E.G. Usher Memorial Hospital) and Ingwe (St Apollinaris District Hospital) Municipalities, and one psychiatric hospital (Umzimkhulu Psychiatric Hospital) located at Umzimkhulu Municipality. A few clinics and mobile teams also provide health services in this district. However, of note is that prior to having a designated psychiatric hospital in Sisonke District, mental health services were provided by psychologists and psychiatrists who visited once or twice a month from other districts. Intermittently there have been clinical psychology services provided at Usher Memorial Hospital.

5.1.1.1. Greater Kokstad Municipality.

The sample for this study was drawn from only two municipalities within Sisonke District namely, the Greater Kokstad and Kwa Sani Municipalities. Information from Statistics South Africa (2011b) indicates that Kokstad lies on the south-west tip of KwaZulu-Natal and is bordered by Matatiele Local Municipality on the west, and Lesotho and part of the Eastern Cape on the north-west. This municipality is considered to be the commercial centre in the Sisonke District. The then Mayor of Greater Kokstad Municipality acknowledged in the Reviewed

Integrated Development plan of 2008/2009 that this municipality was faced with numerous challenges such as a high percentage of low income earning households, service backlogs in the provision of water and sanitation, and housing demand for formal housing, to mention only a few (Greater Kokstad Municipality, 2008). Although in a subsequent review of 2012 – 2017 problems such as unemployment, challenges of the provision of water and sanitation, and the high percentage of low income earning households were still a concern, an increase in availability of and access to high quality amenities such as education, training, medical, recreational and cultural facilities was reported (Greater Kokstad Municipality, 2012). Statistics South Africa (2011b) reported an improved scenario whereby the majority of households (85%) in Greater Kokstad Municipality reside in formal dwellings and approximately 36% of residences are owned and fully paid off. However, the Harry Gwala Health District Plan (2014) shows that these dwellings are mainly composed of low cost houses. Approximately 98% of households have access to piped water from either inside the dwelling, inside the yard or from water supplied on a community stand. Only 7.4% of the population in Greater Kokstad Municipality is reported to speak isiZulu as their first language while the majority of the population speaks isiXhosa (69.5%), followed by those who speak English (8.6%), Afrikaans (6.1%), Sesotho (4.2%) and those who speak other languages (4.2%) (Statistics South Africa, 2011b).

5.1.1.2. Kwa Sani Municipality.

According to Statistics South Africa (2011b), Kwa Sani Municipality is located at the foothills of the southern Drakensburg, and is bordered by Umkomazi Wilderness area to the west, Greater Kokstad to the south-west, Ingwe Local Municipality to the east, and Impendle Local Municipality to the north. This municipality has the smallest population in Sisonke District, and the residents of the district live in both rural and farm areas (Harry Gwala Health District Plan, 2014). About 67.5% of households in this municipality live in formal dwellings and only 37.9% of dwellings are owned and fully paid off. This district is characterised by high levels of illiteracy and unemployment, poor condition of school buildings and limited access to water and sanitation. Regarding education, approximately 13% of the Kwa Sani population have no formal schooling, 35% have some primary schooling, 29% have some secondary schooling, 17% obtained their grade 12 certificate and only 6% have attained a tertiary level of education (Kwa Sani

Municipality, 2011). Only 41% of the Kwa Sani population is employed, and of those that are employed 17% earn less than R400 per month, and 6% earn between R400 and R800 per month (Kwa Sani Municipality, 2016). The agriculture and tourism sectors are the major economic drivers of Kwa Sani Municipality. To promote agriculture and tourism, the municipality has initiated the following programmes: support of commercial production of vegetables; livestock owners' day celebration; tourism month flagship programme; Duzi 2 Sani 4X4 Expedition; Kwa Sani intercultural food tasting expo; handcraft promotion, as well as other efforts geared towards the improvement of informal trade (Kwa Sani Municipality, 2016).

Statistics South Africa (2011b) also indicates that in Kwa Sani Municipality less than 42.9% of households have access to piped water from inside the dwelling, inside the yard or from a community stand and, according to The Local Government Handbook (2015), approximately 44% of households are headed by females. About 75% of the community has access to electricity and 43% have access to refuse removal services (Kwa Sani Municipality, 2016). Regarding first language spoken at Kwa Sani Municipality, 79.3% of the population speaks isiZulu followed by English (10.2%), isiXhosa (2.3%), Sesotho (1.6%) and 6.6% is accounted for by other languages (Statistics South Africa, 2011b). According to the Harry Gwala Health District Plan (2014), this municipality does not have a hospital or community health clinic (CHC) but has two smaller clinics, Underberg Clinic and Tsatsi Memorial Clinic. These clinics are situated in Underberg and Mqatsheni, respectively. The Underberg Clinic has a maternal and obstetric unit and its location makes it possible to attract a high volume of patients as it is situated close to the taxi rank. People residing in the far rural areas of this district have difficulties in accessing clinic services due to the lack of transport facilities, and those who reside in the northern region of the municipality use the clinic in Impendle Municipality as it is closer to them than Underberg (Kwa Sani Municipality, 2016). There are, however, no specialised mental health services offered in this municipality.

5.2. Research Design

Every study is unique and the way in which research studies are conducted therefore differs. Research design refers to a conceptual structure within which research is conducted and it constitutes the blueprint for the collection, measurement and analysis of data (Kothari, 2004). Thus, the function of a research

design is to provide a practical overview of methodological issues involved in the design of the study. According to Durrheim (1999b), a research design provides a strategic framework for action that serves as a bridge between research questions and the execution or implementation of the research. Despite variations in content and style of research designs, Hakim (2000) states, they all have in common a focus not on *how* to do any type of research but on *when* and *why* any particular design should be chosen for a project. Therefore, decisions regarding what, where, when, how much, by what means concerning a research study constitute a research design (Kothari, 2004). In brief, a research design identifies and describes the overall kind of study to be conducted (Pilkington & Pretorius, 2015).

It goes without saying that different designs are best suited to answer different kinds of questions. On the one hand, according to Pilkington and Pretorius (2015), the decision of which design to use is usually guided by the research questions and the type of information the researcher is seeking to obtain. On the other hand, Clark-Carter (2010) argues that the choice of research design and measures could also be influenced by statistical analysis to be performed on data. In other words, what data is required, what methods are going to be used to collect and analyse data, and how all of this is going to answer the research question, guides the research approaches and design to be employed (Van Wyk, 2011). This study explores three broad different research topics: 1) the notions regarding mental illness and its causes; 2) perceptions and attitudes toward mental illness; and 3) attitudes and knowledge related to help-seeking. The research approach adopted for this study is quantitative and involves cross-sectional and correlational designs that use the survey method.

5.2.1. Quantitative approach.

Quantitative research emerged around 1250 A.D. and was driven by investigators with the need to quantify data (Williams, 2007). Historically, according to Punch (2003), experimental designs (where the researcher manipulates one or more variables in order to study the effects on other variables) were used and dominated quantitative approaches. The same author (Punch, 2003) states, however, that there has been a move away from a narrow concentration on experimental methods to more widely applicable approaches using non-experimental methods such as social observations of naturally occurring variation in variables. Furthermore, there are certain behaviours that cannot be studied in

experimental situations and these behaviours aptly lend themselves to observational or quantitative research designs (Jackson, 2012). For example, Brown, Cozby, Kee and Worden (1999) state that it would be impractical to manipulate child-rearing practices for research purposes. Even if it were possible to assign parents randomly to two child-rearing conditions, such as using withdrawal of love versus physical types of punishment, Brown et al. (1999) suggest that such manipulation would be unethical. Instead of manipulating variables such as child-rearing practices, researchers using a quantitative approach would observe them in a quantifiable manner as they occur in their natural settings. This also shows that in a quantitative study data does not have to be naturally available in a quantitative form. To substantiate this, Muijs (2011) argues that a non-quantitative phenomenon such as a person's beliefs can be turned into quantitative data through measurement instruments, for example, using Likert scales.

Different researchers define quantitative research differently. Kothari (2004) and Punch (2003) define a quantitative approach as research that involves the generation of numerical data which can be subjected to rigorous statistical analysis in a formal and rigid fashion. Casebeer and Verhoef (1997), as well as Sukamolson (2005), provide a much broader definition of quantitative research as the numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect. From these definitions, it becomes apparent that quantitative studies emphasise the measurement and analysis of relationships between variables (Casebeer & Verhoef, 1997). According to Gavin (2008), a major objective in quantitative research is to organise, summarise, and simplify information about data collected in more manageable forms such as tables and graphs, and, even more usefully, as statistical summaries. It is important to note that use of the concept 'quantitative' does not describe a single research design. Various research designs exist to conduct different types of quantitative research. Among them, those that are relevant and are used in this research are cross-sectional, correlational and survey designs. A discussion of these designs will follow shortly.

According to Johnson and Onwuegbuzie (2004), as well as Neuman (2000), the quantitative approach has a number of advantages such as being useful to studying large numbers of people, data analysis is relatively less time-consuming

when using statistical software, and data collection using some quantitative methods such as telephone interviews and self-report measures is relatively quick. The number of phenomena that can be studied in a single quantitative project using questionnaires is vast, thus making quantitative research quite flexible and economical (Sukamolson, 2005). Struwig and Stead (2001) add that the strength of quantitative research lies in its ability to generalise results beyond the confines of the research sample. When applying quantitative methods, Casebeer and Verhoef (1997) propose that numerical estimation and statistical inference from a generalisable sample are often used in relation to a larger population of interest. This is possible when data is based on a random sample of sufficient size (Johnson & Onwuegbuzie, 2004). Quantitative research, according to Sukamolson (2005), is also useful to quantify opinions, attitudes and behaviours and to find out how the whole population may feel about a certain issue.

In spite of their distinguishing strengths, Kura (2012) states that quantitative approaches may be criticised for their lack of rigour, for ignoring the reality of the social world of the researched, for neglecting the socio-cultural contexts of phenomena, and for counting and analysing variables, because numbers do not provide any detailed explanation of a research phenomenon. Quantitative research is also usually critiqued for giving a weak theoretical account of how constructs are derived (Struwig & Stead, 2001). In addition, with regard to this weakness, Johnson and Onwuegbuzie (2004) state that the quantitative researcher may miss out on phenomena that are occurring because of the focus on hypothesis-testing rather than on theory- or hypothesis-generation. Therefore, it is apparent that certain questions may be better suited to be answered using quantitative methods because quantitative research is essentially about collecting numerical data (Sukamolson, 2005). It is thus essential to use the right data collection tools, but even more important to use the correct research design to suit the aims of a study.

5.2.2. Cross-sectional design.

In a cross-sectional design, data is collected from more than one participant using a survey at a single point in time (Bryman, 2008; Dunn, 2010; Punch, 2003), although the recruitment of participants may take place across a longer period of time (Sedgwick, 2014). This implies that information gathered in cross-sectional studies represents what is going on at only one point in time.

Studying change of behaviour over time using cross-sectional design would, therefore, be very difficult. To study change over time, according to Bethlehem (1999), would mean repeating a survey at a number of different points in time. Doing this, however, is likely to encroach in the area of longitudinal surveys. In a longitudinal study participants are observed at multiple time points thereby allowing trends in an outcome to be monitored over time (Sedgwick, 2014). Participants in this study completed the questionnaires once only, and no follow-up activities were scheduled. While cross-sectional designs are usually conducted to estimate the prevalence (or frequency) in a population at a given point in time (Mann, 2003), they could also be used to collect data on individual characteristics (Levin, 2006) or level of a particular attribute. Some authors (Rubin, Amlot, Page & Wessely, 2009; ul Haq, Hassadi, Shafie, Forooqui & Aljadhey, 2012) have used cross-sectional design to study the knowledge and attitudes of their sample of various health-related topics.

According to Mann (2003), and Salkind (2010), cross-sectional studies are relatively inexpensive and quick to conduct because researchers can test different demographic variables at the same time. They are usually based on a questionnaire survey and allow for the possibility of assessing more than one outcome (Sedgwick, 2014). The generalisability of cross-sectional studies is usually good because they tend to be representative of the population being studied. To increase the likelihood of making inferences about the population as a whole, Zheng (2015) suggests that the study sample must be selected at random. Cross-sectional studies are also useful for public health planning, understanding disease aetiology and for the generation of hypotheses (Levin, 2006).

From its description, it is apparent that a cross-sectional study has an inherent problem due to the fact that conclusions are based on data gathered at one time (Babbie & Mouton, 2001). It would, therefore, be difficult to make inferences about changes that occur over time when using a cross-sectional design (Salkind, 2010). Therefore, only an association, and not causation, can be inferred from a cross-sectional study (Sedgwick, 2014). However, Bryman (2008) suggests that this problem could be solved by writing detailed methodology to allow for replication of the study at another time. Sedgwick (2014) also agrees that cross-sectional studies are sometimes repeated at different times to assess trends over time. However, Sedgwick (2014) cautions that if different participants are

included at each point in time it may be difficult to assess whether changes observed reflect a trend or simply the differences between different groups of participants sampled from the population. A further limitation, according to Mann (2012), is that rare conditions cannot be studied efficiently using cross-sectional studies because even in a large sample there may be no one diagnosed with the disease being studied.

5.2.3. Correlational design.

It is common for researchers to seek to establish a relationship between variables. The motivation for the use of correlational design for this study is an assertion made by Williams (2007), which is that correlational design can be used in quantitative research in response to relational questions of variables within the research. Punch (2003) lends support to this notion by stating that the essence of quantitative research is the study of relationships between variables. When conducting a correlational research study, the interest of the researcher is in determining whether two variables (for example, age or other demographic variables and mental health literacy) are related to each other. The pertinent question here, according to Brown et al. (1999), is whether values of one variable change when the variables of other variables change. For example, a researcher, such as in this study, may be interested in whether attitudes toward mental illness change with level of education. A correlation coefficient is used to assign a numerical value to the observed relationship (Jackson, 2012). In correlational research design (as in cross-sectional design), the researcher does not seek to influence any variable (Gavin, 2008), but to examine the differences (or relationships) between them (Williams, 2007), that is, whether two or more variables are related. For example, a relationship between two variables could be investigated by formulating a hypothesis that there is no relationship between the two variables, and then testing this hypothesis. Brown et al. (1999) list the following four common relationships that are found in correlational research: 1) the positive linear relationship (increases in the value of one variable are associated with increases in the value of the second variable); 2) the negative linear relationship (increases in the value of one variable are associated with decreases in the value of the other variable); 3) the curvilinear relationship (increases in the value of one variable are accompanied by both increases and decreases in the value of the other variable); and 4) no relationship between the variables.

Since no variables are manipulated in correlational design (Devlin, 2006), the primary objectives are to focus only on whether a relationship between variables exists or not, how variables are distributed, and especially how they are related to each other, and why (Punch, 2003). This research can also be considered a correlational study because it seeks to understand mental health literacy in relation to a number of variables such as age, gender, geographical location, exposure to mental illness, and so forth. It does not, however, seek to establish the causal relationship between these variables. Instead, a correlational design will afford this study an opportunity to determine the strength and direction of the relationship between variables (Gavin, 2008; Patel, 2009). This means that, in a correlational design, apart from being able to say that a relationship is present between variables (if present), the researcher should also be able to ascertain if this relationship is strong or weak. According to Jackson (2012), a correlation coefficient is used to measure the degree (or strength) of the relationship between two variables, and this coefficient can vary between -1.00 to +1.00. The weaker the relationship between the variables, the closer the coefficient is to 0 (Jackson, 2012), and a correlation of 0 means that the variables are not related (Patel, 2009). In addition to describing a relationship, according to Jackson (2012), correlations make predictions from one variable to another possible with a certain degree of accuracy. For example, if age and mental health literacy were found to be correlated, this would allow an estimate, within a certain range, of an individual's level of mental health literacy based on knowing that individual's age.

Correlational designs are however not without weaknesses. Two major weaknesses arising in correlational design, according to Brown et al. (1999), are the direction and cause and effect, as well as the third variable problem. Devlin (2006) states that although correlational designs could determine whether variables are co-related or associated, they do not provide an explanation for why this may be the case. This means that correlation does not imply or provide causation. For example, it is possible that X could be found to be correlated to Y, without X causing Y or Y causing X, only for the researcher to find that there is a confounding variable (the third variable) that caused both X and Y without there being a causal relationship between X and Y (Simon & Goes, 2013). Nevertheless, Tredoux (1999) argues that because correlational designs do not manipulate conditions, but instead make co-ordinated observations of unconstrained variables, it is easier to attain reasonably good levels of external validity with them.

5.2.4. Survey.

It is apparent that this study, being quantitative and employing both cross-sectional and correlational designs, was best suited to employ a survey. To substantiate this, Greener (2011) states that a survey:

is based on a sample, with the aim being to have as large a sample as is necessary to capture all of the variation in the population; that is occurs at a single point in time (or as near as possible to a single point in time); it is predominantly quantitative; and the aim is to seek patterns within that quantitative data (p. 39).

In addition, given the objectives of this study, a survey design was considered as most relevant to be employed because it is flexible and is best suited to study people's opinions, attitudes, beliefs and values regarding a wide range of issues at a given time (Rosnow & Rosenthal, 1996; Stangor, 2004). Surveys are also used to examine group differences and to test causal propositions about the sources of attitudes, beliefs and behaviour (Weisberg, Krosnick & Bowen, 1996). However, it is important to note that not all surveys are quantitative in their approach. Nevertheless, the focus of this study is on quantitative surveys which use numerical data produced by the measurements of variables (Punch, 2003).

Goodwin (2005) defines a survey as a structured set of questions or statements given to a group of people to measure their attitudes, beliefs, values or tendencies to act. For Gavin (2008), a survey refers to a research method for gathering data in a non-experimental way that could include the use of questionnaires, interviews or unobtrusive observations. There are a number of important considerations of survey research that the researcher in this study paid attention to, and they are discussed in various parts of this chapter. These include, firstly, defining research objectives and formulating research questions (Greener, 2011; Muijs, 2011). Objectives are defined by Punch (2003) as a statement, at a reasonably high level of generality and abstraction, of what the survey is trying to find out. Research questions, on the other hand, are used to provide a sharp focus that is more specific to the objectives of the study. What the research questions are attempting to answer follow directly from the objectives of the study (Greener, 2011). The second consideration of survey research is the accurate description of the population being studied and specification of the sampling procedures used,

since the reliability of surveys depends greatly on the care taken in selecting a sample (Struwig and Stead, 2001). This implies that the sample is not selected haphazardly or from people who volunteer to participate, but is scientifically chosen so that each person in the population has an equal chance of selection (Gavin, 2008). The third consideration is the design of the instrument and the actual data collection procedure (Muijs, 2011). Information is collected by means of a standardised procedure (a questionnaire in the current study) so that every participant is asked the same questions (Gavin, 2008). Each of these considerations is interdependent with one other. It would be difficult to determine the sample if the objectives of the survey are unknown. Similarly, the choice of an instrument will also affect the survey methodology and the sampling method that can be employed (Stopher, 2012).

There are a number of advantages that have made survey research popular among researchers. Survey research is praised by Sukamolson (2005) for using scientific sampling to measure characteristics of the population with statistical precision. Particularly in large surveys, according to Bethlehem (1999), statistical tests always produce significant results. This enables comparison between groups that can be related to the entire population and a degree of certainty is therefore possible (Sukamolson, 2005). Furthermore, Muijs (2011) adds that survey studies are also efficient in terms of enabling a researcher to gather large numbers of data at reasonably low cost and effort compared to other methods such as experiments and observations. The same author is also of the opinion that surveys have, as an advantage, the ability to easily guarantee respondents' anonymity, which may lead to more candid answers than less anonymous methods such as interviews (Muijs, 2001). This, according Greener (2011), should enhance participants' honesty and the feeling that they can say what they believe without being concerned whether their views will in some way be used against them. Gavin (2008) concurs that individual respondents should never be identified in reporting survey findings and that all results in a survey must be presented in completely anonymous summaries such as statistical tables and charts.

Surveys also have a number of disadvantages. In the first place, collecting information about a large population is very expensive and could be time-consuming (Bethlehem, 1999). In the second place, Gavin (2008) states that

difficulties are encountered with surveys, such as a poor response rate which may be associated with a poorly constructed method. If a sample survey is affected by non-response, Bethlehem (1999) cautions that this may result in invalid estimates of population characteristics. However, according to Greener (2011), if the researcher can show that their survey response rate is representative of their sample, and that their sampling method was reliable, then they have a good basis for arguing that their results are reliable. Gavin (1999) adds that a further disadvantage of survey approaches is that there is a possibility that people may answer questions in a socially desirable way in an attempt to portray themselves in a positive manner, irrespective of accuracy. Fourthly, surveys also suffer the limitation of forcing respondents into particular response categories such as Likert scales, thereby limiting the range of responses (Simon & Goes, 2013). Muijs (2001) argues that the use of a standardised questionnaire, which is by its nature limited in length and depth of responses, thus makes it difficult to establish a deeper understanding of processes and contextual differences. Surveys, therefore, are very limiting to participants in terms of participants' ability to elaborate or clarify their positions on their responses.

5.2.4.1. Self-administered questionnaire.

Although survey designs are quite flexible and different methods are used to collect data, Muijs (2011) argues, however, that they are all characterised by the collection of data using standardised techniques. According to van Vuuren and Maree (1999), the data collection techniques that are used for surveys include personal interviews, telephone interviews, questionnaires and diaries. Researchers will sometimes also combine these methods. The nature of information required from the participants of this study was based on the aims and objectives underpinning the study, and how best to elicit this information was what informed the decision to select the particular data collection method used. Self-administered questionnaires were used in this study to collect data from participants. In this technique, Struwig and Stead (2001) state that data is obtained from questionnaires completed by the respondents. While self-administered questionnaires are usually read and completed by the participant, the researcher or research assistants involved in this study were present when participants completed these questionnaires. According to Rosnow and Rosenthal (1996), this provides an opportunity to establish rapport with the participants and to stimulate

the trust and cooperation needed to probe sensitive areas. Another advantage, according to Clark-Carter (2010), is to afford participants an opportunity to ask clarity-seeking questions, if there are any, and to answer them immediately. This also addresses a concern raised by Greener (2011), which is that participants completing self-administered questionnaires are likely to respond to different words and concepts in different ways when they lack clarity regarding the meanings of these words and concepts. Although resistance may still be encountered, Clark-Carter (2010) argues that self-administered questionnaires produce the best response rate when completed in the presence of the researcher.

The major problem with self-administered questionnaires relates to the veracity of the responses (Jackson, 2012). The researcher should, thus, be concerned with whether respondents provide reliable information. To illustrate this shortcoming, Babbie (2011) provides an example of where, in a study of child rearing, respondents might be asked to report the age at which they first talked back to their parents. Apart from the problem of defining 'talking back' to parents, Babbie (2011) argues that it is doubtful that most respondents would remember this with any degree of accuracy. Respondents completing self-administered questionnaires must therefore be competent and willing to answer questions posed to them.

5.3. Instrument

The Attitudes and Beliefs about Mental Health Problems: Professional and Public Views' Questionnaire (Jorm et al., 1999) was used to collect data in order to achieve the aims and objectives of the current study. This questionnaire is a self-administered instrument, and was originally designed by Jorm et al. (1997) when they were conducting a study entitled 'Mental health literacy: a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment' in Australia. The questionnaire has since been used in many similar studies (Goldney, Fisher, Dal Grande & Taylor, 2005; Jorm et al., 2006; Link et al., 1999; Mccann, Lu & Berryman, 2009).

The questionnaire is divided into three parts. The first part of the questionnaire contains information explaining the survey and issues related to the participants' consent to take part in the study. This section also elicits basic demographic data from participants such as age, gender, marital status, highest level of education, and so forth. There is no part of the questionnaire where

participants are asked about any personally identifying data such as names, identity numbers, home addresses, and the like.

The second part of the questionnaire presents vignettes of different characters who meet the diagnostic criteria (according to the DSM-5: American Psychiatric Association, 2013) for depression, schizophrenia, social phobia, or posttraumatic stress disorder (PTSD). Information regarding the onset, duration, frequency, course and severity of the specific behaviours exhibited by the respective target characters is included in each of these vignettes. The effect(s) of the mental illness on the vignette character is also depicted as part of the description of these vignettes.

The third part of the questionnaire consists of questions that are aimed at eliciting participants' knowledge, attitudes and perceptions of mental illness. The first few questions are open-ended and allow participants to freely express their opinions using their own words in order to formulate a deeper understanding and comprehensive information from their responses. Examples of questions asked include the following:

- What, if anything, would you say is wrong with John?
- How do you think John could best be helped?
- Imagine John is someone you have known for a long time and care about. You want to help him. What would you do?

Most questions that follow in the questionnaire are comprised mainly of Likert-type scales and a few that require 'yes' or 'no' answers. In summation, these questions measure participants' opinions regarding the cause of the illness, their ideas related to different professionals and treatments that could possibly be helpful, the likelihood of a patient's recovery, social distance and attitudes towards people with mental illness, possible sources of knowledge regarding mental illness, as well as knowledge of available treatment facilities.

5.3.1. Concerns and adaptation of the instrument.

The Attitudes and Beliefs about Mental Health Problems: Professional and Public Views' Questionnaire was originally designed for a population greatly different from that of South Africa. The researcher in this study was therefore concerned that this questionnaire may not entirely meet or reflect the language and cultural context of the current study population. This necessitated the adaptation of this questionnaire to the South African context. Several changes

were made to the questionnaire during adaptation, which will be discussed in this section.

In the first part of the questionnaire, the consent form was changed to introduce the researcher, the aim of the study, and broad areas of enquiry that are covered in this study. In the section enquiring about demographic information, items asking participants if they were widowed or living with a partner were added to the questions related to marital status. Items eliciting information about the district in which participants lived, their race, their highest level of education attained, their religious affiliation and language spoken were also modified to reflect the South African context.

It has already been stated that the original questionnaire used vignettes covering four mental illnesses namely depression, schizophrenia, social phobia and PTSD. In the second part of the questionnaire, only two diagnoses included in the original questionnaire, depression and schizophrenia, were retained for this study. However, the details of the vignettes were adapted from Goldney et al. (2005) and Jorm et al. (1997). The third vignette used in this study depicted the symptoms of someone who meets the diagnostic criteria for alcohol dependency, and this was adapted from Link et al. (1999). To substantiate the selection of diagnosis for each vignette, depression has been found to be among the most prevalent DSM disorders in numerous studies conducted in South Africa (Stein et al., 2008; Williams et al., 2008). In large epidemiological surveys, the lifetime prevalence of major depressive disorder was found to be about 10 per cent of the general population (Joska, 2007). In a nationally representative household survey conducted in South Africa between 2002 and 2004, Tomlinson et al. (2009) found the lifetime prevalence of major depression to be 9.7%, with the prevalence being significantly higher among females than males.

Regarding the choice of the second vignette, schizophrenia is a complex syndrome that inevitably has a devastating effect on the lives of the person affected and their family members (Barlow & Durand, 2011) and has a significant impact on health services and the economy of the country (Baumann, 2007). Its prevalence appears to be in the 0.5% - 1.5% range of the adult population worldwide (Jordaan, 2010), and the incidence is remarkably similar across the world, in both developed and developing nations (Baumann, 2007). A vignette used in this study for schizophrenia was also adapted from Link et al. (1999).

With respect to the third vignette, substance related disorders are highly prevalent among the South African population and are a serious concern. Recent

data on the prevalence of alcohol use and abuse shows that 9.9% of females and 27.6% of males in South Africa can be considered to be alcohol dependent (Thom, 2007). According to Williams et al. (2008), the estimated prevalence of substance abuse in South Africa is at least twice as high as that in other WHO World Mental Health countries. A vignette describing a person suffering from alcohol dependence was therefore also taken from Link et al. (1999) to be used in the questionnaire employed in this study.

In order to make the vignettes of this study more relevant to the South African sociocultural context, the following additions were made to them. Firstly, the names of the characters presented in the vignettes of the original DSM questionnaire were Jenny for the female character, and John for the male character. In this study, these names were replaced by Zanele and Bheki for the female and male characters, respectively. Secondly, for the vignette depicting someone suffering from schizophrenia, the voices were made to be specifically that of the character's grandmother who had passed away 10 years ago. Visual hallucinations of the grandmother were also added to the vignette. The rationale behind this decision was to make the character more culturally relevant to the South African population, since the ancestors play an important part within African cosmology.

Furthermore, in the depression vignette, a suicidal behaviour was added in an attempt to strengthen the clinical nature of the vignette to participants. No changes were made to the alcohol dependency vignette. Care was taken to ensure that the language used in these vignettes and the whole questionnaire was easy, accessible, and common to South Africans in general. Appendix A shows the three vignettes used in this study. To control for stereotypes associated with certain gender roles, the names Zanele and Bheki were assigned to all three vignettes. However, the results of this study are presented according to diagnosis assigned to a vignette, not by vignette gender.

Once the modification of the vignettes was completed, and even prior to the completion of the adaptation process of the entire questionnaire, diagnoses presented in these vignettes were confirmed by requesting three clinical psychologists with more than three years of clinical experience to read and provide a diagnosis for each vignette. They all correctly diagnosed these vignettes. Vignettes used in this study have been used previously in studies of mental health literacy abroad (Fisher & Goldney, 2003; Jorm et al. 1999; Jorm et al. 2006; Link et al. 1999). Vignettes in general have also been used in numerous studies of this

nature in Australia (Mccan et al., 2009, Marie & Miles, 2008, Scott & Chur-Hansen, 2008), South Africa (Samouilham & Seabi, 2010), Israel (Levav et al., 2004) and Germany (Schomerus et al., 2009).

Questions contained in the third part of the questionnaire that aim to elicit participants' knowledge, attitudes and perceptions of mental illness remained largely unchanged. A few changes made to this part of the questionnaire however included adding a prognostic question, for example, what do you think is the cause of Zanele's problem/s? In other Likert type questions where a list of possible answers is provided, some items common to the South African cultural context were added. For example, *sangoma* (diviner), *nyanga* (herbalist) and *umthandazi* (faith healer) were added on the list of different professionals who could possibly help the character depicted in the vignette. Some items added to the questionnaire in the current study were derived from previous studies of mental health literacy (Barlett, Travers, Cartwright & Smith, 2006; Marie & Miles, 2008; van 't Veer et al., 2006). Examples of specific questions contained in the questionnaire are provided in the next chapter when reporting on the results of the study. A complete copy of a questionnaire used in this study is attached as Appendix B.

The questionnaire, in general, was adapted to the South African language spoken by the participants to reduce the likelihood of ambiguity. The whole questionnaire was written intentionally in an easy and 'free from jargon' English. The researcher in this study had anticipated that, since the study was a community survey, some participants may be more likely to be comfortable completing the questionnaire using their mother tongue. The vignettes and the complete questionnaire were, therefore, translated into isiZulu. This was done by adhering to Babbie and Mouton (2001), Flisher, Ziervogel, Chalton and Robertson (1993), as well as Rosnow and Rosenthal's (1996) suggested translation guidelines. Two experienced isiZulu translators with a university postgraduate qualification (Honours Degree) in Psychology were asked to translate the questionnaire. The first one translated the English questionnaire into isiZulu and then the other back-translated the isiZulu version into English without having seen the English version. After this forward and back translation, these translators had a meeting with the researcher where both the translated and back-translated versions were compared with the initial English version of the questionnaire. Where discrepancies in these translations were noted, they were resolved through discussion and consensus among translators.

The main challenge experienced and acknowledged by these translators was the lack of uniform isiZulu words for medical and psychiatric terminology. Where no equivalent isiZulu words could be thought of this was resolved through making use of different words that constitute a sentence that still conveys the essence of the meaning contained in the word. Once the two translators and the researcher were satisfied with this process, both the English and isiZulu versions of these questionnaires were presented to one of the supervisors of this study, who has extensive experience in the translation of psychological concepts into isiZulu, for a final check and editing. Copies of the isiZulu versions of the vignettes are attached as Appendix C, while Appendix D comprises the complete copy of the isiZulu questionnaire used in this study.

5.3.2. Pre-testing the instrument.

Once translation was completed, in a pilot pre-test five people from the community were asked to pre-test the questionnaire. All of them were first language isiZulu speakers; three of them completed the isiZulu version of the questionnaire and another two completed the English version. They were all subsequently interviewed individually to detect inadequacies in the questionnaire's translation. They were specifically encouraged to comment on the questions and how they were posed. There are authors, such as Czaja & Blair (2005), who hold the view that pre-tests are a necessity. The aim of conducting the pilot pre-test was to test the questionnaire and to detect its possible flaws. Pre-testing also afforded the researcher an opportunity to ascertain participants' concerns regarding items contained in the questionnaire. The two participants who completed the English version of the questionnaire were satisfied with the way questions were asked. Their main concern however was that the questionnaire is too long and that most participants may lose interest and may leave many questionnaires incomplete. The three participants who completed the isiZulu version of the questionnaire, on the other hand, made many grammatical suggestions. A meeting was then held with the two people who were involved with the translation of the questionnaire to discuss and incorporate suggestions made by these participants.

Given that pre-testing the instrument only involved five individuals, according to Czaja and Blair (2005) this number is too small to use to estimate cooperation or screening eligibility rates. In addition, the researcher in this study

was concerned that there may be some aspects of the data collection process that pre-testing alone would not address. Therefore, these concerns necessitated the need for a pilot testing.

5.4. Pilot Study

A pilot study was conducted in this study, acting on the suggestion by Stopher (2012) that before a survey is committed to the field, the questionnaire and the various designs and procedures of the survey should be piloted. This is particularly pertinent, according to Clark-Carter (2010), when the researcher uses an existing questionnaire in a new population. Further supporting his advice, Stopher (2012) states that it has been proven time after time that surveys that are fielded without piloting result in problems that could have been avoided had pilot studies been conducted. Pilot studies can be used for various reasons, including:

1) To identify possible problems with the proposed research using a small sample of respondents before the main study is conducted (Kanjee, 1999). In this study, the main reason for conducting a pilot study was to ascertain whether the questions contained in the questionnaire made sense to participants. The wording of a questionnaire is very crucial in any survey (Rosnow & Rosenthal, 1996) and a pilot study was therefore used in this study to detect and correct ambiguities, and to check whether there were any words that needed to be simplified or adapted that could have been missed during the pre-testing of the questionnaire.

2) The researcher used the pilot to check the clarity of instructions and to determine whether any procedural difficulties were encountered during the administration of the questionnaire. This was done to ensure that all aspects in administering the questionnaire worked as planned or to ascertain whether there would be a need to refine the instrument and procedures before the main study was conducted.

3) Stopher (2012) adds that pilot studies may also be used to assess the response rates and completion rates of a survey. This was particularly relevant for this study because the researcher was concerned about the length of the questionnaire and the amount of time it would take to administer the questionnaire. Apart from establishing the average time it took to complete the questionnaire, the focus here was also on how many of the people who were approached to participate would decline permission to do so, or would not complete all the questions in the questionnaires, and what would be their reasons.

4) Lastly, according to Kanjee (1999), pilot studies are also useful to research assistants' training. Given the nature and scope of this research, a total of five research assistants (graduates with psychology as a major and those who had previously participated in major research projects as research assistants) were recruited and trained to collect data for this study. In anticipation of the respondents being isiXhosa speakers in the Kokstad area, two of the five research assistants were fluent in speaking isiXhosa and the other three had a good command of the language. Piloting this study was useful in this regard because it afforded the research assistants an opportunity to become familiar with the procedures involved in and administration of the questionnaire. Attention was also paid to errors that could possibly be made by research assistants in their administration of the questionnaire. Research assistants were given notebooks and encouraged to write down questions and problems as they encountered them during the administration of the questionnaires. Debriefing meetings were held with research assistants at the end of each day of the pilot study to discuss their experiences and concerns. The pilot study was conducted for a period of one week in the month prior to data collection in the main study.

5.4.1. Pilot location.

The pilot sample was recruited from Greytown in the province of KwaZulu-Natal. Greytown is situated in Umzinyathi District, which falls under Umvoti Municipality. It is approximately 75 kilometres (kms) north of the capital city of KwaZulu-Natal, Pietermaritzburg. Greytown was selected because the researcher considered the town to have a population and economic characteristics somewhat similar to Greater Kokstad and Kwa Sani Municipalities. A meeting was held with both the offices of the municipal manager and the South African Police Service (SAPS) informing them of the pilot study, its aim and objectives as well as the presence of the researcher and research assistants in the community. This served as obtaining entry and obtaining gatekeepers' permission in Greytown. Both the municipal manager and SAPS attached their official stamps on copies of ethical clearance letters as an indication of their consent and approval for the pilot study to be conducted at Greytown. The letter showing these stamps is attached as Appendix E.

5.4.2. Pilot sample.

While there are no specific rules about the size of a pilot survey sample, Stopher (2012), and Czaja and Blair (2005) recommend that a relatively large number of participants should be recruited using the exact procedures planned for the study. Following on the suggestion made by Stopher (2012) that the sample size for a pilot survey should be in the range of 3 to 7 per cent (or more) of the main sample, 93 participants were recruited to participate in a pilot of this study. Steps followed to recruit pilot sample are similar to the ones used to recruit the sample for the main study and are detailed in section 5.6.2.2, under data collection. Details of their demographic distribution show that of these 93 participants, 61 (65.6%) were females and 32 (34.4%) were males. Their ages ranged from 18 to 72 years, with 35.9 years being the mean age. Distribution according to age categories showed that there were 25 (55.9%) pilot participants between the ages of 18 – 34, 22 (23.7%) between the ages of 35 – 49, 14 (15.1%) between 50 – 64, and 5 (5.4%) in the category of 65 and above. Regarding their marital status, 68 (73.1%) were single, 18 (19.4%) married, 4 (4.3%) widowed and 3 (3.2%) were living with a partner. Distribution according to educational level shows that 5 (5.4%) of the pilot sample had never been to school, 11 (11.8%) had a primary level of education, 62 (66.7%) and 15 (16.1%) had attained secondary and tertiary levels of education, respectively. Regarding religion, 80 (86.0%) of the pilot sample were Christians, 4 (4.3%) Jehovah's Witness, 1 (1.1%) Muslim, 6 (6.5%) African Religion, and 2 (2.2%) reported to be non-religious. 90 (96.1%) of the participants in the pilot sample speak isiZulu as their home language, and only 1 (1.1%) recorded Afrikaans, Sepedi, or *Other*, each, as their home language. Table 5.2 shows a summary of these results. Data collected from the pilot study is not included in the results of this study because the aim of the pilot study was only to test methodologies for data collection.

Table 5.2: Demographic information of the pilot sample

Demographics	n	%
Gender		
Female	61	65.6
Male	32	43.4
Age		
18 – 34	52	55.9
35 – 49	22	23.7
50 – 64	14	15.1
65+	5	5.4
Marital status		
Single	68	73.1
Married	18	19.4
Widowed	4	4.3
Living with a partner	3	3.2
Education level		
Never went to school	5	5.4
Primary	11	11.8
Secondary	62	66.7
Tertiary	15	16.1
Religion		
Christian	80	86.0
Jehovah's Witness	4	4.3
Muslim	1	1.1
African Religion	6	6.5
Non-Religious	2	2.2
Home language		
Afrikaans	1	1.1
isiZulu	90	96.8
Sepedi	1	1.1
Other	1	1.1

5.4.3. Procedural difficulties encountered.

In general, not many procedural difficulties were encountered when piloting this study. The only difficulties experienced were related to: 1) the time it took to complete the questionnaire; 2) the high number of spoilt questionnaires; and 3) the inclusion of non-African participants. It was initially stated in the information sheet of the pilot study that it would take 20 to 30 minutes to complete

the questionnaire. However, it became apparent that to complete the questionnaire took a greater amount of time than initially thought. Most participants showed some level of uneasiness with the time spent to complete the questionnaire because they had been informed that only 30 minutes of their time was required for completion. Such participants were reminded that they were not required to complete answering the questionnaire, and some withdrew, but others went ahead to complete the questionnaire. Research assistants were each instructed to observe how much time, on average, it took to complete the questionnaire. A general impression was that the average time required to complete the questionnaire was 45 minutes.

The researcher checked the questionnaires completed at the end of each day with a focus to determine how many of them would be usable. About 10 questionnaires were spoilt on the first day of the pilot study. Many of these questionnaires were incomplete and some were answered without following instructions, for example, some participants selected more than one answer on several occasions where only one answer was required. To deal with this problem, the research assistants were instructed to be present and to monitor the participants to ensure that they followed the instructions when completing the questionnaire.

There were about three questionnaires that were completed by non-African participants, a further two were completed by Indian participants and one by a coloured participant. Reminding research assistants that the targeted sample of this study were 'black Africans' only became a standard part of the briefing every morning before the start of data collection.

5.4.4. Adaptation.

Adaptations to the questionnaire or procedure of administering the questionnaire included the following issues. Firstly, the time it took to complete the questionnaire on the information sheet had to be changed from 20 – 30 minutes to 45 minutes. This was helpful because it prepared participants for the realistic amount of time it would take for them to complete the questionnaire. This improved the rate of completed questionnaires and decreased spoilt questionnaires. Secondly, it was only noticed after the pilot study when data was captured that the category of 'divorced' was not included as an option under the

demographic information eliciting marital status of participants. This category was therefore added in the later version of the questionnaire used in this study.

5.4.5. What was learnt from the pilot study?

There are a number of important lessons that emerged from the pilot study. Apart from the adaptations made to the questionnaire as stated above, the pilot study proved important in terms of the significance of thorough training of the research assistants, teamwork, and short briefing meetings every morning prior to proceeding with data collection. The importance of establishing rapport with the research participants was also learnt from the pilot study. Research assistants noticed that participants were more likely to answer the questionnaire in full when a good rapport was established, when participants understood what the study is all about and when the participants were informed about how important it would be for their ideas to be included in the study, as well as when they were informed from the beginning that close to an hour of their time was required to complete the questionnaire.

5.5. Reliability and Validity of the Study

5.5.1 Reliability.

Reliability refers to “the dependability of a measurement instrument, that is, the extent to which the instrument yields the same results on repeated trials” (Durrheim, 1999c, p. 88). This refers to the consistency of the research instrument. The rationale behind the concept of reliability, according to Durrheim and Wassenaar (1999), is based on the expectation that individuals will score similarly on a reliable measure on numerous occasions. This means that if the same results are obtained every time the study may be repeated, then the study is reliable. The researcher in this study was mindful of the advice suggested by Czaja and Blair (2005), namely that to enhance reliability the questions should measure the dimension or construct of interest and that respondents should be able to interpret the questions as intended. Pre-testing the questionnaire was a useful measure in the current study to ensure that participants interpreted the questions as intended.

There are a number of methodologies available to test for the reliability of a questionnaire. The most commonly used method by quantitative researchers is through the process of calculating inter-item consistency (Dunn, 2010). The researcher in this study used Cronbach's alpha on data obtained from the pilot study to calculate the internal consistency of the items comprising the questionnaire. According to Clark-Carter (2010), Rosnow and Rosenthal (1996), as well as Stead (2001), Cronbach's alpha is a commonly-used measure of internal-consistency reliability that is used with questionnaires based on a Likert scale. The reliability of the questionnaire for this study was anticipated to be confirmed with a Cronbach's alpha coefficient greater than 0.7 (Coolican, 2004; de Vaus, 2002), and the closer to 1 the better because high internal consistency would mean that the items were all measuring the same construct or idea (Devlin, 2006). The Cronbach's alpha (α) coefficient for this study was .89 for the pilot study, and .85 for the main study. The higher values, typically above +.80, according to Dunn (2010), are desirable because they indicate greater consistency.

5.5.2. Validity.

In addition to reliability, the researcher also ensured that the questionnaire employed in this study is valid. Validity refers to whether a measure is truthful or genuine (Jackson, 2012), or in other words, whether the questionnaire measures what it claims to measure. This, according to Stead (2001), refers to the extent to which a research design is scientifically sound or appropriately conducted. Different types of validity are usually examined in a research study. Three important ones that are relevant for this study are:

(1) Face validity, which is the degree to which the test seems to measure the appropriate concept at face value (Weisberg et al., 1996). This concerns whether the questionnaire appears to measure what it claims to measure at face value. Stead (2001) argues that if the questionnaire lacks face-value, the research participants may question the purpose of completing the questionnaire. The three psychologists who were asked to review the vignettes used in this study, as well as the five people who participated in the pre-testing of the questionnaire, all agreed that the questionnaire appeared to measure what it purported to measure.

(2) Content validity is described by Jackson (2012) as the extent to which a measuring instrument covers a representative sample of the domain of behaviours to be measured. In this study, different questions were used to measure different

aspects of knowledge and attitudes toward mental health and help-seeking behaviours. According to Dunn (2010), a conventional approach to determining the content validity of a questionnaire is to have it reviewed by a panel of expert judges in the field of enquiry. This was carried out by the three psychologists who had also confirmed the face validity of the questionnaire of this study.

(3) Construct validity refers to the degree to which a test measures the theoretical construct or abstract variable it was intended to measure (Stead, 2001). This means that construct validity is related to the theoretical knowledge of the concept being measured. While a construct is an abstraction of something that cannot be seen, it can be inferred because, according to Babbie (2011), it is based on the logical relationship among variables. Babbie (2011) adds that this can be measured by developing certain theoretical expectations about the way in which a certain variable relates to other variables. For example, in this study better knowledge of mental illness is expected to relate more closely with less stigmatising attitudes towards mental illness and improved help-seeking behaviours. To improve construct validity, given that the questionnaire used in this study measures different aspects of mental health literacy, various items measuring a particular aspect (for example, knowledge of treatment options for mental illness) were arranged to be aligned together, for example, to form knowledge of treatments that are likely to be helpful for mental illness. This procedure is recommended by Muijs (2011). According to Czaja and Blair (2005), validity also requires that the respondents interpret the question as intended. Validity in this manner was tested during the pre-testing of the questionnaire in this study.

The following guidelines to improve the validity of the questionnaire, provided by Stangor (2004), were taken into consideration during piloting of this study: 1) making sure that questions are understandable and not ambiguous; 2) attempting to get respondents to take the questionnaire seriously by emphasising that the honesty of their responses is important; 3) making items nonreactive; 4) choosing items that seem 'reasonable' and which represent a broad range of questions concerning the topic of interest; and 5) using an existing scale in which reliability and validity have already been established. Furthermore, the three psychologists who were asked to check the vignettes of this study were also asked to ensure whether they think the questionnaire meets these three kinds of validity and whether they were all in agreement that it does.

5.6. Procedure for Main Study

The following section outlines the methodological procedure that was followed for the main study. It begins with a discussion of the sample and the sampling procedure, followed by an explanation of how entry into the research sites was gained. The specific data collection methods and techniques used to analyse the data are also presented in this section, and finally, the ethical considerations are discussed.

5.6.1. Sample and sampling.

The sample for this study was drawn from the population of both Greater Kokstad and Kwa Sani Municipalities in Sisonke District. A probability sampling method called stratified, multistage cluster sampling was adopted for this research. According to van Vuuren and Maree (1999), probability sampling allows for each member of the target population to have a known chance of being selected into the sample. As a result, the likelihood that the sample is representative of the population is increased, as is the ability to use the sample to draw inferences about the wider population (Stangor, 2004). Cluster sampling is often used when it is either impossible or impractical to compile an exhaustive list of all the elements composing the target population (Babbie & Mouton, 2001). For example, in this study it would have been impractical to compile a list of all people residing in Sisonke District. Cluster sampling randomly assigns groups from a large population and then surveys everyone within the groups (Kelley, Clark, Brown & Sitzia, 2003). This method can use a one- or two-level (or more) randomisation process (Lunsford & Lunsford, 1995). For the current study, first, stratification was based on the provincial districts of KwaZulu-Natal. The researcher wrote the names of the 9 provincial districts on separate pieces of paper and placed them in a box, shook it and selected one. The Sisonke District was selected. The second stage was to select the municipality. The researcher placed the names of the five municipalities of Sisonke District on separate pieces of paper and placed them in a box, shook it and randomly selected two. These were Greater Kokstad and Kwa Sani. The third stage was a random selection of participants. This stage will be described in detail in the next section when the procedure followed is presented.

5.6.2. Procedure.

The process of data collection began upon receiving permission and ethical clearance from the University of KwaZulu-Natal's Humanities and Social Sciences Research Ethics Committee (UKZN's HSSREC). Details pertaining to the ethical clearance required in this study are discussed later in this chapter under ethical considerations, subsection independent review, paragraph 5.8.1. An ethical clearance letter is attached as Appendix E.

5.6.2.1. Gatekeepers' permission.

Prior to collecting data, meetings were held with community gatekeepers in order to gain entry into the research sites and to obtain access to the participants. Gatekeepers usually have a say over who is permitted or denied entry or access to research participants. According to Terre Blanche and Kelly (1999), gatekeepers are usually parties who have vested interests either in the issue at hand or in the wellbeing of the potential research participants. These authors advise that it is beneficial to be on good terms with gatekeepers in order to ensure that the research study does not get sabotaged along the way (Terre Blanche & Kelly, 1999). Different meetings were scheduled and held with the municipal managers and the person in charge of the SAPS units in both Greater Kokstad and Kwa Sani Municipalities where this research was conducted. At these meetings, the background to the study, its aims and objectives, as well as the data collection procedure were explained in some detail. Once the gatekeepers were satisfied and understood the study and its procedures, they signed and stamped a copy of the ethical clearance letter that had been obtained from UKZN's HSSREC. Copies of these letters signed and stamped by gatekeepers from Greater Kokstad and Kwa Sani Municipalities are attached as Appendices F and G, respectively. These gatekeepers also provided the researcher with their telephone numbers so that they could easily be contacted in the event of problems being encountered in the community.

Interestingly, a ward committee member at Kokstad approached the team on the second day of data collection and enquired what the study is about. He was pleased to hear about the study and he also provided his contact number in case the team experienced difficulties in the community. At Kwa Sani, a ward councillor was selected during a routine random selection of participants, and she

agreed to take part in the study. Upon completion of the questionnaire she showed eagerness to help the research assistants to recruit participants. However, she was informed that the recruitment of participants is based on a certain random technique and that she therefore would not be able to recruit members of the community that she knew to participate in the study.

The heads of the SAPS from both research sites also assured the research team of safety and security. There was an agreement in these meetings that the research team would be identifiable by carrying specific bags with certain colours and identifiable name tags. On the days of data collection, the patrol vehicles of the SAPS were alerted to the presence of the research team in order to increase safety and patrol activities in those communities. A caution by Kelly (1999) that problems often arise when researchers are introduced into the research sites by gatekeepers because the participants associate the researcher with the vested interests of the gatekeeper was taken into account. As a result, the gatekeepers did not accompany the research team during data collection, but the SAPS did provide safety and security from a distance by visible patrols in the areas where data collection took place.

5.6.2.2. Data collection.

The researcher acknowledges that designing a strategy to recruit participants from their homes would have been much more desirable in this study. However, given the scope of this research, the geographical nature (rural, scattered) of the research sites and cost constraints, it would have been very time-consuming and too expensive to conduct a randomised household survey for this study. Instead, a randomised public recruitment strategy was adopted. Randomisation is a process that gives everyone in the population an equal chance of being part of the sample (Weisberg et al., 1996). Johnson and Onwuegbuzie (2004), as well as Zheng (2015), have argued, in their discussion of the quantitative approach and cross-sectional design, that random sampling increases generalisation about the whole population, especially when the sample is sufficient.

Data was collected between August and December of 2014. Participants in this study were randomly recruited from public places that usually attract a large

number of people, such as shopping complexes, taxi or bus stations, township streets, and some from their homes. To select participants, a specific random sampling technique called the systematic selection procedure was used with the aid of a computer program called *Randomizer*. In the systematic selection procedure, according to Weisberg et al. (1996), a random number is selected to choose the first research participant, and then some people are skipped to choose the next person based on the next random number, and so on. A *Randomizer* is a computer program that generates a set of random numbers. During each day of data collection, a *Randomizer* would be computed to generate 5 new sets with unique 50 integers in each, with each integer having a value between 1 and 200. Appendix H is an example of 5 sets of random numbers generated by this computer program. Research assistants would each be given a set of these random numbers to use to select participants. This means, if the integers of the first set are 1, 4, 11, 12, 15, 22, 35, the first person to be met when recruiting participants would be approached and asked to participate in the study, this would be followed by the 4th person, then the 11th person, and so on. In this way, selection bias was eliminated. 787 participants were intended to be recruited for the study. This number was informed by the population sizes of the two municipalities (Greater Kokstad and Kwa Sani), as depicted in Table 5.1 in page 122, as well as Watson's (2001) guidelines for establishing a base sample size. This table assumes a 95% confidence level, a 5% margin of error and 50% degree of variability.

A brief meeting was held with the research assistants every morning prior to them and the researcher going out to collect data. The aim of the meeting was to motivate and remind them of the importance of adhering to recruitment and data collection procedures, more specifically to adhere to the ethical procedures required in a study of this nature. These meetings also provided an opportunity for the researcher to answer or clarify questions or issues if the research assistants had any. Research assistants were then dropped off at different locations for data collection. These were mostly places that tend to attract a large number of people such as towns, shopping malls, bus or taxi ranks. Other participants were recruited from the streets in the communities.

When a potential participant was identified using random numbers generated by *Randomizer*, they were approached and asked to participate in the study. The research assistants first introduced themselves and explained the reason

for approaching the potential participant. The first objective would be to establish a rapport with and to ascertain whether the person was over the age of 18 (because no one below the age of 18 was allowed to take part in the study) and if they were willing to participate in the study. If the person refused to participate, the research assistant would check what the next number was on the list of random numbers and would begin counting to obtain to the next possible participant. If people were met in a group, the counting would still be conducted in the same way and only the person identified through this counting would be asked to participate. If they agreed to participate in the study, then they would be requested to move away from the group to ensure less distraction.

Once a participant had agreed to take part in the study and rapport had been established, the study was introduced to the participants. The rationale for the study and information contained in the informed consent form was explained (Appendices B and D), and instructions pertaining to filling in the questionnaire were also provided by the research assistants. Particular emphasis was placed on confidentiality and anonymity, and research assistants were specifically instructed to ensure that participants understood the role of their participation and their rights. It was also made very clear to all to participants that they were allowed to withdraw, without any repercussion, from the study at any point should they feel the need to do so, and that their participation is absolutely voluntary. Participants were asked whether they understood the instructions or had any questions before completing the questionnaire. The research assistants were available to answer any questions or to provide clarity where necessary during the completion of the questionnaire. Participants had a choice of completing the English or isiZulu version of the questionnaire. For participants who could not read and/or write, the research assistants read the questionnaire aloud for them and recorded their responses. Each participant was randomly given a questionnaire depicting only one of the three vignettes representing depression, schizophrenia or alcohol dependency, as described earlier.

5.6.2.2.1. Challenges experienced during data collection.

Although data collection was a smooth process, there were some difficulties that were experienced and worth noting. Firstly, the time required to complete the questionnaire was experienced by some participants as too extensive. The average time taken to complete the questionnaire was

approximately 40 minutes. Given that participants were asked to take part in the study while going about their daily business, some indicated that they were in a hurry and therefore unable to participate in the study. There were also participants who began the process of completing the questionnaires but then withdrew from the study because they were in a hurry to go somewhere. However, it became apparent that if participants were informed that it would take them close to an hour to complete the questionnaire and their participation was valued, that this increased the questionnaire completion rate. This adaptation was incorporated into the standard recruitment procedure at a very early stage of data collection and it proved successful.

Another problem experienced during data collection was to do with participants who wanted to know more concrete details related to the vignettes represented in the questionnaire than the information that was provided. For example, some participants wanted to know if the people depicted in a vignette had matriculated, what type of job they were engaged in, if they had siblings and what their birth order was, as well as whether some traditional rituals had been performed, just to mention a few. To deal with this problem, the research assistants were encouraged to tell participants that not much information is known about this person in the vignette, and that they were only expected to answer on the basis of what little information was provided.

The rate at which data collection was taking place also became a concern to the researcher. On average, each research assistant would have about eight completed questionnaires per day. There were days where some had only 5 completed questionnaires. The research assistants reported that older participants tended to take more time thinking about their answers and asking clarity-seeking questions. It was also reported that some participants, after completing the questionnaire, would want to recommend certain people to be included in the study. These participants were very disappointed when they were told that there was a specific procedure to be used to select participants and that their recommendations in this regard would not be followed through.

5.6.3. Cleaning of data.

Data cleaning, according to Suhr (2011), is a process of verifying data and checking values to make sure they are not out of range or incorrect. To clean data in this study, frequency analysis was performed on all items of the questionnaire.

During this process, according to Czaja and Blair (2005), data is examined for such things as skip-pattern errors, patterns of missing items or excessive numbers of missing items, proper use of 'other specify' categories, and so forth. If an anomaly was noticed, the researcher went back to the questionnaires to verify and rectify the issue. It was easy to perform this process because all questionnaires were assigned case numbers, ranging from 1 to 787. This process is significant as it enables the researcher to detect problems early enough so that corrective measures can be taken before the actual data analysis commences.

Once the data cleaning process was complete, data was screened for normality and homogeneity using Shapiro-Wilk's test and Levene's test respectively. The results of the tests of normality show that most of the scores were fairly normal ($p > 0.05$) and the test of homogeneity did not reveal much variance, thus suggesting that data was fairly normally distributed.

5.6.4. Details of the final sample.

The sample comprised black Africans of both genders, and all educational levels. Selection to participate in this study was not based on an individuals' level of socio-economic status. A total number of 822 participants took part in this study. Ten of them exercised their right to withdraw from the study once they had already started filling in the questionnaire. Another 25 questionnaires were excluded from the study sample because more than half of the questionnaire was incomplete. This means that this study had a total nonresponse rate of 4.2% ($n= 35$) when these two figures are combined. The final total sample of this study was thus made up of 787 participants. Of the total sample ('total sample' is used in this study to refer to both the Greater Kokstad and Kwa Sani sample combined), 606 (77%) and 181 (23%) of participants were recruited from the Greater Kokstad and Kwa Sani Municipalities, respectively. These totals average well with the population percentages of these municipalities based on their total populations as depicted in Table 5.1, previously shown. Figure 5.2 below presents a graphical representation of these figures. Regarding gender distribution, 490 (62.3%) females and 297 (37.7%) males participated in this study. About 563 (71.5%) participants were single, 191 (24.3%) married, 3 (0.4%) separated or divorced, 16 (2.0%) widowed and 14 (1.8%) living with a partner. The home languages spoken by most of the participants were isiXhosa (67.2%), isiZulu (28.6%), followed by Sesotho (3.7%). Table 5.3 below presents the sample distribution according to gender, marital status and home

language of participants. It is important to note here that since the questionnaires were translated into isiZulu, participants who spoke isiXhosa and Sesotho were also able to read and speak isiZulu. No difficulties were experienced regarding the understanding of the isiZulu language during the administration of the questionnaire. Although isiZulu and isiXhosa are both Nguni languages that are closely related, people who speak Sesotho in these areas are in the minority and are able to quickly learn and speak these languages fluently. Other South African languages, combined, accounted for less than 4 (1%) of the languages spoken by participants.

Figure 5.2: Sample distribution according to municipality

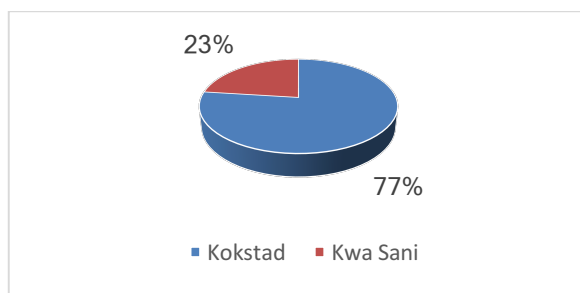
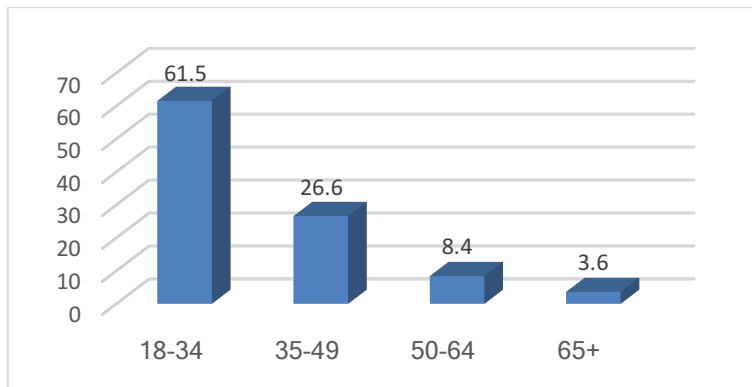


Table 5.3: Sample distribution according to gender, marital status and home language

Demographics	n	%
Gender		
Female	490	62.3
Male	297	37.7
Marital status		
Single	563	71.5
Married	191	24.3
Separated/divorced	3	0.4
Widowed	16	2.0
Living with a partner	14	1.8
Home language		
isiZulu	225	28.6
Sepedi	1	0.1
Setswana	1	0.1
English	2	0.3
Sesotho	29	3.7
isiXhosa	259	67.2

The ages of participants ranged from 18 to 86, with 34 years being the mean age. Age was categorised into the following four age groups: 18 - 34 ($n = 484$, 61.5%), 35 – 49 ($n = 209$, 26.6%), 50 – 64 ($n = 66$, 8.4%) as well as 65 and above ($n = 28$, 3.6%). These age categories have previously been used by a South African study which investigated the lifetime prevalence of psychiatric disorders (Stein et al., 2008). Figure 5.3 presents the sample distribution by age.

Figure 5.3: Percentages of sample distribution by age



The distribution of respondents according to their level of education attained shows that 28 (3.6%) of participants had never attended school, 155 (19.7%) attained a primary level of education, and 531 (67.5%) and 73 (9.3%) had attained secondary and tertiary levels of education, respectively. Regarding religious affiliation, 683 (86.8%) of the participants were Christians while 59 (7.5%) indicated that they were non-religious. All remaining religious affiliations accounted for 46 (5.9%) participants. Table 5.4 shows a detailed breakdown of the demographic characteristics of the total sample according to level of education and religious affiliation. Due to ethical reasons related to obtaining permission and informed consent when including minors as research participants, participants under the age of 18 did not form part of this sample.

Table 5.4: Sample distribution according to level of education and religious affiliation

Demographics	n	%
Level of education		
Never went to school	28	3.6
Primary	155	19.7
Secondary	531	67.5
Tertiary	73	9.3
Religious affiliation		
Atheist	20	2.5
Christian	683	86.8
Jehovah's Witness	2	0.3
Muslim	2	0.3
African Religion	21	2.7
Non-Religious	59	7.5

5.7. Data Analysis

Data was captured and analysed using Statistical Package for Social Sciences for Windows (IBM SPSS Statistics) version 24.0. The purpose of data analysis using statistics is to organise, summarise and interpret data (Gravetter & Wallnau, 2004). Descriptive and inferential statistical analyses were performed to achieve these purposes. According to Isotalo (2009), descriptive and inferential statistics are interrelated, and it is almost always necessary to use them both as descriptive statistics in order to organise and summarise data before inferential statistical analyses may be performed to provide a more thorough analysis of the subject under investigation.

5.7.1. Descriptive statistics.

Descriptive statistics provide numerical and graphical procedures to summarise data collected in a clear and understandable way (Jaggi, 2003). Data is reduced into a simpler summary and patterns in data are identified using descriptive statistics. This includes the calculation of various descriptive measures such as averages and percentages (Isotalo, 2009). Descriptive statistical analysis, using frequency distribution and cross-tabulation, was performed first on the data collected that addressed the demographic variables and key questions of this research in order to help the researcher to gain an initial impression of the data

(Durrheim, 1999a). Tables, bar graphs and pie charts are used in this study for an easy graphic presentation of the results.

5.7.2. Inferential statistics.

Inferential statistics are used to draw inferences about data collected or populations being investigated (Gravetter & Wallnau, 2004). This form of statistical analysis includes methods such as interval estimation and hypothesis testing (Isotalo, 2009). The two inferential statistical methods used in this study are Chi-square analysis and regression analysis.

5.7.2.1. Chi-square analysis

The Chi-square (χ^2) goodness-of-fit is a nonparametric statistical test that is used for comparing categorical information against what would be expected (Jackson, 2012). It does not measure the value of a set of items, but compares the frequencies of various categories of items in a random sample. Chi-square statistics, according to Diener-West (2008), may be used to test the hypothesis of no association between two or more groups, populations, or criteria. According to Gavin (2008), and Jackson (2012), the following assumptions must be met before using the Chi-square test: 1) the sample must be randomly selected; 2) data must be reported in raw frequencies, not percentages; 3) measured variables must be independent; 4) values or categories on independent and dependent variables must be mutually exclusive and exhaustive; and 5) observed frequencies should be greater than 5. Chi-square analysis was performed to test the relationship between some of the demographics or variables and questions that this research seeks to address. It does not necessarily mean that without strictly adhering to these assumptions Chi-square analysis may not be performed. In such instances, according to Brown (2004), the Yates correction factor may be applied.

5.7.2.2. Regression analysis

Regression analysis is also another way of testing relationships between variables. In the current study, regression analysis was also performed to determine the predictors of mental health literacy. According to Clark-Carter (2010), in regression analysis there is an assumption that one variable is a variable to be

predicted (a dependent variable) and one or more variables (independent variables) are used to predict the outcome of the dependent variable. In particular, demographic variables were tested to determine whether they predicted a conceptualisation of and attitudes toward mental illness.

Where the dependent variables are nominal with more than two levels, multinomial logistic regression analysis was performed. According to Weisberg et al. (1996), nominal variables are made up of distinct categories that are not related in any numerical or orderly fashion. An example of nominal variables would include gender, measured using males and females, or race, such as Black, White, Indian or Coloured. Gravetter and Wallnau (2004) state that it is possible to determine whether the two variables are the same or different if they are measured on a nominal scale, but if they are different it cannot be determined how big the difference is. Multinomial logistic regression is used to predict the probability of category membership on a dependent variable based on multiple independent variables (Starkweather & Moske, 2011).

In this study, items that were assessed using a Likert-scale and were classified as ordinal dependent variable were analysed using ordinal logistic regression analysis. In this analysis, the outcome variable is ordered and has more than two levels (Liu, 2009). However, these ordered outcome variables do not have any intrinsic numeric qualities such as *strongly agree*, *agree*, *neutral*, *disagree* or *strongly disagree* on a Likert-scale (Weisberg et al., 1996). This means that while these variables can be ranked in terms of their magnitude, the interval between them cannot be presumed equal (Jamieson, 2004).

For all statistical analysis performed, the level of statistical significance with a p value of 0.05 or less was considered statistically significant. Given a considerable number of statistical analyses performed on the data set and the possible problem of increased chances of spurious significance findings, a particular focus was made towards findings of stronger certainty.

5.7.3. Demographic variables excluded from analysis.

It is important to note that although race, religious affiliation and home language were included among demographic variables in the questionnaire, they will not be included in the results of this study because all participants were black South Africans, and the majority (86.8%) were Christians, and spoke isiXhosa (67.2%) and isiZulu (28.6%). Socio-demographic correlates of these variables would yield

no significant information or patterns that would be meaningful for analysis. Furthermore, an analysis according to socio-economic class will not be reported on since this was not formally assessed and the selection of participants was not based on this variable.

5.8. Ethical Considerations

Ethical considerations are highly significant in any research. According to Stopher (2012), these considerations are to do with what is morally correct to ask people to do, and how to treat those who are asked to participate in surveys. Weisberg et al. (1996) warn that there is a considerable potential for abuse in scientific research in general and survey research in particular. Careful consideration of ethical implications played an important role in this study to help the researcher to guard against that abuse. Upholding ethical principles and processes promotes respect for the dignity of research participants and balances risks against benefits (Benatar, 2002). The ethical considerations of the current research were largely influenced by the basic philosophies underlying research codes relevant to research with human subjects. In particular, principles that provide a coherent framework for evaluating the ethics of research studies proposed by Emanuel, Wendler, Killen and Grady (2004), Emanuel et al. (2000) as well as Wassenaar (2006) guided the researcher in guaranteeing ethical conduct in this study. Among the most widely discussed ethical principles, the principle of respect for research participants formed the basic tenet on which the ethics of the current research are based. La Vertu and Linares (1990) have grouped elements involved in this principle into two main aspects: on the one hand, respect for the rights of the person submitting to the research as well as for the actual person; and, on the other hand, respect for the general well-being of those participating in the research. The majority of ethical principles adhered to in the current study (independent review, informed consent, autonomy, competence, confidentiality and anonymity, non-maleficence, beneficence) could be viewed as parts of the overall respect for research participants (Emanuel et al., 2000; Quest & Marco, 2003).

5.8.1. Independent review.

In early years, researchers often took upon themselves the task of judgement regarding appropriate enrolment, and assessment of the risks and benefits of participating in research with little or no attention paid to ethical considerations (Quest & Marco, 2003). Adherence to ethically sound research principles is usually regulated by ethics committees. International guidelines require that all research involving human subjects must be submitted for review of their scientific merit and ethical acceptability to an independent ethics committee (Council for International Organizations of Medical Sciences, 1991). According to Weisberg et al. (1996), university-based research on human subjects must also be approved in advance by a review committee. The University of KwaZulu-Natal requires that every research study undertaken by its staff and students be subjected to ethics review. The review process, according to Jackson (2012), involves completing an application form in which the researcher details the method to be used in the study, the risks or benefits related to participating in the study, and the means of obtaining informed consent and maintaining participants' confidentiality. Ethics review committees are designed to provide third party review thereby minimising conflicts of interest, protecting the welfare of research participants through attention to risks, benefits, and informed consent, and avoiding exploitation of vulnerable individuals and populations (Benatar, 2002; Kaas et al., 2007). In brief, the main focus of these review committees is to protect research participants from harm and to ensure that they had given valid consent (Slowther, Boynton & Shaw, 2006). According to the World Medical Association (2001), this committee must be independent of the researcher, the sponsor or any other kind of undue influence and should act in conformity with the laws and regulations of the country in which research is performed. In the current study, ethical clearance was sought and obtained from the UKZN's HSSREC before the researcher could proceed with data collection. The ethical clearance number of this study is HSS/0527/013D and the copy of this ethical clearance is attached as Appendix E. To conclude, it is very important to note that the researcher in the current study was mindful of Orb, Eisenhauer and Wynaden's (2000) cautions that although ethical review boards scrutinise research proposals, the researchers themselves are ultimately responsible for protecting the participants.

5.8.2. Informed consent.

Obtaining informed consent is a prerequisite for participants to take part in any research. Consent is usually obtained with the use of a consent form, which is signed by the research participant before their participation in research (Jackson, 2012; Schofield, 2014). However, the process of obtaining the participant's informed consent is a great deal more complex than the mere signing of a form, but instead is a voluntary agreement to participate in research. According to Durrheim and Wassenaar (1999), as well as Wasunna, Tegli and Ndebele (2014), informed consent should be a process that involves conveying accurate and relevant information about the study, its purpose, potential benefits, known risks, alternatives and procedures, in a language which the participant best understands. This would make it possible for participants to decide whether to take part in the research study or not. Mandal and Parija (2014) emphasise that information entailed in a consent form must be true, should cover all the relevant aspects, and no fact should be hidden however seemingly important or unimportant.

In the current study, no participants were coerced to take part. Prior to participating in this study, all participants were required to sign a written informed consent form that detailed the aims of the study and their rights as participants. The consent form was available in isiZulu and English and was written in simple and clear language free from jargon. Copies of this consent form in both English and isiZulu languages can be seen as Appendices B and D, respectively. Both versions of the consent form were made available to the participants to choose from as it was logical that the participants would, in the first instance, opt for the form in their own language. For those participants who are unable to read and write, a consent form was read aloud to them by the researcher or research assistants. Once all participants indicated that they had understood the aims of the study and their rights as participants, and had been given a chance to ask questions and were satisfied, they were asked to sign a consent form or mark 'X' in place of their signatures if they were unable to write. The researcher in the current study was very mindful of the fact that the principle of informed consent is closely related to the principle of autonomy and competence. Nnebue (2013) substantiates this by suggesting that in order for informed consent to be considered valid, the consent must be given voluntarily and the participant must be competent.

5.8.3. Autonomy.

Seeking the informed consent of people before involving them in research is now, quite rightly, viewed as the standard and obligatory way of respecting their autonomy (Edwards, 2005). This should demonstrate that the autonomous participant has not been controlled or coerced in any way into consenting (Schofield, 2014). Therefore, the goal for an autonomous individual is to decide on his or her own, without undue manipulation by others, whether or not to participate in a study (Stiggelbout et al., 2004). For an autonomous decision to take part in research to be made, Hewlett (1996) states that participants must be provided with sufficient and unbiased information regarding the research study before they sign a consent form. To enhance autonomy, prior to signing a consent form, participants must be made aware that they are free to withdraw from the study at any time, without having to provide any reason whatsoever (Edwards, 2005; Stead, 2001). Schofield (2014) states very clearly that to achieve autonomous participation in any research the information sheet (or consent form) must make it clear that participants do not have to take part if they do not wish to do so and that they can withdraw from the study at any time without that decision affecting them in any negative way. This unconditional and absolute right of withdrawal from participating in the current study was made explicitly clear to each and every participant.

Although the consent form used in this study states that participants were free not to answer any particular question if they did not wish to, and that their participation was voluntary, autonomy was further enhanced verbally to each participant. Upon reading or having informed consent read to participants, they were personally asked if they understood that their participation is voluntary and that they have the right to withdraw from the study at any point if they should so wish. They were further informed that they did not have to provide reasons for withdrawing and that there would be no consequences for their withdrawal. Participants only proceeded to answer the rest of the questionnaire after indicating that this was clearly understood. Approximately 10 participants requested to withdraw from the study once they had started filling in the questionnaire. Although they were not asked the reason for withdrawing, about 6 of them volunteered this information and indicated that they did not have enough time because they were in a hurry. Some of those who exercised their autonomous right and withdrew from the study conveyed the impression that the questionnaire

was too long and completing the questionnaire would thus be too time-consuming. Data obtained from participants who withdrew from the study was not included for data analysis for two reasons: 1) most of these participants had not completed even half of the questionnaire and a great deal of information was missing; and 2) the main important reason to exclude data obtained from these participants was to respect their decision to exercise their right to withdraw and not be part of the study.

5.8.4. Competence.

Another important ethical consideration linked to informed consent and autonomous decision-making is competence. In essence, the *capacity* for informed consent and autonomous choice is a prerequisite for attaining informed consent and autonomy (Ursin, 2009). Schofield (2014) defines competence in research ethics as a participant having the decision-making capacity to utilise the information they have been given to make a free and voluntary decision. However, it is important to note that not all individuals are competent to make these kinds of decisions. In fact, Quest and Marco (2003) argue that some people (especially those that are vulnerable) may possess adequate autonomy, but may lack the capacity to understand or communicate opinions regarding participation in research. Where some or all of the research participants are likely to lack competence and be vulnerable to coercion or undue influence, such as children, prisoners or mentally disabled persons, additional safeguards have to be included in the study to protect the rights of these research participants (Wichman, 1998). In most of these cases, consent or assent of a family member or someone with legal responsibility for the participant would be required (Bournot-Trites, & Belanger, 2005; Slowther et al., 2006). Some individuals may need extensive protection to the extent of needing to be excluded from participating in research or other activities that may be harmful to themselves.

The basic principle observed in the current study, as stated by Slowther et al. (2006) is that research cannot (and should not) be carried out where it involves individuals who lack the capacity to give consent, unless it is not possible to conduct the research in any other way, for example, research on infants or people in intensive care units. All individuals under the age of 18 were regarded as minors and were excluded from participating in the current study. King and Churchill (2000) advise that persons under the age of 18 are generally not legally competent

to consent to participate in research, on the one hand. However, on the other hand, Alderson (2007) argues that adult research subjects are only assumed competent unless they obviously show serious incompetence. The inclusion of participants under the age of 18 in the current research would have lengthened the process of obtaining informed consent from them. Written consent from their parents would first have had to be obtained before they could give their assent to participate (Morrow & Richards, 1996). This would have taken much more time given the manner in which participants were recruited (randomly in the community) or else would have meant a deviation from the standardised participant recruitment procedure. Thus the decision to exclude minors from participating in the study, due to time and procedural limitations, was taken.

5.8.5. Confidentiality and anonymity.

The confidentiality and anonymity of research participants was maintained throughout this study. Ethical guidelines and textbooks all note the importance of enhancing confidentiality and anonymity in research (Emanuel et al., 2004; Wassenaar, 2006; Wasunna et al., 2014; Weisberg et al., 1996). These concepts are related but are different. According to Clark (2006), and Wiles, Crow, Heath and Charles (2008), the principle of confidentiality is taken to mean not disclosing to other parties identifiable information about individuals gathered during the process of research, on the one hand. To assure someone of confidentiality means that what has been discussed will not be repeated, or at least not without the participant's permission (Wiles, Crow et al., 2006). On the other hand, anonymity is defined by Ong and Weiss (2000) as a condition in which the identity of the respondent is not known. This is akin to the principle of privacy. Violation of confidentiality can occur when identifying information about the research participant is disclosed or disseminated to audiences for whom it was not intended without the participant's authorisation (Frankel & Siang, 1999).

Violation of confidentiality may occur not only deliberately, but also accidentally. According to Wiles et al. (2006), the best way of protecting the confidentiality of research participants, even from the possibility of accidentally breaking confidentiality, is through the process of anonymisation. Authors such as Clark (2006) as well as Crow and Wiles (2008) write that the commonly-used method of anonymising research participants is through the use of pseudonyms.

Confidentiality and anonymity of participants was strictly maintained throughout the current study. The nature of the current study (being quantitative/survey) required no need whatsoever to identify participants or to know which participant had completed which questionnaire. There was no need to even assign pseudonyms to participants in this study because nowhere in the questionnaires were participants required to fill in personally identifying information such as names, identity numbers, telephone numbers, residential addresses or any other information that could possibly identify them. Questionnaires were only given case numbers, ranging from 1 to 787, when data was computed in order to identify a particular questionnaire should there be a need to do so during the process of data cleaning and statistical analysis. It was stated in the consent form, and participants were also informed that their anonymity and confidentiality would be ensured. To further provide assurance to participants of confidentiality and anonymity, given the fact that protection of participants' identities also applies to publications (Orb et al., 2000), they were verbally informed that the results of the study would be reported on and presented in numerical and summary form, thus eliminating any possibility of presenting their identifying details. Emanuel et al. (2000) also agree that research ethics do not end with the signing of a consent document but also encompass the actual implementation, analysis, and dissemination or publication of research.

5.8.6. Non-maleficence.

Every research study should always be motivated by benevolent regard of its participants and stringent obligations of non-maleficence. According to Quest and Marco (2003), to conduct ethically sound research, the researcher must take appropriate steps to ensure that participants, including their families and communities, will not suffer undue medical, social and psychological harm in the name of research. Human research should never injure the people being studied, regardless of whether they have volunteered for the study (Babbie, 2011). The researcher is therefore obligated to carefully assess harms foreseeable from the research and to work assiduously to minimise or eliminate them (King & Churchill, 2000). Following this assessment, the researcher is compelled to disclose to participants the risks associated with being a participant in a research project (Lawrence, 2007).

Participants in the current study were recruited from the general community and the study did not seek vulnerable individuals as part of the sample. No direct physical or psychological harm was envisaged to be incurred by participants through the process of taking part in this study. However, it was acknowledged that there could be participants who have direct (personal) or indirect experience of mental illness (e.g. family members or relatives). The possibility that some of these participants could have previously suffered discrimination due to their mental illness or could even have discovered their mental illness in the course of this study was also taken into account. In response to this anticipation, plans were in place to refer participants who showed signs of distress from participating in this study. These participants were to be referred to their nearest mental health facility for management and care. The researcher held meetings with these facilities to ascertain the possibility of coping with the likely higher demand for consultations should the need arise. The researcher took note of the fact that it may take months for such participants to be attended to unless prior arrangement was in place to see them in the case of emergencies. Research assistants were trained and skilled enough to recognise the signs of distress, and to terminate the interview and refer participants accordingly. A few participants in the Greater Kokstad Municipality (less than 10) indicated that they did have someone at home with similar characteristics or symptoms to the vignette character. Such participants were given the telephone numbers of the psychology department at Usher Memorial Hospital in Kokstad to seek professional assistance. No participants with such encounters come forth in Kwa Sani Municipality.

5.8.7. Beneficence.

Ethical treatment of research participants not only implies respect for their decisions but also promotion of their well-being (La Vertu & Linares, 1990). Bulger (1994), Wichman (1998), as well as Quest and Marco (2003) state that beneficence with respect to research suggests that researchers will: 1) do no harm to the participants; and 2) ensure that the research itself will be designed to maximise possible benefits and minimise risks to the participants. According to Slowther et al. (2006), every research study conducted should benefit research participants directly, or the wider population, and the benefit of the research should significantly outweigh the potential harm to participants. When judging a research project according to the principle of beneficence, King and Churchill (2000) recommend that the research should be measured not by the potential for participation to benefit subjects, but instead should be measured by the design and goals of the research project and its promise of benefit to society. Frankel and Siang (1999) regard *benefits*, in broad terms, as gain to society or science through contribution to the knowledge base, gain to the individual through improved well-being, or improvement of the individual by giving him or her a voice. They consider *harms* to include, but these are not limited to, death and injury, psychological abuse, loss of privacy and public exposure, and they argue that these may not only affect individuals but the general society as well (Frankel & Siang, 1999).

Emphasising the principle of beneficence further, Benatar (2002) makes the argument that every research study must improve the lives of the participants by ensuring that research involving them results in beneficial results being made available to individuals and their communities. Having participated in the research, the participants and host community have the right to know what was found and its implications for practice and policies (Emanuel et al., 2004). Emanuel et al. (2000) recommend that the results of ethically sound studies should be disseminated, although publication in peer-reviewed journals need not be the primary or only mechanism to do so. Although it was stated in the consent form and participants were made aware that the results of this study will result in a doctoral thesis and will be published in accredited journals, it became apparent from the first few participants recruited that they wanted to know how they will personally benefit from taking part in the study. The researcher immediately standardised a response to this as a routine prior to participants signing a consent form. Every participant was informed that there are no direct, immediate, personal

benefits for taking part in the study. However, they were informed that their participation will benefit their communities and will assist in gaining new knowledge about people's understanding of mental illness. They were further informed that information obtained from them could be used by health planners for the provision of mental health services, government officials or other community-based organisations engaged in health training and community education. Participants appeared to be satisfied with this answer.

The findings of this study will also be disseminated in executive summary form and a presentation to the gatekeepers, such as the SAPS, municipal managers, ward councillors and so forth, who assisted in allowing access to participants will be facilitated. The executive summary of the results will also be made available and will be presented to the Department of Health at KwaZulu-Natal provincial level. Care will be taken to ensure that these results are presented in a language that these gatekeepers and stakeholders are most comfortable with. Emanuel et al. (2000) support this idea, and state that research should generate greater improvements in health or well-being, the state of scientific understanding, and the feasibility of implementing intervention should be of a higher value.

In summation, the researcher in the current study adhered strictly to all these ethical principles and bore in mind that a breach in these principles at any level may render the research unethical. Also, the comment by Emanuel, Wendler and Grady (2000) that ethical requirements for research do not end when participants either sign the consent form and participate in research or refuse to sign the consent form, but continues throughout their participation and even after their participation ends, was and will be treated with utmost respect throughout this study.

5.8.8. Data storage.

The data collected for this study is stored on a memory stick and the questionnaires are kept safely in the office of the researcher at the University of KwaZulu-Natal in the School of Applied Human Sciences, Discipline of Psychology. Data and the questionnaires will be retained for a period of five years after which they will be destroyed.

5.9. Conclusion

This chapter presented the research methodology that was followed to bring this study to realisation. A description of where this study was conducted, Sisonke District, was provided in the initial section of the chapter. This was followed by a presentation of the quantitative research design and the motivation for its selection, the data collection instrument and an account of how it was adapted for the purpose of this study. This process entailed pre-testing the questionnaire and conducting a pilot study. The procedure followed in the main study and the methods of statistical data analysis used to interpret the data were also presented in this chapter. This chapter concluded with a discussion of the ethical considerations taken in account, which were rigorously observed throughout the process of conducting this study. The next two chapters present the results of the study.

Chapter 6

Results: Part I

This chapter presents the results of this study. It begins with the presentation of the demographic characteristics of the sample. The main results are then presented in the following three main sections: Part I presents the results on the conceptions of mental disorders; knowledge and attitudes toward help-seeking and interventions for mental health problems as well as the attitudes towards mental illness are presented in the next chapter. Significant values of statistical tests such as Chi-square, and other appropriate tests, will also be presented where results are significant. Tables and graphs will be used to provide an accessible view of the results. This chapter ends with a conclusion whereby key findings will be summarised.

6.1. Demographic Characteristics of the Sample

Of the total sample ($n = 787$), 606 (77%) and 181 (23%) of participants were recruited from the Greater Kokstad and Kwa Sani Municipalities, respectively. Of the total sample, 490 (62.3%) females and 297 (37.7%) males participated in this study. The ages of participants ranged from 18 to 86, with mean age of 34 years and standard deviation of 12.93. Age was further categorised into the following four age groups: 18 – 34 ($n = 484$, 61.5%), 35 – 49 ($n = 209$, 26.6%), 50 – 64 ($n = 66$, 8.4%) as well as 65 and above ($n = 28$, 3.6%). These age categories have previously been used in a South African study of lifetime prevalence of psychiatric disorders (Stein et al., 2008). Due to ethical reasons related to seeking permission and consent when including minors as research participants, participants under the age of 18 did not form part of this sample. The distribution of respondents according to their level of education shows that the majority of participants ($n = 531$, 67.5%) had a secondary level of education followed by those that had a primary level of education ($n = 155$, 19.7%). Only 73 (9.3%) respondents had attained a tertiary level of education, and 28 (3.6%) had never attended school. Demographic characteristics of the sample according to gender, age and education are presented in Table 6.1.

Table 6.1: Demographic characteristics of the sample by municipality

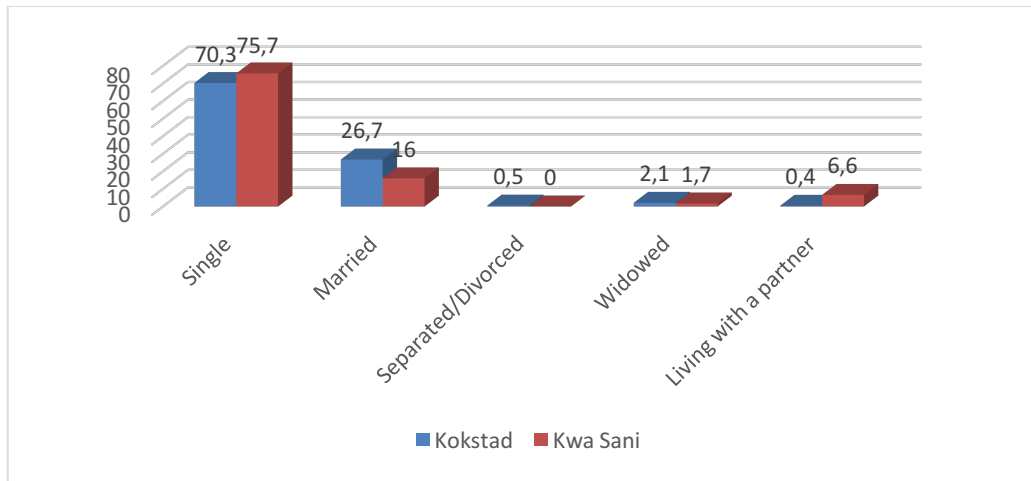
Characteristics	Kokstad N= 606 (77%)	Kwa Sani N= 181 (23.0%)	Total N= 787	χ^2 / Fisher's exact test
Gender				
Female	369 (60.9%)	121 (66.9%)	490 (62.3%)	2.107
Male	237 (39.1%)	60 (33.1%)	297 (37.7%)	
Age groups				
18-34	365 (60.2%)	119 (65.7%)	484 (61.5%)	2.153
35-49	167 (27.6%)	42 (23.2%)	209 (26.6%)	
50-64	53 (8.7%)	13 (7.2%)	66 (8.4%)	
65+	21 (3.5%)	7 (3.9%)	28 (3.6%)	
Education				
Never went to school	19 (3.1%)	9 (5.0%)	28 (3.6%)	6.398
Primary	120 (19.8%)	35 (19.3%)	155 (19.7%)	
Secondary	403 (66.5%)	128 (70.7%)	531 (67.5%)	
Tertiary	64 (10.6%)	9 (5.0%)	73 (9.3%)	

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Chi-square analysis was performed to compare the differences between the sample across the two municipalities (Greater Kokstad and Kwa Sani) in terms of the demographic variables of gender, age groups and education. As can be seen in Table 6.1 above, the results show no significant differences in the distribution of these variables across the two municipalities. This suggests a somewhat similar or equivalent distribution of the sample according to these variables.

Regarding marital status, the majority of participants ($n = 563$, 71.5%) were single, followed by 191 (24.3%) and 16 (2.0%) that were married and widowed, respectively. A small percentage of participants recorded living with a partner ($n = 14$, 1.8%) or being separated or divorced ($n = 3$, 0.4%). Figure 6.1 below presents these results graphically. Of note, there were more participants living with a partner in Kwa Sani ($n = 12$, 6.6%) than Kokstad ($n = 2$, 0.4%), on the one hand. On the other hand, there were more married participants in Kokstad ($n = 162$, 26.7%) than in Kwa Sani ($n = 29$, 16%). However, due to the small sample size, as indicated by more than 40% of the cells having expected values < 0.5 , a test of significant differences could not be performed between these two geographical areas using marital status as a demographic variable.

Figure 6.1: Participants' marital status



With respect to religious affiliation, 683 (86.8%) participants were Christians and 59 (7.5%) indicated that they were non-religious. All remaining religious affiliations accounted for a total of 45 (5.9%) participants. The home languages spoken by most of the participants were isiXhosa ($n = 529$, 67.2%), isiZulu ($n = 225$, 28.6%) and Sesotho ($n = 29$, 3.7%). Other South African languages accounted for approximately 4 (1%) participants combined. Table 6.2 shows these results in detail. Once more, a test of statistical differences between these variables could not be performed due to over 40% of cells having expected values < 0.5 .

Table 6.2: Demographic variables between Kokstad and Kwa Sani according to religion and language

Characteristics	Kokstad N= 606 (77%)	Kwa Sani N= 181 (23.0%)	Total N= 787	χ^2 / Fisher's exact test
Religion				
Atheist	20 (3.3%)	0 (0.0%)	20 (2.5%)	
Christian	529 (87.3%)	154 (85.1%)	683 (86.8%)	
Jehovah's Witness	2 (0.3%)	0 (0.0%)	2 (0.3%)	
Muslim	2 (0.3%)	0 (0.0%)	2 (0.3%)	
African Religion	12 (2.0%)	9 (5.0%)	21 (2.7%)	
Non-Religious	41 (6.8%)	18 (9.9%)	59 (7.5%)	
Language				
isiZulu	62 (10.2%)	163 (90.1%)	225 (28.6%)	
Sepedi	0 (0.0%)	1 (0.6%)	1 (0.1%)	
Tswana	0 (0.0%)	1 (0.6%)	1 (0.1%)	
English	2 (0.3%)	0 (0.0%)	2 (0.3%)	
Sesotho	24 (4.0%)	5 (2.8%)	29 (3.7%)	
isiXhosa	518 (85.5%)	11 (6.1%)	529 (67.2%)	

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Trends noted in the demographics of the sample show that fewer males than females participated in this study. Despite the fact that females generally outnumber males, the fact that more females took part in the study is likely to be due to migrant labour patterns that have resulted in men working in the mines and urban areas and seeking better employment opportunities. The majority of participants are also young adults between the ages of 18 and 34, who are single and have attained a secondary level of education. The design of the study and its methodologies are likely to have influenced this trend. Being a survey that randomly recruited participants mostly during the day when the majority of much older and married individuals are at work could have resulted in the recruitment of more young adults. There were also more participants who speak isiZulu from Kwa Sani Municipality, on the one hand. On the other hand, more participants from Kokstad speak isiXhosa. It is possible that more isiXhosa-speaking participants from Kokstad being selected is due to the historical background of this area as it used to belong to the Eastern Cape, a province predominantly populated by isiXhosa-speaking inhabitants.

Although this is not part of the sample demographics, the researcher deemed it important to show here how the vignettes were distributed across the two municipalities. As stated in the previous chapter, each participant was

randomly assigned to one of the three vignettes. A test of significant differences shows no significant differences between how the vignettes were distributed between Kokstad and Kwa Sani Municipalities. Table 6.3 shows these results in detail.

Table 6.3: Distribution of the vignettes between Kokstad and Kwa Sani

Characteristics	Kokstad N= 606 (77%)	Kwa Sani N= 181 (23.0%)	Total N= 787	χ^2 / Fisher's exact test
Vignette				
Depression	197 (32.5%)	62 (34.3%)	259 (32.9%)	0.213
Schizophrenia	199 (32.8%)	57 (31.5%)	256 (32.5%)	
Alcohol	210 (34.7%)	62 (34.2%)	272 (34.6%)	
dependency				

*p < 0.05, **p < 0.01, ***p < 0.001

6.2. Conceptions and Causes of Mental Disorders

Results regarding participants' explanations of mental disorders and labels attached to these disorders as depicted in a vignette are presented first in this section. The focus is not on the correct usage of diagnostic labels with regard to mental disorders, but on participants' conceptualisations of mental disorders and what participants would call, or how they would describe these conceptualisations in their own language. This will be followed by results related to participants' aetiological beliefs, that is, what participants thought was the cause of the mental illness. Apart from presenting the results on the beliefs about the aetiology of mental disorders in relation to demographic variables, the last part of this section presents the results concerning the relationship between the ability to recognise mental illness and aetiological beliefs.

6.2.1. Conceptions of mental disorders.

To assess how mental disorders are conceptualised, participants were asked what they would say is wrong with or is happening to someone depicted in any of the three vignettes. Participants' free responses varied too greatly to permit meaningful statistical analysis. Their responses were therefore assigned to five different categories: 1) medical (e.g. HIV positive, TB, fever, physically sick, always tired etc.); 2) psychological (e.g. low self-esteem, depression, mentally disturbed,

losing the mind, stressed, not in the right frame of mind, hallucinations etc.); 3) social (e.g. isolating oneself, having no one to talk to, lack of family or social support, financial problems etc.); 4) traditional (e.g. being troubled by ancestors, failure to perform traditional rituals, possession by ancestral spirits etc.); and 5) not indicated (e.g. these are all those who did not answer this question). Table 6.4 below presents a more detailed list of categories used to conceptualise mental illness and examples of responses that participants gave to any of the three vignettes presented to them. Three registered clinical psychologists were asked separately to verify the five categories, and they were all in agreement with these. Categories created for other responses or questions to be presented in this chapter as well as in the next chapter were also checked by these psychologists and agreed upon.

Table 6.4: Categories used to conceptualise mental illness and examples of responses

Category of explanation	Examples of responses
Medical	HIV positive, TB, fever, physically sick, AIDS, always tired, some sort of an illness, suffering from health problems, not feeling well, drinking too much because of AIDS, no appetite, ill, unwell, life has come to an end maybe because of HIV, weight loss, too much alcohol in the body, etc.
Psychological	Low self-esteem, depression, mentally disturbed, losing the mind, abused, becoming mentally ill, change of behaviour, depressed, drinking too much, failure to accept grandmother's death, feeling sad, shy, not well mentally, seeing unreal people, lack of confidence, hearing voices, miserable, etc.
Social	Isolating oneself, having no one to talk to, lack of social or family support, financial problems, being alone, not treated well by community, family problems, life is not going well, problems at work, relationship difficulties, etc.
Traditional	Being troubled by ancestors, failure to perform traditional rituals, possession by ancestral spirits, ancestors want a cow to be slaughtered, ancestral spirit entering, probably did things that people did not like, etc.

More than half of the total participants ($n = 480$, 61%) reported that the person presented in any of the vignettes suffered from a psychological problem, followed by problems that were social ($n = 167$, 21.2%) and medical ($n = 107$, 13.6%) in nature. These results are shown in Table 6.5 below. An analysis according to a

specific disorder showed a similar explanation trend for schizophrenia and alcohol dependency where these conditions were largely explained as psychological and social in nature. However, the third explanation given for schizophrenia was traditional and for depression was medical in nature.

It is apparent from Table 6.5 that for schizophrenia, 133 (52%) participants in the sample thought that this condition was a psychological problem, followed by 85 (33.2%) and 21 (8.2%) who thought that the condition was social and traditional, respectively. However, depression was conceptualised as a psychological problem by 97 (37.5%) participants followed by 93 (35.9%) who conceptualised it as a medical condition and 68 (26.3%) who explained it as a social problem. The overwhelming majority of participants ($n = 250$, 91.9%) explained alcohol dependency as a psychological problem, followed by 14 (5.1%) and 4 (1.5%) who explained this condition as social and medical problems, respectively. Figure 6.2 below presents a visual summary of respondents' recognition beliefs of the three disorders. For a clearer understanding, Table 6.6 below provides specific examples that participants used to explain different mental disorders. It becomes noticeable from this table that similar explanations for mental disorders were used across different disorders. For example, AIDS and TB were used as medical explanations for both depression and alcohol dependency, and financial difficulty was used as a social explanation across the three disorders.

Chi-square analysis shows significant differences between explanations of mental disorders and specific mental disorders (vignettes), thus showing that more participants in this study, $\chi^2 (8, N = 250) = 313.27, p < 0.001$ were likely to conceptualise alcohol dependency as a psychological problem.

Table 6.5: Percentages of respondents' recognition of the disorder

Category of explanation	Disorder, N (%)			Total (%)
	Depression	Schizophrenia	Alcohol Dependency	
Medical	93 (35.9%)	10 (3.9%)	4 (1.5%)	107 (13.6%)
Psychological	97 (37.5%)	133 (52.0%)	250 (91.9%)***	480 (61.0%)
Social	68 (26.3%)	85 (33.2%)	14 (5.1%)	167 (21.2%)
Traditional	0 (0.0%)	21 (8.2%)	0 (0.0%)	21 (2.7%)
Not indicated	1 (0.4%)	7 (2.7%)	4 (1.5%)	12 (1.5%)
Total	259	256	272	787 (100%)

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Figure 6.2: Recognition beliefs of the three disorders

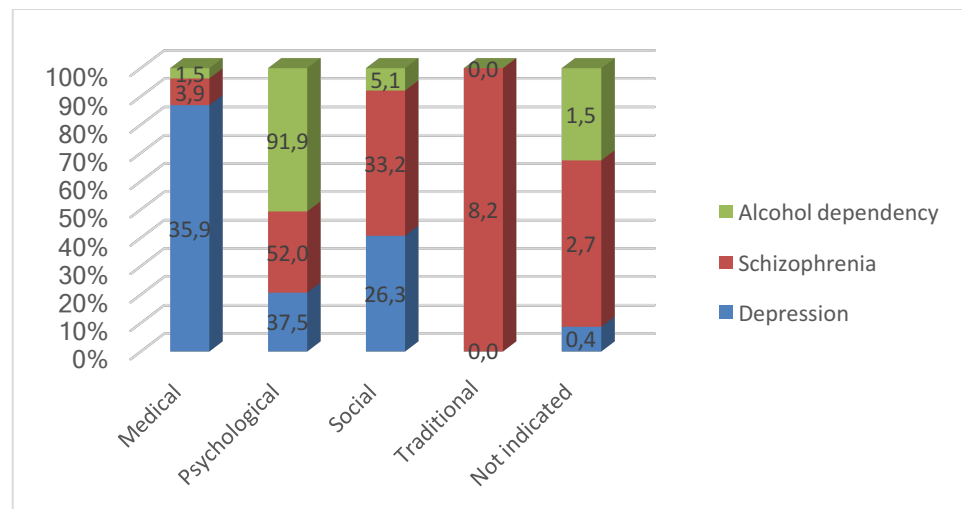


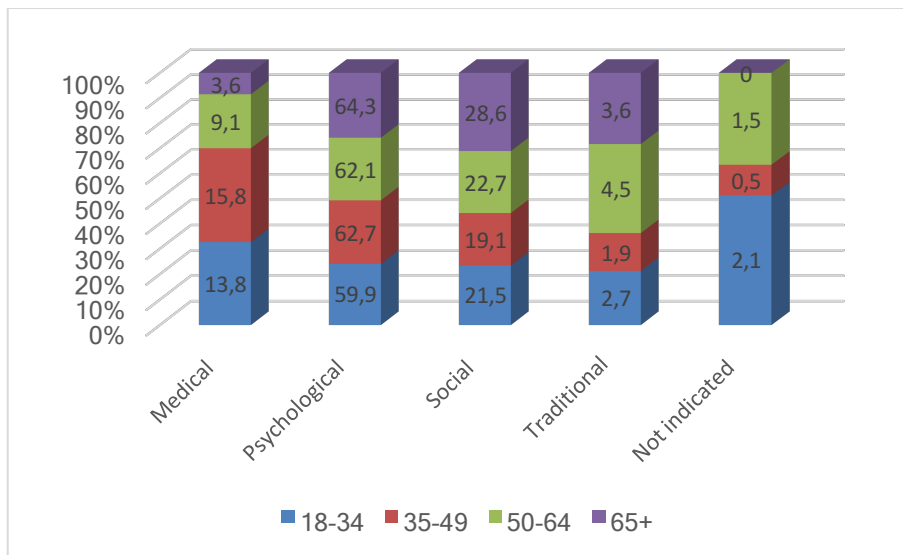
Table 6.6: Examples used to explain mental disorders

Category of explanation	Disorder		
	Depression	Schizophrenia	Alcohol dependency
Medical	AIDS, fever, a gall problem, HIV positive, feeling unwell, being sick or ill, no appetite, physically sick, weight loss, TB, poor health, some illness troubling him, always tired, not feeling well, ill, life has come to an end maybe because of HIV	Feeling unwell, being sick, some sort of an illness	He is sick, suffering from health problems, TB, too much alcohol in the body, drinking too much because of AIDS
Psychological	Abused, suicidal, being worried, sleeping difficulties, feeling miserable, feeling sad, low self-esteem, feeling depressed, shy, stressed, forgetful, mentally disturbed, depression	Affected badly by grandmother's death, becoming psychologically ill, losing the mind, beginning to be mad, being traumatised, depressed, emotional problems, not accepting death of a grandmother, mentally disturbed, being delusional, stressed, thinking too much, lost his mind, mental illness, change of behaviour,	Abusing alcohol, addicted to alcohol, alcohol intoxication, difficult to control alcohol drinking, drinking too much alcohol, facing some depressing situation, stressed, lost his mind, mentally disturbed, not well mentally
Social	Family problems, keeping a secret from others, failing to do daily tasks, not living within budget, unresolved family issues, not getting enough love from family, financial problems, no support from parents	Being lonely, community not treating this person well, family not supportive, financial problems, there is a big problem, isolating self from other people	There is a problem that forces this person to drink alcohol, starting an alcoholic lifestyle, personal problems, thinking too much about his problems, having no one to talk to, problems at work, financial problems
Traditional	None	Troubled by ancestors, ancestors want a goat to be slaughtered, ancestral spirit entering this person, probably did things that people did not like, bewitchment, <i>ukuthwasa</i> ,	None

6.2.1.1. Explanations of mental illness and demographic variables.

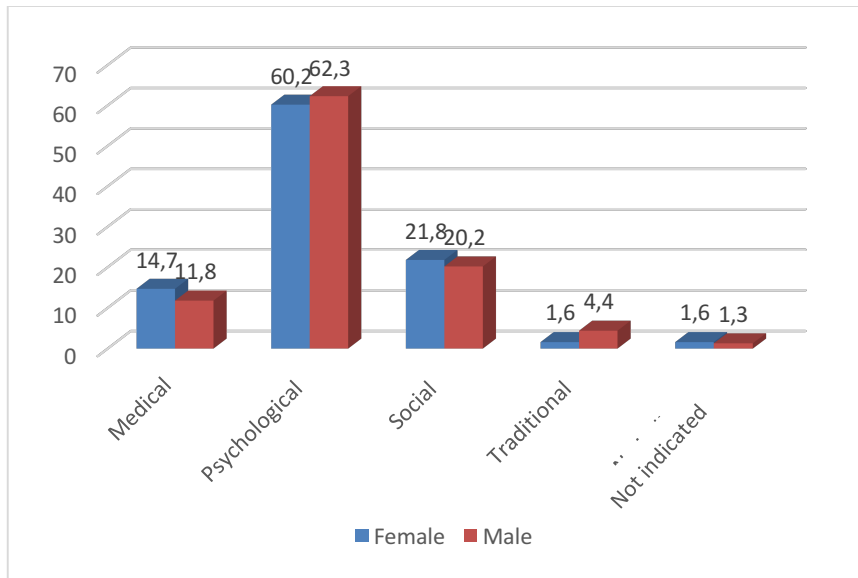
Chi-square analysis using age, gender and education variables showed no significant results with regard to explanations of mental illness. However, it is evident that participants of all age groups explained mental illness as psychological in nature. As depicted in Figure 6.3 below, about 33 (15.8%) participants between the ages of 35 – 49 used medical explanations for mental illness. Social explanations for mental illness were used more by participants over the ages of 65 ($n = 8$, 28.6%). Traditional explanations for mental illness were used more by participants between the ages of 50 – 60 ($n = 3$, 4.5%).

Figure 6.3: Explanations of mental illness according to age



Regarding gender, both male and female participants used psychological followed by social explanations for mental illness. However, medical explanations for mental illness were used by more females ($n = 72$, 14.7%), and traditional explanations were used more by males ($n = 13$, 4.4%). Figure 6.4 below provides a visual presentation of these results.

Figure 6.4: Explanations of mental illness according to gender



6.2.1.2. Explanations of mental illness by geographical location.

An analysis of participants' explanations of mental illness according to geographical location was conducted as it was anticipated that responses of participants from more urban areas (Kokstad) would differ from those of participants from rural areas (Kwa Sani). The results show that participants from Kokstad explained all three disorders as psychological problems. However, 25 (43.9%) and 60 (96.8%) of the participants from Kwa Sani explained both schizophrenia and alcohol dependency as psychological problems, respectively, and 24 (38.7%) explained depression as a medical problem. Table 6.7 below shows these results in greater detail. No significant differences were found between gender variable and geographical location on Chi-square analysis. Others variables do not meet statistical assumption for Chi-square analysis in terms of explanations of mental illness.

Table 6.7: Explanations of mental illness according to geographical location

Category of explanation	Depression		Schizophrenia		Alcohol dependency	
	Kokstad	Kwa Sani	Kokstad	Kwa Sani	Kokstad	Kwa Sani
Medical	69 (35%)	24 (38.7%)	6 (3.0%)	4 (7.0%)	4 (1.9%)	0 (0.0%)
Psychological	78 (39.6%)	19 (30.6%)	108 (54.3%)	25 (43.9%)	190 (90.5%)	60 (96.8%)
Social	49 (24.9%)	49 (24.9%)	61 (30.7%)	24 (42.1%)	13 (6.2%)	1 (1.6%)
Traditional	0 (0.0%)	0 (0.0%)	19 (9.5%)	2 (3.5%)	0 (0.0%)	0 (0.0%)
Not indicated	1 (0.5%)	0 (0.0%)	5 (2.5%)	2 (3.5%)	3 (1.4%)	1 (1.6%)

6.2.1.3. Predictors of conceptualisation of mental illness

Multinomial logistic regression analysis was conducted to determine demographic factors that predict conceptualisation of mental illness. The results of multinomial logistic regression analysis in Table 6.8 below show that the odds of participants between the ages of 35 – 49 conceptualising mental illness as social rather than medical were 0.10 times those of participants aged 65 and above (OR = .10, 95% CI = .01 to 1.0). Regarding gender, females were less likely, compared to males, to conceptualise mental illness as traditional instead of medical (OR = .31, 95% CI = .10 to .94). An analysis according to level of education shows that the odds of participants with primary education conceptualising mental illness as psychological rather than medical was 0.81 times less likely than participants with a tertiary level of education (OR = .19, 95% CI = .05 to .61).

Table 6.8: Multinomial logistic regression analysis of conceptualisation of mental illness and demographic variables

Variable	Psychological		Social		Traditional	
	B	OR (95% CI)	B	OR (95% CI)	B	OR (95% CI)
Age						
18 - 34	-1.849	.15 (.07/1.4)	-2.039	.13 (.01/1.2)	-1.769	.17 (.05/6.2)
35 – 49	-1.705	.18 (.01/1.7)	-2.225	.10 (.01/1.0)*	-2.394	.09 (.01/3.9)
50 - 64	-1.224	.29 (.02/3.1)	-1.427	.24 (.02/2.6)	-.375	.68 (.01/28.6)
65+	0 ^b		0 ^b		0 ^b	
Gender						
Female	-.221	.81 (.47/1.3)	-.025	.97 (.55/1.7)	-1.159	.31 (.10/.94)*
Male	0 ^b		0 ^b		0 ^b	
District						
Kokstad	.172	1.1 (.66/2.1)	-.043	.95 (.52/1.7)	1.466	4.3 (.84/22.2)
Kwa Sani	0 ^b		0 ^b		0 ^b	
Education						
No schooling	-.443	.64 (.09/4.5)	-.034	.96 (.11/8.1)	2.219	9.1 (.27/303.2)
Primary	-1.659	.19 (.05/.61)**	-.647	.52 (.14/1.8)	-.211	.80 (.05/11.2)
Secondary	-.904	.40 (.14/1.1)	-.174	.84 (.26/2.6)	.779	2.1 (.21/22.0)
Tertiary	0 ^b		0 ^b		0 ^b	

Note: Reference category is medical (n = 107).

B = Logistic coefficient. SE = Standard Error. OR= Odds Ratio. 95% CI = 95% Confidence interval.

*p < 0.05, **p < 0.01, ***p < 0.001

^b = This parameter is set at zero because it is redundant

6.2.1.4. Labelling of conditions by participants.

Given that participants in this study were all black South Africans who mainly spoke indigenous African languages as their first language, as well as the lack of established African vocabulary for psychiatric illness, this study did not seek to determine whether participants assigned correct diagnostic labels to mental illness or not. Instead, the aim was to ascertain what participants would call or how they would describe mental illness in their own language. When asked what they would call the problem presented in the vignette, participants' responses varied too

greatly to permit statistical analysis. Table 6.9 presents a summary of labels used by participants for each of the three disorders. Interestingly, 232 (29.5%) of the participants used the label *stress* to any of the three mental disorders presented to them. Of those who used *stress* as a label, 100 participants used this label for the depression vignette, while 55 and 77 participants used this label for schizophrenia and depression, respectively.

Table 6.9: Labels used for mental disorders

Labels used		
Depression	Schizophrenia	Alcohol dependency
<ul style="list-style-type: none"> ▪ AIDS ▪ Forgetfulness ▪ Mental disturbance ▪ General sickness ▪ Bipolar ▪ Depression ▪ Stress ▪ Family crisis ▪ Fatigue ▪ Fever ▪ Cancer ▪ Low self-esteem ▪ Illness ▪ Not well ▪ Traumatized ▪ HIV ▪ Hopeless ▪ TB ▪ Mental illness ▪ Loneliness ▪ Suicidal ▪ Mental illness ▪ Paranoia 	<ul style="list-style-type: none"> ▪ Calling to become a traditional healer ▪ Ancestral calling ▪ Bad luck ▪ Possessed by ancestral spirit ▪ Abused ▪ Mental disturbance ▪ Bewitchment ▪ <i>Ukuthwasa</i> ▪ Depression ▪ Mental illness ▪ Fear ▪ Death of a grandmother ▪ Madness ▪ Traumatized ▪ Not well ▪ Hopeless ▪ Loneliness ▪ Losing the mind ▪ Stress 	<ul style="list-style-type: none"> ▪ Alcohol addiction ▪ Alcohol abuse ▪ Alcohol dependence ▪ Alcoholic ▪ Drunkard ▪ Depression ▪ Drinking problem ▪ Drinking too much ▪ Failing to deal with problems ▪ Not well ▪ Mental illness ▪ Stress ▪ Peer pressure ▪ Traumatized

For the depression vignette, most participants called mental illness by a variety of other labels such as having AIDS, mental disturbance, general sickness, bipolar, depression, stress, fever, fatigue, HIV positive, TB, suicidal, mental illness, low self-esteem, and so forth. Only 21 (8.1%) of the participants who were shown a depression vignette were able to label this vignette correctly. Labels such as calling to become a traditional healer, bad luck, madness, mental disturbance, bewitchment, *ukuthwasa*, depression, fear, traumatized, losing the mind, stress, and so on were ascribed to the schizophrenia vignette. A diagnostic label of depression was used by 47 (6%) of the participants who were shown the vignette depicting schizophrenia. Regarding alcohol dependency, commonly used labels were alcohol addiction, alcohol abuse, alcohol dependence, drunkard, depression, stress, mental illness, peer pressure, traumatized, and so forth. Only 6 (2.2%) participants were able to correctly label the vignette depicting alcohol dependency.

6.2.2. Beliefs about aetiology.

Beliefs about aetiology of mental illness were assessed in a number of different ways. Firstly, participants were asked an open-ended question about their beliefs regarding aetiology of mental illness. Secondly, they were given a list of possible aetiological factors and asked to select the ones that they think were most likely to be the cause of a condition presented in a vignette.

Participants were first asked what they thought was the cause of the illness of a person depicted in a vignette. Their free responses were categorised into the following five aetiological belief categories based on face validity: 1) medical (e.g. loss of weight, having sexually transmitted disease, genetically inherited, tiredness, being physically sick without knowing that you are sick, etc.); 2) psychological (e.g. mental disturbance, low self-confidence, stress, mourning difficulties, thinking too much, lack of self-control, etc.); 3) social (e.g. problems at home or at work, unemployment, lack of social support, bad influence from friends, relationship problems, financial problems, etc.); 4) traditional (e.g. ancestors, the need to slaughter for ancestors, possession by ancestral spirits, the need to perform traditional rituals, etc.); 5) not indicated (all those who did not answer this question). Table 6.10 presents the categories of aetiological beliefs and examples provided by participants. Of note, no participants ascribed religious aetiological beliefs to mental illness when answering this question.

Table 6.10: Categories of aetiological belief and example of responses

Category of aetiology	Examples of responses
Medical	Fatigue, chest, allowing to be overpowered by sickness, genetic predisposition, unprotected sex, physically sick without knowing, loss of weight, having sexually transmitted disease, HIV, loss of appetite, illness that is afraid to disclose, diabetes, weak health, infected by others, loss of energy, AIDS, maybe pregnancy, not cleansing body system, sexual intercourse, TB, etc.
Psychological	Abuse, addiction to alcohol, being controlled by alcohol, anger, anorexia, not accepting death of a grandmother, stress, worrying, depression, drinking too much alcohol, drugs, losing the mind, mental illness, anger, failure to accept that there is a problem, too much thinking, mind not working properly, low self-esteem, mental disturbance, not going to counselling after the grandmother's death, etc.
Social	Bad influence from friends, being afraid what others would say, being alone, boredom, being silly, unemployment, unhappy at home, facing difficult times, financial problems, lack of social support, friends, having no one to talk to, friends who drink alcohol, problems at work, relationship problems, family problems, ill treatment at work, life problems, peer pressure, family problems, etc.
Traditional	Ancestors, ancestors want something, ancestors want him to slaughter, ancestral spirit, bewitched, <i>ukuthwasa</i> , loved by ancestors, a need to slaughter for the ancestors, the deceased grandmother, need to perform traditional rituals, etc.

Worth mentioning with regard to the table above is that over 93 (11.8%) participants thought that any of the three disorders could be caused by stress. In general, for all three vignettes, the majority of the participants believed that mental illness is caused by psychological ($n = 340$, 44.5%), followed by social ($n = 274$, 34.8%) and medical ($n = 96$, 12.2%) factors. Only a small percentage of participants ($n = 39$, 5%) believed that mental illness is caused by traditional factors, and this was mostly associated with the schizophrenia vignette. Detailed percentages of respondents' aetiological beliefs are shown in Table 6.11 below.

Table 6.11: Percentages of the respondents' aetiological beliefs

Aetiological beliefs	Disorder, <i>n</i> , (%)			Total (%)
	Depression	Schizophrenia	Alcohol Dependency	
Medical	79 (30.5%)	11 (4.3%)	6 (2.2%)	96 (12.2%)
Psychological	78 (30.1%)	126 (49.2%)	146 (53.7%)	350 (44.5%)
Social	92 (35.5%)	76 (29.7%)	106 (39.0%)	274 (34.8%)
Traditional	0 (0.0%)	37 (14.5%)	2 (0.7%)	39 (5%)
Not indicated	10 (3.9%)	6 (2.3%)	12 (4.4%)	28 (3.6%)
Total	259	256	272	787 (100%)

The most likely aetiological belief for depression was socially related ($n = 92$, 35.5%) followed by those that were medically ($n = 79$, 30.5%) and psychologically ($n = 78$, 30.1%) related. For schizophrenia, 126 (49.2%) participants believed that psychological factors are likely the causes for this disorder, followed by 76 (29.7%) and 37 (14.5%) participants who believed that schizophrenia is caused by social and traditional factors, respectively. However, for alcohol dependency, more participants ($n = 146$, 53.7%) believed that this disorder is caused by factors that are psychological, followed by 106 (39.0%) participants who believed that this disorder is caused by social factors, with only 6 (2.2%) attributing the cause of alcohol dependency to medical factors. Figure 6.5 presents these results graphically and Table 6.12 presents examples of aetiological beliefs according to different disorders. Chi-square analysis to determine if there are differences regarding aetiological beliefs and a particular mental illness indicates that most participants believed that alcohol dependency is due to psychological aetiological factors, $\chi^2 (8, N = 146) = 199.19, p < 0.001$.

Figure 6.5: Respondents' aetiological beliefs of mental illness

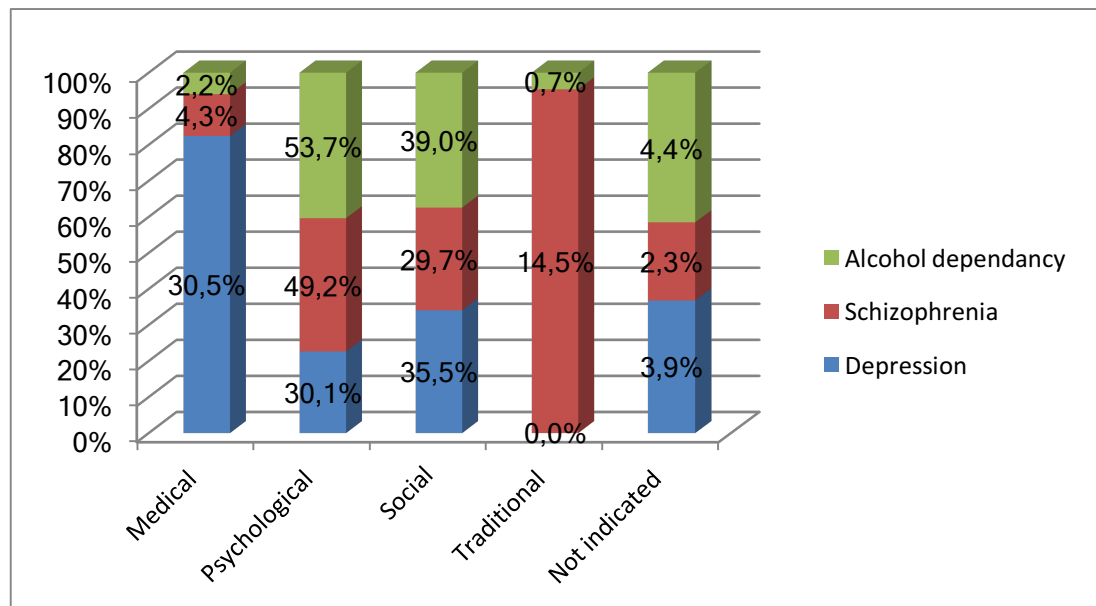


Table 6.12: Examples of aetiological beliefs according to disorders

Aetiological beliefs	Disorder		
	Depression	Schizophrenia	Alcohol dependency
Medical	Chest, genetic predisposition, HIV positive, diabetes, unprotected sex, weak health, inherited this illness, loss of appetite, physical illness, maybe pregnancy, physically sick without knowing, sexually transmitted disease, not cleansing body system, fatigue, allowing to be overpowered by sickness, loss of energy, etc.	Genetic inheritance, some kind of an illness, HIV positive, sickness, never accepted HIV status, madness caused by HIV, etc.	Sickness, some illness, maybe is sick and doesn't want to talk, illness that is afraid to disclose, TB, etc.
Psychological	Always tired, anger, anorexia, worrying, lack of confidence, too much thinking, low self-esteem, mental illness, not receiving counselling about his problems, stress, traumatised, etc.	Abuse, not accepting death of a grandmother, depressed, drugs, feeling worthless, too much thinking, losing the mind, hearing grandmother's voice, low self-esteem, maybe using illegal drugs, mentally disturbed, missing grandmother, seeing dead grandmother, stress, not going to counselling after grandmother's death, mind not working properly, traumatised, using drugs, etc.	Addiction to alcohol, being controlled by alcohol, depression, drinking too much alcohol, drugs, alcohol dependence, failure to accept that there is a problem, too much thinking, stress, mentally disturbed, misbehaving, traumatised, being worried by something, etc.
Social	Facing difficult times, family problems, problems at work, financial difficulties, problems that are difficult to deal with, being secretive, lack of social support, unhappy at home, unemployment, etc.	Being alone, family problems, having no one to talk to, isolating self too much, life problems, etc.	Bad influence from friends, being afraid what others would say, being alone, boredom, family problems, friends, being silly, a lot of problems, friends who drink alcohol, unemployment, friends who drink alcohol, financial problems, peer pressure, relationship problems, etc.

Table 6.12: Examples of aetiological beliefs according to disorders *continued*

		Disorder	
Aetiological beliefs	Depression	Schizophrenia	Alcohol dependency
Traditional	None	Ancestors want something, ancestors want him to slaughter, ancestral spirit, bewitchment, <i>ukuthwasa</i> , loved by ancestors, a need to slaughter for the ancestors, failed to perform certain rituals, the deceased grandmother, need to perform traditional rituals, possessed by ancestral spirit,	Ancestors, maybe bewitchment, etc.

6.2.2.1. Aetiological beliefs about mental illness and demographic variables

Chi-square analysis using the variable of gender does not indicate significant differences regarding participants' aetiological beliefs. Other demographic variables do not meet assumptions necessary to perform Chi-square analysis. However, all demographic variables, with the exception of age, reflect the same pattern of aetiological beliefs, whereby psychological factors, followed by social and medical factors are considered to be the causes of mental disorders. With regard to the variable of age, about 11 (39.3%) participants aged 65 and above believed that mental illness is caused by both psychological and social factors, followed by 3 (10.7%) participants who believed that mental illness is caused by traditional factors. Table 6.13 shows these results in detail.

Table 6.13: Aetiological beliefs according to age

Aetiological belief	Age category			
	18 - 34	35 - 39	50 - 64	65+
Medical	54 (11.2%)	35 (16.7%)	6 (9.1%)	1 (3.6%)
Psychological	220 (45.5%)	86 (41.1%)	33 (50.0%)	11 (39.3%)
Social	166 (34.3%)	72 (34.4%)	25 (37.9%)	11 (39.3%)
Traditional	21 (4.3%)	13 (6.2%)	2 (3.0%)	3 (10.7%)
Not indicated	23 (4.8%)	3 (1.4%)	0 (0.0%)	2 (7.1%)

6.2.2.1.1. Aetiological beliefs by geographical location

Chi-square analysis to determine whether there are differences between aetiological beliefs of mental illness according to a geographical location indicates that more participants from Kwa Sani believed that mental illness is caused by psychological factors, $\chi^2 (4, N = 99) = 13.12, p < 0.05$. Table 6.14 presents these results in detail. Statistical analysis according to specific disorders shows that participants from both Kokstad and Kwa Sani believed that schizophrenia and alcohol dependency are caused by psychological factors. However, with regard to depression, more participants from Kokstad ($n = 76, 38.6%$) believed that this disorder is caused by social factors, on the one hand. On the other hand, more participants from Kwa Sani ($n = 26, 41.9%$) believed that depression is caused by psychological factors. These results are presented in Table 6.15.

Table 6.14: Aetiological beliefs according to geographical location

Aetiological beliefs	Geographical location	
	Kokstad	Kwa Sani
Medical	77 (12.7%)	19 (10.5%)
Psychological	251 (41.4%)	99 (54.7%)*
Social	223 (36.8%)	51 (28.2%)
Traditional	35 (5.8%)	4 (2.2%)
Not indicated	20 (3.3%)	8 (4.4%)

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 6.15: Aetiological beliefs according to geographical location and specific disorder

Category of explanation	Depression		Schizophrenia		Alcohol dependency	
	Kokstad	Kwa Sani	Kokstad	Kwa Sani	Kokstad	Kwa Sani
Medical	65 (33.0%)	14 (22.6%)	8 (4.0%)	3 (5.3%)	4 (1.9%)	2 (3.2%)
Psychological	52 (26.4%)	26 (41.9%)	94 (47.2%)	32 (56.1%)	105 (50.0%)	41 (66.1%)
Social	76 (38.6%)	16 (25.8%)	56 (28.1%)	20 (35.1%)	91 (43.3%)	15 (24.2%)
Traditional	0 (0.0%)	0 (0.0%)	35 (17.6%)	2 (3.5%)	0 (0.0%)	2 (3.2%)
Not indicated	4 (2.0%)	6 (9.7%)	6 (3.0%)	0 (0.0%)	10 (4.8%)	2 (3.2%)

6.2.3. Relationship between explanations of mental illness and aetiological beliefs.

This part of the chapter presents the results of the analysis to determine if there is a relationship between how participants explain mental illness and their aetiological beliefs. The objective is to determine whether the manner in which mental illness is conceptualised is related to what is believed to be its cause. The results, depicted in Table 6.16, indicate that 56 (52.3%) participants who explained mental illness as a medical illness also believed that mental illness is caused by medical factors. The same trend, where explanations of mental illness are related to aetiological beliefs, is also found between psychological (51.3%), social (42.5%), and traditional (52.4%) variables. 246 (51.3%) of the participants who explained mental illness as a psychological illness were also of the belief that mental illness is caused by psychological factors. 71 (42%) and 11 (52%) of the participants who used social and traditional explanations of mental illness, respectively, also believed that mental illness is due to social and traditional factors, respectively.

Chi-square analysis was also conducted to test if the relationship between participants' explanations of mental illness and their aetiological beliefs is significant. Chi-square results revealed statistically significant relationships between how mental illness is explained and aetiological beliefs. For example, this test shows that the majority of participants who explained mental illness as a psychological problem also believed that mental illness is caused by psychological factors, $\chi^2 (16, N = 246) = 316.17, p < 0.001$. This suggests that participants' explanations of mental illness are related to causal beliefs of mental illness.

Table 6.16: Relationship between views about mental illness and aetiological beliefs

Aetiological beliefs	Explanations of mental illness, <i>n</i> , (%)				
	Medical	Psychological	Social	Traditional	Not indicated
Medical	56 (52.3%)	22 (4.6%)	17 (10.2%)	0 (0.0%)	1 (8.3%)
Psychological	30 (28.0%)	246 (51.3%)	64 (38.3%)	6 (28.6%)	4 (33.3%)
Social	15 (14.0%)	182 (37.9%)	71 (42.5%)	2 (9.5%)	4 (33.3%)
Traditional	0 (0.0%)	18 (3.8%)	9 (5.4%)	11 (52.4%)	1 (8.3%)
Not indicated	6 (5.6%)	12 (2.5%)	6 (3.6%)	2 (9.5%)	2 (16.7%)

6.2.3.1. Predictors of aetiological beliefs.

Multinomial logistic regression analysis was conducted to determine predictors of aetiological beliefs using demographic variables. The results of the multinomial logistic regression analysis presented in Table 6.17 indicate that gender ($p < 0.01$) and education ($p < 0.05$) significantly predicted the aetiological beliefs for mental illness. Specifically, female participants, were almost 0.61 times less likely to believe that traditional factors, rather than medical factors, cause mental illness as compared to males (OR = .39, 95% CI = .17 to 8.51). With regard to education, the odds of participants with a secondary level of education believing that psychological factors, instead of medical factors, cause mental illness were 0.35 times those of their counterparts with a tertiary level of education (OR = .35, 95% CI = .12 to 1.03).

Table 6.17: Multinomial logistic regression analysis of causal beliefs and demographic variables

Variable	Psychological		Social		Traditional	
	B	OR (95% CI)	B	OR (95% CI)	B	OR (95% CI)
Age						
18 – 34	-1.107	.33 (.03/3.06)	-1.061	.34 (.03/3.19)	-2.142	.11 (.00/1.56)
35 – 49	-1.560	.21 (.02/1.93)	-1.500	.22 (.02/2.04)	-2.175	.11 (.00/1.49)
50 – 64	-.717	.48 (.04/4.98)	-.832	.43 (.04/4.44)	-2.201	.11 (.00/2.01)
65+	0 ^b		0 ^b		0 ^b	
Gender						
Female	-.263	.76 (.47/1.25)	-.266	.76 (.46/1.26)	-.940	.39 (.17/8.51)**
Male	0 ^b		0 ^b		0 ^b	
District						
Kokstad	-.503	.60 (.34/1.05)	.060	1.06 (.58/1.92)	.708	2.03 (.63/6.53)
Kwa Sani	0 ^b		0 ^b		0 ^b	
Education						
No schooling	-1.125	.32 (.04/2.32)	-.502	.60 (.08/4.26)	-.930	.39 (.02/5.42)
Primary	-.921	.39 (.12/1.31)	-.517	.59 (.177/2.01)	-.926	.39 (.07/2.03)
Secondary	-1.042	.35 (.12/1.03)*	-.912	.40 (.13/1.20)	-1.25	.28 (.07/1.16)
Tertiary	0 ^b		0 ^b		0 ^b	

Note: Reference category is medical ($n = 96$).

B = Logistic coefficient. SE = Standard Error. OR = Odds Ratio. 95% CI = 95% Confidence interval.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

^b = This parameter is set at zero because it is redundant

6.2.4. Aetiological beliefs assessed on a Likert-scale.

In order to develop a deeper understanding of participant's aetiological beliefs of mental illness, participants were asked to indicate their beliefs from a list of 10 possible aetiological factors. To be more specific, participants were asked how likely is it that Bheki's situation might have been caused by the following: own bad character, chemical imbalance in the brain, the way he was raised, stressful circumstances in his life, genetic or inherited problems, God's will, failure to perform certain cultural rituals, ancestral anger, evil spirits/sorcery, and punishment for sins

he committed. Participants scored these 10 possible causes on a four-point Likert-scale, ranging from: 1 (very likely), 2 (somewhat likely), 3 (less likely) to 4 (don't know). For all three mental disorders combined, more than half of the participants ($n = 470$, 59.7%) believed that mental illness is very likely to be caused by stressful circumstances in life. Another 269 (34.2%) and 248 (31.5%) of the participants believed that own bad character and ancestral anger, respectively, were very likely to be the cause of mental illness. Table 6.18 shows these results in greater detail.

A Chi-square analysis was performed to test the differences between participants' aetiological beliefs and the three mental disorders depicted in the vignettes. The results indicate that most participants believed that schizophrenia, when compared to depression and alcohol dependency, is very likely to be caused by: stressful circumstances in life, $\chi^2 (6, N = 163) = 16.89, p < 0.05$; ancestral anger, $\chi^2 (6, N = 100) = 15.35, p < 0.05$; failure to perform certain cultural rituals, $\chi^2 (6, N = 97) = 19.91, p < 0.01$; evil spirits/sorcery, $\chi^2 (6, N = 82) = 12.89, p < 0.05$; as well as God's will, $\chi^2 (6, N = 68) = 33.65, p < 0.001$. Although no significant differences were found regarding depression and alcohol dependency, stressful circumstances in life was rated as very likely to be a cause of these illnesses. Over one-third, 93 (35.9%) and 83 (32.0%) of participants also believed that own bad character and chemical imbalance in the brain, respectively, is very likely to be the cause of mental illness. Own bad character and evil spirits were considered by 94 (34.6%) and 84 (30.9%) of participants, respectively, to be the second and third possible causes of alcohol dependency.

Table 6.18: Participants' beliefs about the causes of mental illness

Beliefs about causes	Disorder %			Total %	Pearson Chi-square		
	Depression	Schizophrenia	Alcohol dependence		χ^2 value	df	P-value
Own bad character	93 (35.9%)	82 (32.0%)	94 (34.6%)	269 (34.2%)	5.902	8	.658
Chemical imbalance in the brain	83 (32.0%)	76 (29.7%)	79 (29.0%)	238 (30.2%)	5.867	8	.662
The way he was raised	65 (25.1%)	72 (28.1%)	72 (26.5%)	209 (26.6%)	4.857	6	.562
Stressful circumstances in life	135 (52.1%)	163 (63.7%)	172 (63.2%)	470 (59.7%)	18.848	8	.016*
Genetic or inherited problems	60 (23.2%)	76 (29.7%)	63 (23.2%)	199 (25.3%)	12.182	8	.143
God's will	53 (20.5%)	68 (26.6%)	42 (15.4%)	163 (20.7%)	33.657	6	.000***
Failure to perform certain cultural rituals	62 (23.9%)	97 (37.9%)	77 (28.3%)	236 (30.0%)	19.917	6	.003**
Ancestral anger	72 (27.8%)	100 (39.1%)	76 (27.9%)	248 (31.5%)	15.357	6	.018*
Evil spirits/sorcery	68 (26.3%)	82 (32.0%)	84 (30.9%)	234 (29.7%)	12.892	6	.045*
Punishment of sins committed	50 (19.3%)	67 (26.2%)	59 (21.7%)	176 (22.4%)	8.384	6	.211

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

6.2.4.1. Aetiological beliefs assessed on a Likert-scale and demographic variables.

Chi-square analysis further indicated that 42.9% and 46.4% of participants over the age of 65, when compared to other age groups, believed that the way the person was raised, $\chi^2 (9, N = 12) = 27.53, p < 0.001$, and ancestral anger, $\chi^2 (9, N = 13) = 26.83, p < 0.001$, respectively, were very likely to be the cause of mental illness. Furthermore, the same group of participants over the age of 65, when compared to other age categories, believed that mental illness is caused by failure to perform certain cultural rituals, $\chi^2 (9, N = 11) = 17.43, p < 0.05$. More participants within the age category of 35 – 49 believed that mental illness is very likely to be caused by stressful circumstances in life, $\chi^2 (9, N = 129) = 18.57, p < 0.05$. God's will was considered by more participants between the ages of 50 to 64 (27.3%) as the cause of mental illness, $\chi^2 (9, N = 18) = 19.23, p < 0.05$. Table 6.19 below presents these results in detail.

Chi-square analysis according to the level of education shows that more participants (42.9%) who had never attended school, when compared to participants with other levels of education attained, believed that failure to perform certain cultural rituals, $\chi^2 (9, N = 12) = 18.12, p < 0.05$, and ancestral anger, $\chi^2 (9, N = 12) = 20.32, p < 0.05$ were very likely to be the cause of mental illness. Another 32.1% of participants who had never attended school also believed that mental illness is caused by punishment of sins committed, $\chi^2 (9, N = 9) = 16.93, p < 0.05$. These results are presented in Table 6.20.

Table 6.19: Very likely aetiological beliefs assessed on a Likert-scale according to age

Beliefs about causes	Age categories				Total %	Pearson Chi-square		
	18 - 34	35 - 49	50 - 64	64+		χ^2 value	df	P-value
Own bad character	153 (31.6%)	75 (35.9%)	29 (43.9%)	12 (42.9%)	269 (34.2%)	10.071	9	.345
Chemical imbalance in the brain	148 (30.6%)	81 (38.8%)	32 (48.5%)	11 (39.3%)	272 (34.6%)	12.712	9	.176
The way he was raised	117 (24.2%)	57 (27.3%)	23 (34.8%)	12 (42.9%)	209 (26.6%)	27.531	9	.001***
Stressful circumstances in life	288 (59.5%)	129 (61.7%)	37 (56.1%)	16 (57.1%)	470 (59.7%)	18.576	9	.029*
Genetic or inherited problems	110 (22.7%)	62 (29.7%)	19 (28.8%)	8 (28.6%)	199 (25.3%)	12.100	9	.208
God's will	102 (21.1%)	36 (17.2%)	18 (27.3%)	7 (25.0%)	163 (20.7%)	19.237	9	.023*
Failure to perform certain cultural rituals	128 (26.4%)	74 (35.4%)	23 (34.8%)	11 (39.3%)	236 (30.0%)	17.434	9	.042*
Ancestral anger	129 (26.7%)	86 (41.1%)	20 (30.3%)	13 (46.4%)	248 (31.5%)	26.831	9	.001*
Evil spirits/sorcery	131 (27.1%)	69 (33.0%)	21 (31.8%)	13 (46.4%)	234 (29.7%)	11.794	9	.225
Punishment of sins committed	99 (20.5%)	46 (20.0%)	23 (34.8%)	8 (28.6%)	176 (22.4%)	15.719	9	.073

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 6.20: Aetiological beliefs assessed on a Likert-scale according to level of education

Beliefs about causes	Educational level				Total %	Pearson Chi-square		
	No schooling	Primary	Secondary	Tertiary		χ^2 value	df	<i>P</i> -value
Own bad character	9 (32.1%)	60 (38.7%)	181 (34.1%)	19 (26.0%)	269 (34.2%)	14.163	9	.117
Chemical imbalance in the brain	13 (46.4%)	57 (36.8%)	186 (35.0%)	16 (21.9%)	272 (34.6%)	11.331	9	.254
The way he was raised	10 (35.7%)	46 (29.7%)	130 (24.5%)	23 (31.5%)	209 (26.6%)	13.751	9	.131
Stressful circumstances in life	14 (50.0%)	94 (60.6%)	321 (60.5%)	41 (56.2%)	470 (59.7%)	9.541	9	.389
Genetic or inherited problems	6 (21.4%)	43 (27.7%)	132 (24.9%)	18 (24.7%)	199 (25.3%)	8.257	9	.508
God's will	8 (28.6%)	31 (20.0%)	113 (21.3%)	11 (15.1%)	163 (20.7%)	10.880	9	.281
Failure to perform certain cultural rituals	12 (42.9%)	54 (34.8%)	156 (29.4%)	14 (10.2%)	236 (30.0%)	18.121	9	.034*
Ancestral anger	12 (42.9%)	62 (40.0%)	151 (28.4%)	23 (31.5%)	248 (31.5%)	20.323	9	.016**
Evil spirits/sorcery	8 (28.6%)	51 (32.9%)	153 (28.8%)	22 (30.1%)	234 (29.7%)	3.473	9	.943
Punishment of sins committed	9 (32.1%)	43 (27.7%)	112 (21.1%)	12 (16.4%)	176 (22.4%)	16.932	9	.050*

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

6.2.4.2. Predictors of aetiological beliefs assessed on a Likert-scale.

Ordinal regression analysis was performed to determine the predictors of aetiological beliefs using demographic variables as predictors. The findings presented in Table 6.21 indicate that district, education, and the type of disorder (vignette) predict aetiological beliefs. To be specific, an analysis according to district shows an association between Kokstad and the belief that mental illness is caused by own bad character (OR = .48, 95% CI = -1.03 to -.42), chemical imbalance in the brain (OR = .56, 95% CI = -.86 to -.28), the way the person was raised (OR = .52, 95% CI = -.96 to -.34), stressful circumstances in life (OR = 1.77, 95% CI = .22 to .92), genetics or inherited problems (OR = .46, 95% CI = -1.08 to -.45), failure to perform certain cultural rituals (OR = .63, 95% CI = .77 to -.16), ancestral anger (OR = .60, 95% CI = -.81 to -.20), evil spirits/sorcery (OR = .54, 95% CI = -.86 to -.25), and punishment of sins committed (OR = .55, 95% CI = -.91 to -.28). Kwa Sani was set as a reference category. For education, with tertiary level set as reference category, associations between no schooling and chemical imbalances in the brain (OR = .38, 95% CI = -1.79 to -.15), failure to perform certain cultural rituals (OR = .38, 95% CI = -1.77 to .17), and punishment of sins committed (OR = .43, 95% CI = -1.65 to -.03) were found. For primary level of education, an association was found between failure to perform certain cultural rituals (OR = .42, 95% CI = -1.38 to -.35), ancestral anger (OR = .47, 95% CI = -1.28 to -.25), and punishment of sins committed (OR = .45, 95% CI = -1.32 to -.27). An analysis according to the type of disorder (vignette) using alcohol dependency as a reference category indicates an association between depression and stressful circumstances in life (OR = 1.68, 95% CI = .17 to .84), as well as genetic or inherited problems (OR = .85, 95% CI = -.48 to .14). With regard to schizophrenia, an association was found with God's will (OR = .50, 95% CI = -1.02 to -.36).

Table 6.21: Ordinal regression analysis of aetiological beliefs and demographic variables

	Own bad character	Chemical imbalances in the brain	The way he was raised	Stressful circumstances in his life	Genetic or inherited problems	God's will	Failure to perform certain cultural rituals	Ancestral Anger	Evil spirits/sorcery	Punishment of sins he committed
Variable	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)
Age										
18 - 34	.123 (-.57/.81)	.385 (-.31/1.08)	.397 (-.30/1.09)	-.284 (-.98/.49)	.261 (-.44/.96)	.352 (-.35/1.05)	.490 (-.20/1.18)	.462 (-.23/1.16)	.623 (-.08/1.32)	.548 (-.15/1.25)
35 - 49	-.004 (-.72/.71)	.073 (-.65/.79)	.342 (-.38/1.06)	-.315 (-1.08/.45)	.036 (-.69/.76)	.546 (-.18/1.27)	.206 (-.51/.92)	-.020 (-.73/.70)	.498 (-.23/1.26)	.512 (-.21/1.24)
50 - 64	-.353 (-1.16/.45)	-.147 (-.96/.66)	-.264 (-1.07/.54)	-.239 (-1.10/.62)	-.217 (-1.03/.59)	-.156 (-.97/.65)	.025 (-.78/.83)	.202 (-.60/1.01)	.395 (-.41/1.20)	-.091 (-.90/.72)
65+	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Gender										
Female	-.003 (-.26/.26)	-.221 (-.48/.04)	-.028 (-.29/.23)	-.157 (-.44/.13)	-.127 (-.39/.14)	-.180 (-.45/.09)	.057 (-.32/.20)	-.165 (-.43/.09)	-.137 (-.40/.12)	-.193 (-.46/.07)
Male	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
District										
Kokstad	-.731 (-1.03/-.42) ***	-.584 (-.86/-.28) ***	-.653 (-.96/-.34) ***	.572 (.22/.92) ***	-.767 (-1.08/-.45) ***	-.238 (-.55/.07)	-.466 (-.77/-.16) ***	-.508 (-.81/-.20) **	-.559 (-.86/-.25) ***	-.598 (-.91/-.28) ***
Kwa Sani	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Education										
No schooling	.170 (-.62/.96)	-.969 (-1.79/-.15) *	.200 (-.59/.99)	.213 (-.62/1.05)	-.002 (-.81/.80)	-.689 (-1.50/.12)	-.977 (-1.77/-.17) **	-.638 (-1.43/.16)	.061 (-.73/.85)	-.846 (-1.65/-.03) *
Primary	-.363 (-.87/.14)	-.450 (-.95/.05)	.254 (-.25/.76)	-.066 (-.61/.48)	-.463 (-.98/.05)	-.503 (-1.03/.03)	-.869 (-1.38/-.35) ***	-.767 (-1.28/-.25) **	-.202 (-.71/.30)	-.799 (-1.32/-.27) **
Secondary	-.094 (-.53/.35)	-.362 (-.80/.08)	.513 (.06/.96) *	-.154 (-.63/.33)	-.228 (-.68/.22)	-.372 (-.84/.09)	-.519 (-.96/-.07) *	-.202 (-.64/.24)	-.009 (-.45/.43)	-.399 (-.86/.06)
Tertiary	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Vignette										
Depression	-.058 (-.36/.25)	.034 (-.27/.34)	-.130 (-.44/.18)	.514 (.17/.84) **	-.166 (-.48/.14) **	-.428 (-.75/-.10)	.183 (-.12/.49)	.082 (-.22/.39)	.158 (-.15/.46)	-.027 (-.34/.29)
Schizophrenia	.101 (-.21/.41)	-.105 (-.41/.20)	-.127 (-.44/.18)	-.013 (-.36/.33)	-.399 (-.71/-.08)	-.696 (-1.02/-.36) ***	-.433 (-.74/-.11)	-.495 (-.80/-.18)	.127 (-.18/.43)	-.097 (-.41/.22)
Alcohol Dependency	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a

E = Estimate. 95% CI = 95% Confidence interval. *p < 0.05, **p < 0.01, ***p < 0.001. ^a = This parameter is set at zero because it is redundant

6.2.5. Conclusion.

To sum up this section, the results show that more participants in this study had a generic conceptualisation of mental illness and used psychological terms such as low self-esteem, mental disturbance, stress, depression, not being well mentally, lack of confidence, to mention a few. Other participants explained mental illness in terms of social (e.g. having no one to talk to, lack of family support, financial problems, problems at work) and medical (e.g. TB, HIV/AIDS, suffering from health problems, unwell, weight loss) expressions. More males between the ages of 18 and 34 from Kwa-Sani mainly considered mental illness to be a psychological problem.

Further analysis reveals that with regard to specific disorder, apart from explaining schizophrenia and depression in terms of psychological and social explanations, these disorders were also explained as traditional and medical illnesses, respectively. Common examples of explanations used by participants who described schizophrenia in traditional terms include bewitchment, being troubled by the ancestors, ancestral spirit entering the person, the person having done things that other people do not like, and so forth. Regarding depression, commonly used examples by participants who conceptualised this disorder as a medical illness include the following: TB, HIV/AIDS, fever, weight loss, poor health, and so on. A test of statistical significance shows that alcohol dependency is believed to be a psychological problem. Common examples of descriptions used by participants who viewed alcohol dependency as a psychological problem include the following: alcohol intoxication, facing some depressing situation, stress, being mentally disturbed, etc. With regard to what participants would call mental illness, more participants called mental illness *stress*. Correct labels of depression and alcohol dependency were used by a very small number of participants. Labels ascribed to depression by most participants include AIDS, stress, fever, depression, TB, HIV, and the like. For schizophrenia, commonly used labels include ancestral calling, bewitchment, fear, madness, etc. Alcohol addiction, alcohol abuse, depression, stress or medical illness are some of the commonly used labels for alcohol dependence.

Interestingly, it appears that participants' conceptualisation of mental illness informs their beliefs about its causes. More participants believed that mental illness is caused by factors that are psychological (e.g. stress, depression, abuse, anger, low self-esteem, etc.), followed by causes that are social (e.g. bad

influence from friends, unemployment, financial problems, lack of social support, etc.) and medical (e.g. fatigue, physical illness, sexually transmitted diseases, HIV/AIDS, etc.) in nature. A test of statistical differences shows that more participants believed that depression is due to a medical cause. However, participants from Kokstad believe that mental illness, schizophrenia in particular, is due to traditional factors.

Interestingly, when given an opportunity to select from a list of possible causes, most participants significantly attribute mental illness, especially schizophrenia, to stressful circumstances in life, God's will, failure to perform certain cultural rituals and ancestral anger, on the one hand. On the other hand, alcohol dependency is significantly believed to be caused by stressful circumstances. More participants over the age of 65 believed that the way the person was raised, ancestral anger, as well as failure to perform certain cultural rituals are aetiological factors for mental disorder. Many participants who have never attended school believed that mental illness is caused by failure to perform certain cultural rituals, ancestral anger, as well as punishment of sins committed.

Chapter 7

Results: Part II

7.1. Knowledge and Attitudes Toward Help-Seeking and Interventions for Mental Health Problems

This chapter will present the results regarding participants' knowledge and attitudes towards help-seeking and other interventions for mental health problems. Participants' preferred sources of help or support will be presented first followed by specific professionals that are preferred for the treatment of mental illness. Presentation of the results regarding medicine/pharmacological treatments perceived as helpful, as well as participants' willingness to seek help will follow next. Views on prognosis of mental illness will also be presented. This will allow for an assessment of participants' prognostic views when what may be considered as appropriate treatment is received. Results regarding participants' awareness of institutions that provide mental healthcare will also be presented in this section. Attitudes toward mental illness will be presented last in this chapter.

7.1.1. Knowledge and attitudes toward help-seeking.

Participants were asked a series of questions to assess their knowledge of and attitudes toward help-seeking and interventions for mental health problems, starting with their preferred sources of help or support for the mentally ill.

7.1.1.1. Preferred sources of help or support.

In order to assess participants' preferred sources of help or support for mental illness, they were specifically asked how they think the people depicted in any of the three vignettes could best be helped. Their free responses to this question varied widely and were therefore grouped into the following seven categories that reflect their preferred sources of help or support: 1) encouraging professional help-seeking (e.g. refer to a professional, and most specified professionals such as a social worker, psychologist, rehabilitation centre, etc.); 2) participant providing support to the patient (e.g. talk to, listen to the problem, ask what is wrong, etc.); 3) referring to a family or friend (e.g. encourage to speak to parents, talk to friends, speak to someone close, etc.); 4) traditional intervention

(e.g. slaughter for the ancestors, consult with a *sangoma*, perform a traditional ritual, etc.); 5) religious intervention (e.g. see a priest, pray for, go to church, read the Bible, etc.) ; 6) other (e.g. this included non-specific referral responses such as be reprimanded, be beaten, just stop drinking, being separated from friends, by getting a job, etc.); and 7) not indicated (these were all participants who did not answer this question). Table 7.1 presents more detailed examples of participants' preferred sources of support or help for someone with mental illness.

Table 7.1: Preferred sources of help or support for the patient

Category of help or support	Examples of responses
Professional help	Refer to a professional, see a social worker, consult a psychologist, rehabilitation centre, being taken to doctors dealing with drugs, counselling, being examined by psychiatric doctors, taken to hospital, going for counselling, seeing a doctor, going to clinic for counselling, etc.
Participant providing support	I will talk to this person, I will listen to their problem, asking what is wrong, being supportive, encourage him to talk to me, plead with him to stop drinking, sit down and talk to him, etc.
Referring to family/friend	Encourage them to speak to their parents, talking to a friend, talking to family members, getting advice from people close to him, get a friend to help him, talking to neighbours, talking to elders in the family, get advice from a friend, talk to someone he is comfortable with, etc.
Traditional intervention	Slaughtering for the ancestors, consulting with a <i>sangoma</i> , perform traditional rituals, accepting ancestors, agreeing to do what ancestors are telling him to do, do a traditional ceremony for the late grandmother, go to a traditional healer, do something for the ancestors, go to a <i>sangoma</i> and slaughter some cattle to become a <i>sangoma</i> , etc.
Religious intervention	See a priest, being prayed for, going to church, reading the Bible, praying, accepting Jesus, being a born-again Christian, faith, needs to ask God for help, needs to be taught the Bible, prayer from church, etc.
Other	Being reprimanded, being beaten, being separated from friends with bad influence, getting a job, being accepted at his home because he is ill, should be taught how to stop being lazy, being with people who will appreciate him, etc.

Table 7.2 shows that, in general, when looking at all three of the disorders combined, more than half of the total participants (n = 451, 57.3%) indicated that the person with mental illness would best be helped by encouraging professional help-seeking, and 152 (19.3%) said by referring him to a family member or a friend. The third preferred source of help or support was in the category of 'other' and was suggested by 83 (10.5%) of the participants. An analysis of the three disorders separately, as can be seen in Table 7.2, indicates the same pattern of preferences regarding sources of help or support for depression and alcohol dependency where encouraging professional help-seeking was preferred, followed by referral to a family member or friend, and other. For schizophrenia, participants' third preferred way of helping a person with this condition was referral to a traditional healer. Chi-square analysis to determine if there is a significant difference between preferred sources of help or support and various demographic variables was not possible due to lower expected count.

Table 7.2: Preferred sources of help or support for the patient and specific disorder

	Disorder			
	Depression	Schizophrenia	Alcohol dependency	Total
Encourage professional help-seeking	181 (69.9%)	125 (48.8%)	145 (53.3%)	451 (57.3%)
Participant providing support	8 (3.1%)	11 (4.3%)	16 (5.9%)	35 (4.4%)
Referring to family or friend	44 (17.0%)	59 (23.0%)	49 (18.0%)	152 (19.3%)
Traditional treatment	2 (0.8%)	32 (12.5%)	2 (0.7%)	36 (4.6%)
Religious treatment	0 (0.0%)	5 (2.0%)	14 (5.1%)	19 (2.4%)
Other	22 (8.5%)	22 (8.6%)	39 (14.3%)	83 (10.5%)
Not indicated	2 (0.8%)	2 (0.8%)	7 (2.6%)	11 (1.4%)

7.1.1.2. Professionals preferred as sources of help or support.

Further analysis was undertaken to ascertain which specific professionals, from those participants who indicated that they would encourage professional help-seeking, would be most preferred. Figure 7.1 presents these results visually. In general, for the three disorders combined, 96 (21.4%) and 91 (20.3%) participants indicated that social workers and counselling, respectively, would be the most preferred professional interventions. Medical doctors and hospitals/clinics were the third preferred professional sources of help or support, chosen by 87 (19.4%) participants. Of special note, psychiatrists were the least preferred professionals,

with only 5 (1.1%) participants in the sample believing that these professionals would best help the person with mental illness. Regarding specific disorders, 48 (26.5%) participants preferred social workers for the treatment of depression. Another 47 (26.0%) and 39 (21.5%) participants preferred hospitals/clinics and medical doctors, respectively, for the treatment of depression. Medical doctors and hospitals/clinics were preferred most by 29 (23.8%) and 22 (18.0%) of participants, respectively, for the treatment of schizophrenia, with the third preferred source of help or support for this disorder being social workers, preferred by 17 (13.9%) participants. Regarding alcohol dependency, professionals that were considered best were rehabilitation centres, preferred by 41 (28.3%) participants, social workers by 31 (21.4%) participants, as well as medical doctors by 19 (13.1%) participants. Table 7.3 presents these results in detail.

Figure 7.1: Professionals preferred as sources of help or support

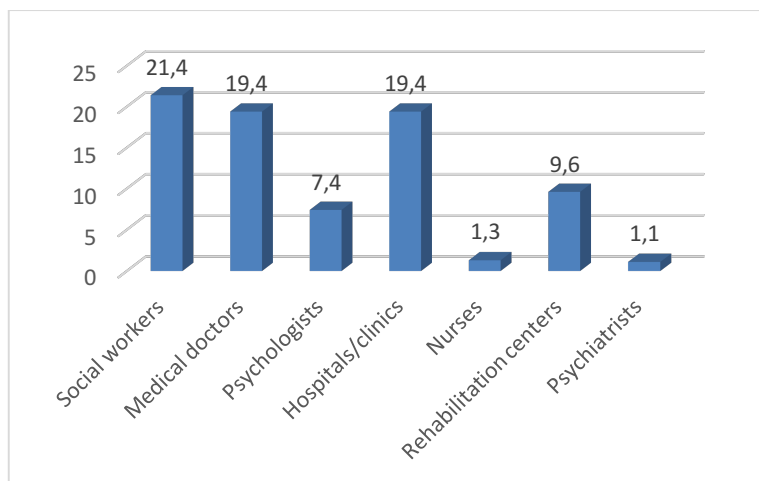


Table 7.3: Professionals preferred as sources of help or support for mental disorders

Professionals	Depression	Schizophrenia	Alcohol Dependency	Total
Social workers	48 (26.5%)	17 (13.9%)	31 (21.4%)	96 (21.4%)
Medical doctors	39 (21.5%)	29 (23.8%)	19 (13.1%)	87 (19.4%)
Psychologists	11 (6.1%)	15 (12.3%)	7 (4.8%)	33 (7.4%)
Hospitals/Clinics	47 (26.0%)	22 (18.0%)	18 (12.4%)	87 (19.4%)
Nurses	4 (2.2%)	0 (0.0%)	2 (1.4%)	6 (1.3%)
Rehabilitation centres	2 (1.1%)	0 (0.0%)	41 (28.3%)	43 (9.6%)
Psychiatrists	0 (0.0%)	4 (3.3%)	1 (0.7%)	5 (1.1%)

7.1.1.3. Professionals and non-professionals as sources of help assessed on a Likert-scale.

Participants were also given a list of 14 professionals and non-professionals who could possibly help the person depicted in the vignette and were asked to indicate which of them were likely to be 'helpful', 'harmful' or 'neither'. When the three conditions presented in the vignettes are combined, as can be seen in Table 7.4, the results indicate that participants rated the family general practitioner (GP) ($n = 686, 87.2\%$) as more helpful followed by a counsellor ($n = 684, 82.3\%$) and a psychologist ($n = 624, 79.3\%$). More than half of the total sample ($n = 408, 51.8\%$) considered dealing with the problem in their own way as harmful. Descriptive analysis according to a specific disorder shows that for depression, the family GP ($n = 231, 89.2\%$), a counsellor ($n = 216, 83.4\%$), and a social worker ($n = 215, 83.0\%$) were perceived by participants as more helpful. Professionals that were considered most helpful for schizophrenia were the family GP ($n = 216, 84.4\%$), followed by a psychologist ($n = 213, 83.2\%$) and both a social worker and psychiatrist ($n = 210, 82\%$). Participants considered the family GP ($n = 239, 87.9\%$), a counsellor ($n = 222, 81.6\%$) and a psychiatrist ($n = 220, 80.9\%$) as more helpful to assist with alcohol dependency. Interestingly, a test of statistical differences between the three disorders shows that more participants (67.6%) were more likely to consider help from close friends as helpful for the treatment of depression, $\chi^2(6, N = 175) = 21.36, p < 0.01$. Psychiatrist, $\chi^2(4, N = 191) = 16.62, p < 0.01$; psychologist, $\chi^2(6, N = 194) = 18.82, p < 0.01$; and *sangoma* $\chi^2(4, N = 117) = 11.32, p < 0.01$, were likely to be perceived as helpful for the treatment of schizophrenia

Table 7.4: Perceived helpful professionals and non-professionals

Helpful professionals/Non-professionals	Disorder			Total %	Chi-square test		
	Depression	Schizophrenia	Alcohol dependence		Chi-square value	df	P-value
Family GP/Doctor	231 (89.2%)	216 (84.4%)	239 (87.9%)	686 (87.2%)	8.792	4	.067
Pharmacist/Chemist	179 (69.1%)	152 (59.4%)	186 (68.4%)	517 (65.7%)	6.755	4	.149
A Counsellor	216 (83.4%)	210 (82.0%)	222 (81.6%)	684 (82.3%)	1.433	4	.838
Social worker	215 (83.0%)	194 (75.8%)	214 (78.7%)	623 (79.2%)	4.480	4	.345
Telephone counselling, like life-line	159 (61.4%)	129 (50.4%)	151 (55.5%)	439 (55.8%)	9.193	4	.056
A psychiatrist	191 (73.7%)	210 (82.0%)	220 (80.9%)	621 (78.9%)	16.621	4	.002*
A psychologist	194 (74.9%)	213 (83.2%)	217 (79.8%)	624 (79.3%)	18.824	6	.004*
Help from close family member	203 (78.4%)	184 (71.9%)	211 (77.6%)	598 (76.0%)	9.187	6	.163
Help from close friends	175 (67.6%)	163 (63.7%)	145 (53.3%)	483 (61.4%)	21.362	6	.002*
<i>iSangoma</i>	84 (32.4%)	117 (45.7%)	94 (34.6%)	295 (37.5%)	11.329	4	.023*
<i>iNyanga</i>	82 (31.7%)	111 (43.4%)	97 (35.7%)	290 (36.8%)	11.019	6	.088
<i>uMthandazi</i>	134 (51.7%)	149 (58.2%)	158 (58.1%)	441 (56.0%)	3.334	4	.503
A church Minister/Priest	175 (67.6%)	176 (68.8%)	194 (71.3%)	545 (69.3%)	3.672	4	.452
Deal with problem own way	102 (39.4%)	80 (31.3%)	90 (33.1%)	272 (34.6%)	7.320	6	.292

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

7.1.1.3.1. Predictors of the helpfulness of professionals and non-professionals

Ordinal regression analysis was conducted to determine predictors of the perceptions of professionals and non-professionals as helpful using demographic variables as predictors. It is important to note that from a list of professionals and non-professionals, counsellor, telephone counselling, a church minister, help from close friends, and to deal with problems on *his* own were not included in this analysis because they violated the model fitting information with p value > 0.05 . The results, as presented in Table 7.5 below, show that all demographic variables were significantly associated with certain professionals and non-professionals.

The results of the analysis according to age, with 65 and above ages set as a reference category, show that ages 18 – 34, 35 – 49, and 50 – 64 age categories predicted the belief that a social worker, psychologist and help from a close family member would be helpful in the treatment of mental illness. To show the odds ratios, ages 18 – 34 were associated with social worker (OR = .37, 95% CI = -1.92 to -.08), psychologist (OR = .71, 95% CI = -1.38 to .70), and help from a close family member (OR = .16, 95% CI = -2.74 to -.89). For participants between the ages of 35 – 49, the odds ratios show the following association: social workers (OR = .38, 95% CI = -1.90 to -.04), psychologist (OR = .29, 95% CI = -2.25 to -.24), and help from a close family member (OR = .29, 95% CI = -2.14 to -.32). The odds ratios for ages 50 – 64 were: social worker (OR = .22, 95% CI = -2.58 to -.44), psychologist (OR = .21, 95% CI = -2.70 to -.41), and help from a close family member (OR = .67, 95% CI = -2.30 to -.32). For gender, with male set as a reference category, an association between female and *nyanga* (herbalist) (OR = 1.35, 95% CI = .02 to .58) was found.

The findings according to district, with Kwa Sani set as a reference category, show a significant association between Kokstad and social worker (OR = 5.97, 95% CI = 1.11 to 2.45), psychiatrist (OR = 3.88, 95% CI = .78 to 1.92), psychologist (OR = 3.43, 95% CI = .67 to 1.78), help from a close family member (OR = 1.66, 95% CI = .06 to .94), *sangoma* (diviner) (OR = .65, 95% CI = -.74 to -.10), as well as *nyanga* (herbalist) (OR = .68, 95% CI = -.70 to -.06). The results according to level of education, with tertiary level set as a reference category, show a significant association between primary level of education and pharmacist (OR = .49, 95% CI = -1.29 to -.10), *sangoma* (diviner) (OR = .50, 95% CI = -1.24 to -.13), *nyanga* (herbalist) (OR = .42, 95% CI = -1.43 to -.31), and *umthandazi* (faith healer) (OR = 3.07, 95% CI = -1.68 to -.56). For secondary level of education, a significant

association was found between *nyanga* (herbalist) (OR = .59, 95% CI = -.93 to -.05) and *umthandazi* (faith healer) (OR = .43, 95% CI = -1.30 to -.38). The results of the analysis according to vignette, with alcohol dependency set as a reference category, show a significant association between depression and psychiatrist (OR = 1.63, 95% CI = .07 to .90). Another significant association is found between schizophrenia and *sangoma* (diviner) OR = 1.07, 95% CI = -.25 to .38) and *nyanga* (herbalist) (OR = .71, 95% CI = -.67 to -.01).

Table 7.5: Ordinal regression analysis of professionals and non-professionals and demographic variables

	Family Doctor	GP/ Pharmacist/ Chemist	Social worker	A psychiatrist	A psychologist	Help from close family member	Sangoma (Diviner)	Nyanga (Herbalist)	uMthandazi (Faith healer)
Variable	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)
Age									
18 - 34	-.553 (-1.82/.72)	.002 (-.96/.97)	-1.007 (-1.92/-.08) *	-.337 (-1.38/.70)	-1.25 (-2.25/-.24) *	-1.819 (-2.74/-.89) ***	.477 (-.37/1.33)	.443 (-.41/1.29)	.305 (-.69/1.22)
35 - 49	-.465 (-1.74/.81)	.179 (-.79/1.15)	-.975 (-1.90/-.04) *	-.416 (-1.46/.63)	-1.251 (-2.25/-.24) *	-1.233 (-2.14/-.32) **	.108 (-.74/.96)	.242 (-.61/1.09)	.515 (-.40/1.44)
50 - 64	-1.054 (-2.54/.43)	-.461 (-1.53/.61)	-1.518 (-2.58/-.44) **	-1.066 (-2.28/.15)	-1.562 (-2.70/-.41) **	-1.316 (-2.30/-.32) **	.305 (-.61/1.22)	.288 (-.62/1.20)	.411 (-.57/1.39)
65+	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Gender									
Female	-.170 (-.60/.26)	-.071 (-.37/.23)	-.020 (-.38/.34)	-.008 (-.37/.35)	-.114 (-.47/.25)	-.176 (-.52/.16)	.238 (-.04/.51)	.303 (.02/.58) *	.257 (-.32/.54)
Male	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
District									
Kokstad	-.568 (-1.02/-.10)	-.272 (-.61/.07)	1.786 (1.11/2.45) ***	1.355 (.78/1.92) ***	1.232 (.67/1.78) ***	.505 (.06/.94) *	-.425 (-.74/-.10) **	-.381 (-.70/-.06) *	-.097 (-.42/.22)
Kwa Sani	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Education									
No schooling	-.289 (-1.84/1.26)	-.493 (-1.52/.53)	.462 (-.68/1.61)	-.753 (-2.15/.64)	-.929 (-2.59/.73)	-.877 (-2.08/.32)	-.286 (-1.21/.64)	-.162 (-1.08/.76)	.858 (-1.81/.09)
Primary	-.032 (-.92/.86)	-.699 (-1.29/-.10) *	.391 (-.34/1.13)	-.001 (-.72/.71)	.682 (-.13/1.50)	-.095 (-.77/.58)	-.690 (-1.24/-.13) *	-.871 (-1.43/-.31) **	-1.123 (-1.68/-.56) ***
Secondary	.055 (-.69/.80)	-.464 (-.95/.02)	.246 (-.38/.87)	.023 (-.57/.61)	.690 (-.02/1.40)	-.060 (-.63/.51)	-.371 (-.83/.09)	-.522 (-.93/-.05) *	-.844 (-1.30/-.38) ***
Tertiary	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Vignette									
Depression	-.195 (-.73/.34)	-.050 (-.41/.31)	-.242 (-.68/.20)	.487 (.07/.90) *	.379 (-.03/.79)	.029 (-.38/.44)	.065 (-.25/.38)	.074 (-.25/.39)	.195 (-.13/.52)
Schizophrenia	.248 (-.25/.74)	.327 (-.03/.68)	.212 (-.21/.63)	-.098 (-.55/.35)	-.170 (-.62/.28)	.275 (-.12/.67)	-.418 (-.74/-.08) *	-.341 (-.67/-.01) *	-.058 (-.39/.28)
Alcohol	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Dependency									

E = Estimate. 95% CI = 95% Confidence interval. *p < 0.05, **p < 0.01, ***p < 0.001. ^a = This parameter is set at zero because it is redundant

7.1.2. Medicines/pharmacological treatments perceived as helpful.

To assess participants' opinion of medication they may consider helpful or appropriate for mental illness, they were given a list of eight medicines/pharmacological treatments to rate as either helpful or harmful for the treatment of a person presented in a vignette. These medicines/pharmacological treatments included vitamins, traditional medicine, antidepressants and sleeping pills, to mention a few. Table 7.6 below shows a complete list of medicines that were presented to participants. The results show that for the treatment of either depression, schizophrenia or alcohol dependency, 543 (69.0%) participants considered vitamins, minerals and tonics as likely to be helpful, followed by 469 (59.6%) and 442 (56.2%) of the participants who viewed antidepressants and anti-psychotics, respectively, as likely to be helpful.

When descriptive analysis was conducted according to a specific disorder, most participants ($n = 209$, 80.7%) believed that vitamins, minerals and tonics were helpful for the treatment of depression. This is followed by 163 (62.9%) and 146 (56.4%) participants who thought that antidepressants and tranquilisers, respectively, would be helpful medications for the treatment of depression. For schizophrenia, vitamins, minerals and tonics were perceived as helpful pharmacological treatments by more participants ($n = 164$, 64.1%), followed by 147 (57.4%) participants who perceived anti-psychotics, and 144 (56.3%) who perceived antidepressants, as helpful. Medicines/pharmacological treatments considered to be helpful for the treatment of alcohol dependency were vitamins, minerals and tonics, rated by 170 (62.5%) participants, followed by antidepressants and antipsychotics rated by 160 (59.6%) and 157 (57.7%) participants, respectively.

A Chi-square analysis to test if participants' responses were significantly different across the three disorders, as can be seen in Table 6.26, indicated that participants were most likely to consider vitamins, minerals and tonics, $\chi^2 (4, N = 209) = 26.66, p < 0.001$, pain relievers, $\chi^2 (6, N = 136) = 13.98, p < 0.05$; antibiotics, $\chi^2 (6, N = 137) = 14.09, p < 0.05$, and tranquilisers, $\chi^2 (6, N = 146) = 13.70, p < 0.05$ as helpful for treating depression. Traditional medicine, $\chi^2 (6, N = 137) = 13.21, p < 0.05$ was considered most helpful for treating schizophrenia.

Table 7.6: Medicines/pharmacological treatments perceived as likely to be helpful

Medicines perceived as helpful	Disorder			Total %	Chi-square test		
	Depression	Schizophrenia	Alcohol dependence		Chi-square value	df	P-value
Vitamins, minerals & tonics	209 (80.7%)	164 (64.1%)	170 (62.5%)	543 (69.0%)	26.665	4	.000***
Traditional medicine	113 (43.6%)	137 (53.5%)	133 (48.9%)	383 (48.7%)	13.213	6	.040*
Pain relievers such as aspirin, Panado, etc.	136 (52.5%)	105 (41.0%)	111 (40.8%)	352 (44.7%)	13.987	6	.030*
Antidepressants	163 (62.9%)	144 (56.3%)	162 (59.6%)	469 (59.6%)	6.368	6	.383
Antibiotics	137 (52.9%)	109 (42.6%)	107 (39.3%)	352 (44.9%)	14.099	6	.029*
Sleeping pills	126 (48.6%)	119 (46.5%)	133 (48.9%)	378 (48.0%)	11.897	6	.064
Anti-psychotics	138 (53.3%)	147 (57.4%)	157 (57.7%)	442 (56.2%)	9.818	6	.133
Tranquilisers such as valium	146 (56.4%)	137 (53.5%)	140 (51.5%)	423 (53.7%)	13.704	6	.033*

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

7.1.2.1. Comparison of medicines/pharmacological treatments by demographics.

A test of statistical differences using Chi-square on various demographic variables in terms of medicines/pharmacological treatments that were perceived as helpful, as presented in Table 7.7, indicates that more females, compared to males, were likely to consider antidepressants, $\chi^2 (2, N = 315) = 15.60, p < 0.001$, antibiotics, $\chi^2 (2, N = 238) = 7.48, p < 0.05$, and sleeping pills, $\chi^2 (2, N = 253) = 11.28, p < 0.01$ as more helpful for the treatment of mental illness, on the one hand. On the other hand, more males, than females, perceived traditional medicine as helpful for the treatment of mental illness, $\chi^2 (2, N = 162) = 6.61, p < 0.05$.

An analysis according to age shows that, compared to other age groups, participants between the ages of 18 – 34 were more likely to consider antidepressants, $\chi^2 (6, N = 309) = 22.70, p < 0.001$ to be more helpful for the treatment of mental illness, on the one hand. On the other hand, while their counterparts between the ages of 50 – 64 were more likely to consider pain relievers, $\chi^2 (6, N = 38) = 22.33, p < 0.001$ and anti-psychotics, $\chi^2 (6, N = 47) = 17.19, p < 0.05$ as more helpful, those above the age of 65 were more likely to perceive sleeping pills, $\chi^2 (6, N = 17) = 20.41, p < 0.01$ and tranquilisers, $\chi^2 (6, N = 18) = 13.52, p < 0.05$ as more helpful for the treatment of mental illness.

An analysis according to educational level indicates that more participants who have never attended school, when compared to those with other levels of education, perceived vitamins, minerals and tonics, $\chi^2 (6, N = 23) = 16.15, p < 0.05$, sleeping pills, $\chi^2 (6, N = 16) = 15.04, p < 0.05$, and tranquilisers, $\chi^2 (6, N = 22) = 14.17, p < 0.05$ as more helpful to treat mental illness. However, traditional medicine was perceived by more participants with primary level of education, $\chi^2 (6, N = 91) = 13.99, p < 0.05$ as helpful for the treatment of mental disorders, when compared to participants with other levels of education.

With regard to location, more participants from Kokstad perceived traditional medicine, $\chi^2 (2, N = 318) = 25.95, p < 0.001$ and pain relievers, $\chi^2 (2, N = 272) = 25.95, p < 0.001$ as more helpful than their counterparts, on the one hand. On the other hand, more of their counterparts from Kwa Sani perceived antidepressants, $\chi^2 (2, N = 138) = 28.30, p < 0.001$, antibiotics, $\chi^2 (2, N = 96) = 6.70, p < 0.05$, tranquilisers, $\chi^2 (2, N = 120) = 15.18, p < 0.01$ and antipsychotics, $\chi^2 (2, N = 119) = 9.38, p < 0.01$ as more helpful for the treatment of mental illness.

Table 7.7: Demographic variables and medicines/pharmacological treatments perceived as helpful

Variable	Vitamins	Traditional medicine	Pain relievers	Antidepressants	Antibiotics	Sleeping pills	Tranquilisers	Anti-psychotics
Gender								
Female	344 (70.2%)	211 (45.1%)	234 (47.8%)	315 (64.3%***)	238 (48.6%*)	253 (51.6%**)	270 (55.1%)	282 (57.6%)
Male	199 (67.0%)	162 (54.5%*)	118 (39.7%)	154 (51.9%)	115 (38.7%)	125 (42.1%)	153 (51.5%)	160 (53.9%)
Age								
18-34	332 (68.6%)	224 (46.3%)	215 (44.4%)	309 (63.8%***)	214 (44.2%)	230 (47.5%)	266 (55.0%)	259 (53.5%)
35-49	137 (65.6%)	103 (49.3%)	84 (40.2%)	102 (48.8%)	86 (41.1%)	91 (43.5%)	98 (46.9%)	117 (56.0%)
50-64	52 (78.8%)	37 (56.1%)	38 (57.6%***)	42 (63.6%)	36 (54.5%)	40 (60.6%)	41 (62.1%)	47 (71.2%**)
65+	22 (78.6%)	19 (67.9%)	15 (53.6%)	16 (57.1%)	17 (60.7%)	17 (60.7%**)	18 (64.3%*)	19 (67.9%)
Education								
No schooling	23 (82.1%*)	15 (53.6%)	16 (57.1%)	22 (78.6%)	19 (67.9%)	16 (57.1%*)	22 (78.6%*)	18 (64.3%)
Primary	117 (75.5%)	91 (58.7%*)	77 (49.7%)	86 (55.5%)	75 (48.4%)	86 (55.5%)	93 (60.0%)	91 (58.7%)
Secondary	361 (68.0%)	252 (47.5%)	235 (44.3%)	309 (58.2%)	233 (43.9%)	247 (46.5%)	271 (51.0%)	289 (54.4%)
Tertiary	42 (57.5%)	25 (34.2%)	24 (32.9%)	52 (71.2%)	26 (35.6%)	29 (39.7%)	37 (50.7%)	44 (60.3%)
Municipality								
Kokstad	423 (69.8%)	318 (52.5%***)	272 (44.9%*)	331 (54.6%)	257 (42.4%)	273 (45.0%)	303 (50.0%)	323 (53.3%)
Kwa Sani	120 (66.3%)	65 (35.9%)	80 (44.2%)	138 (76.2%***)	96 (53.0%*)	105 (58.0%)	120 (66.3%**)	119 (65.7%**)

*p < 0.05, **p < 0.01, ***p < 0.001

7.1.2.1.1. Predictors of medicines perceived as helpful

To assess predictors of medicines perceived as helpful, ordinal regression analysis was performed on these medicines/pharmacological treatments, and the results are presented in Table 7.8. The results show that gender, district, level of schooling, as well as vignette (or the type of disorder), are variables that significantly predict the perception of helpfulness of certain medicines. To be specific, for gender, the results show a significant association between females and traditional medicine (OR = 1.49, 95% CI = .11 - .67), pain relievers (OR = .74, 95% CI = -.57 - -.01), antidepressants (OR = .56, 95% CI = -.87 - -.28), antibiotics (OR = .72, 95% CI = -.60 - -.05), and sleeping pills (OR = .67, 95% CI = -.67 - -.12). Male variable was set as a reference category.

With regard to district, with Kwa Sani as a reference category, the results indicate an association between Kokstad and traditional medicine (OR = .68, 95% CI = -.69 - -.06), antidepressants (OR = 2.68, 95% CI = .60 - 1.37), antibiotics (OR = 1.48, 95% CI = .07 - .71), as well as sleeping pills (OR = 1.72, 95% CI = .22 - .87). For schooling, with tertiary level of education as reference category, an association is found between primary level of education and traditional medicine (OR = .35, 95% CI = -1.60 - -.48) and antidepressants (OR = 2.23, 95% CI = .17 - 1.42), as well as between secondary level of education and vitamins, minerals and tonics (OR = .65, 95% CI = -.94 - .64), traditional medicine (OR = .55, 95% CI = -1.05 - -.13), and antidepressants (OR = 2.14, 95% CI = .21 - 1.30).

Regarding the type of disorder, with alcohol dependency as a reference category, a significant association is found between depression and vitamins, minerals and tonics (OR = .40, 95% CI = -1.30 - .51), pain relievers (OR = .67, 95% CI = -.72 - -.07), as well as antibiotics (OR = .64, 95% CI = -.76 - -.11).

Table 7.8: Ordinal regression analysis of medicines perceived as helpful and demographic variables

	Vitamins, minerals & tonics	Traditional medicine	Pain relievers	Antidepressants	Antibiotics	Sleeping pills	Anti-psychotics	Tranquilisers
Variable	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)
Age								
18 - 34	-.047 (-1.10/1.01)	.680 (-.24/1.60)	-.227 (-1.07/.61)	-.654 (-1.54/.23)	.179 (.68/1.04)	(- .227 (-.63/1.08)	.573 (-.33/1.47)	-.353 (-1.25/.54)
35 - 49	.231 (-.83/1.29)	.678 (-.24/1.60)	.195 (-.65/1.04)	-.017 (-.90/.87)	.443 (.42/1.30)	(- .609 (-.25/1.47)	.580 (-.32/1.49)	.096 (-.80/.99)
50 - 64	-.389 (-1.55/.77)	.442 (-.54/1.42)	-.471 (-1.38/.44)	-.760 (-1.73/.21)	-.152 (1.08/.78)	(- -.138 (-1.07/.79)	-.161 (-1.15/.83)	-.559 (-1.53/.41)
65+	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Gender								
Female	-.090 (-.40/.22)	.398 ** (.11/.67)	-.295 (-.57/-.01) *	-.581 (-.87/-.28) ***	-.332 (-.60/-.05) *	-.397 (-.67/-.12) **	-.175 (-.45/.11)	-.178 (-.46/.10)
Male	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
District								
Kokstad	-.154 (-.51/.20)	-.384 (-.69/-.06) *	.074 (-.24/.39)	.989 (.60/1.37) ***	.391 (.07/.71) *	.547 (.22/.87) ***	.551 (.21/.89)	.638 (.29/.98)
Kwa Sani	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Education								
No schooling	-.1.145 (-2.34/.05)	-.542 (-1.48/.39)	-.893 (-1.83/.05)	-.250 (-1.34/.84)	-.927 (1.88/.03)	(- -.166 (-1.09/.76)	.260 (-.71/1.23)	-.1.227 (-2.30/-.15)
Primary	-.735 (-1.35/-.11)	-.1.042 (-1.60/-.48) ***	-.459 (-1.01/.09)	.802 (.17/1.42) *	-.323 (-.87/.22)	-.181 (-.73/.37)	.355 (-.22/.93)	-.315 (-.88/.25)
Secondary	-.438 (-.94/.64) *	-.595 (-1.05/-.13) *	-.363 (-.83/.10)	.760 (.21/1.30) **	-.280 (-.74/.18)	-.021 (-.48/.44)	.300 (-.18/.79)	-.001 (-.47/.47)
Tertiary	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Vignette								
Depression	-.907 (-1.30/-.51) ***	.068 (-.25/.39)	-.398 (-.72/-.07) *	-.123 (-.47/.22)	-.440 (-.76/-.11) **	.066 (-.25/.38)	.152 (-.17/.48)	-.103 (-.43/.22)
Schizophrenia	-.144 (-.50/.21)	-.333 (-.66/-.00) *	-.125 (-.45/.20)	.071 (-.27/.42)	-.156 (-.48/.16)	-.037 (-.36/.29)	-.034 (-.37/.30)	-.194 (-.53/.14)
Alcohol	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Dependency								

E = Estimate. 95% CI = 95% Confidence interval. *p < 0.05, **p < 0.01, ***p < 0.001
^a = This parameter is set at zero because it is redundant.

7.1.3. Participants' willingness to seek help.

To determine participants' own willingness to seek help, they were asked whether they would go for help if they had a problem right now, like the person depicted in a vignette. Of the total participants, 711 (90.3%) indicated that they would, only 52 (6.6%) said no, and 24 (3.0%) did not know if they would go for help. Detailed results are presented in Table 7.9 below. Chi-square analysis indicated no significant differences between all various demographic variables on this item.

Table 7.9: Participants' willingness to seek help

	Would you go for help?		
	Yes	No	I don't know
Vignette			
Depression	241 (93.1%)	15 (5.8%)	3 (1.2%)
Schizophrenia	228 (89.1%)	20 (7.8%)	8 (3.1%)
Alcohol dependency	242 (89.0%)	17 (6.3%)	13 (4.8%)
District			
Kokstad	547 (90.3%)	42 (6.9%)	17 (2.8%)
Kwa Sani	164 (90.6%)	10 (5.5%)	7 (3.9%)
Gender			
Male	267 (89.9%)	20 (6.7%)	10 (3.4%)
Female	444 (90.6%)	32 (6.5%)	14 (2.9%)
Age			
18-34	442 (91.3%)	29 (6.0%)	13 (2.7%)
35-49	189 (90.4%)	12 (5.7%)	8 (3.8%)
50-64	58 (87.9%)	6 (9.1%)	3 (3.0%)
65+	22 (78.6%)	5 (17.9%)	1 (3.6%)
Education			
No schooling	22 (82.1%)	5 (7.1%)	0 (0.0%)
Primary	136 (87.7%)	11 (7.1%)	8 (5.2%)
Secondary	488 (91.9%)	30 (5.6%)	13 (2.4%)
Tertiary	64 (87.7%)	6 (8.2%)	3 (4.1%)

7.1.3.1 Predictors of participants' willingness to seek help.

Multinomial regression analysis was performed to determine predictors of participants' willingness to seek help. The findings, as depicted in Table 7.10, show that age predicted the willingness to seek help. In particular, participants between the ages of 18 – 34 were almost 3.4 times more likely to seek help than their counterparts aged 65 and above (OR = 3.46, 95% CI = 1.22 to 9.81). Furthermore, the odds of seeking help for participants between the ages of 35 – 49 were also

almost four times more likely than those aged 45 and above (OR = 3.58, 95% CI = 1.15 to 11.11).

Table 7.10: Multinomial logistic regression analysis of participants' willingness to seek help and demographic variables

Variable	Yes		Don't know	
	B	OR (95% CI)	B	OR (95% CI)
Age				
18 - 34	1.242	3.46 (1.22/9.81)**	.807	2.24 (.23/21.14)
35 - 49	1.275	3.58 (1.15/11.11)*	1.204	3.33 (.326/34.12)
50 - 64	.787	2.19 (.60/7.93)	.511	1.66 (.11/24.25)
65+	0 ^b		0 ^b	
Gender				
Female	.039	1.03 (.58/1.85)	-.134	.87 (.32/2.34)
Male	0 ^b		0 ^b	
District				
Kokstad	-.231	.794 (.39/1.61)	-.548	.57 (.189/1.76)
Kwa Sani	0 ^b		0 ^b	
Vignette				
Depression	.121	1.129 (.55/2.31)	-1.341	.26 (.06/1.09)
Schizophrenia	-.222	.801 (.40/1.56)	-.648	.52 (.17/1.56)
Alcohol Dependency	0 ^b		0 ^b	

Note: Reference category is No (n = 52).

B = Logistic coefficient. SE = Standard Error. OR = Odds Ratio. 95% CI = 95% Confidence interval.

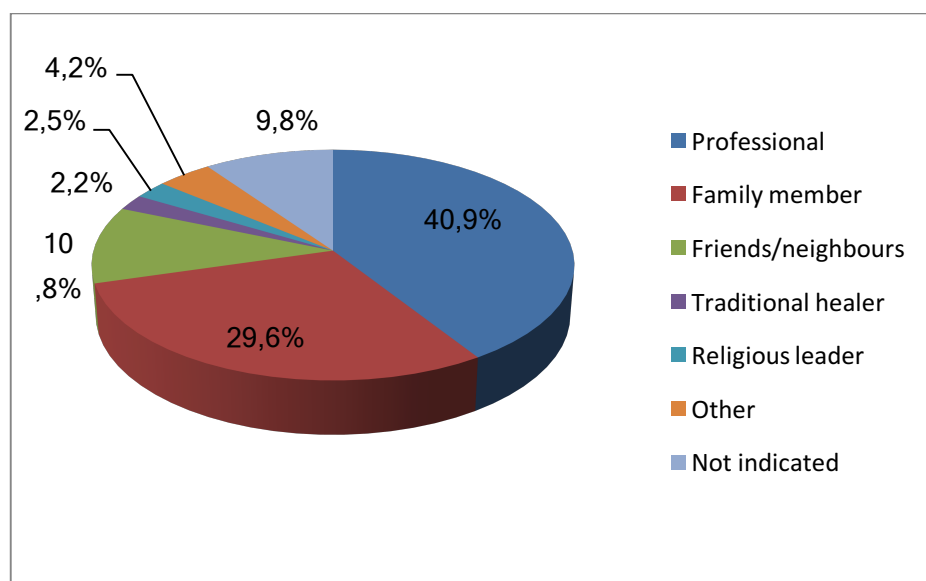
*p < 0.05, **p < 0.01, ***p < 0.001

^b = This parameter is set at zero because it is redundant

7.1.3.2. Participants' preferred sources for help

To assess who participants who show willingness to seek help would consult with, they were asked whom they would ask for help. As presented in Figure 7.2, 322 (40.9%) of the participants who showed willingness to seek help indicated that they would consult a professional, and 233 (29.6%) and 85 (10.8%) indicated that they would consult a close relative/family member and friends/neighbours, respectively.

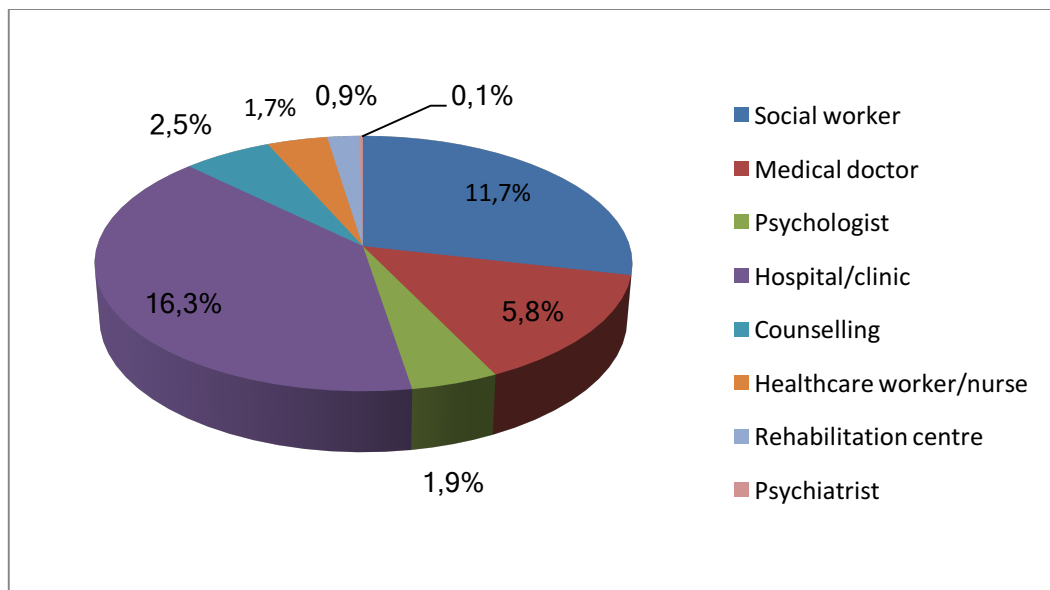
Figure 7.2: Participants' preferred sources for help



7.1.3.2.1. Professionals likely to be consulted.

Further descriptive analysis was undertaken to determine which specific professionals would be consulted by participants who indicated that they would seek professional help. The results indicated that most participants, 128 (16.3%), would go to the hospital/clinic, followed by 92 (11.7%) who would consult with a social worker, and 46 (5.8%) who indicated that they would be likely to consult with a medical doctor. Figure 7.3 below shows the detailed graphical presentation of professionals that participants indicated they would be likely to consult. Over three-quarters ($n = 562$, 79.2%) of participants who indicated that they would seek help if they had a problem like the one depicted in any of the three vignettes indicated that they would be 'very confident' in their ability to ask the identified person for help. Only 3 (0.4%) indicated that they would 'not be confident at all' in their ability to ask for help. When asked what might stop them from seeking help from the person identified, 621 (87.5%) of those participants who indicated they would go for help responded that 'nothing' would stop them. 26 (3.7%) and 19 (2.7%) respondents indicated that 'lack of money for consultation or transport' and 'fear of being judged/stigma', respectively, could possibly stop them from consulting.

Figure 7.3: Professionals likely to be consulted



7.1.4. Prognostic Views.

Participants' prognostic views were explored with two aims. The first aim was to determine what participants think about prognosis of mental illness if the patient receives appropriate treatment and on the other hand when treatment is not received. The second aim was to investigate participants' views regarding prognosis of a mental illness over a long period of time.

7.1.4.1. Views on prognosis and treatment.

To determine views regarding prognosis, participants were asked their prognostic views in the event that the person with mental illness presented in a vignette either received or did not receive the professional help that the participant thought was most appropriate. The majority of participants ($n = 563$, 71.5%) thought that full recovery with no problems was possible if the person received professional help. Correspondingly, more than half ($n = 527$, 67%) of participants thought that no improvement would be noticed without professional help. Table 7.11 and Table 7.12 below show these results in detail. Two hundred participants (78.1%) who completed the vignette related to schizophrenia believed that recovery with no problems was possible if the person received appropriate treatment. The same view was maintained by 69.5% and 67.2% of

participants who completed the vignettes depicting alcohol dependency and depression, respectively.

Table 7.11: Chances of recovery *with* professional help

Prognosis	Vignette, n (%)			
	Depression	Schizophrenia	Alcohol Dependency	Total
Full recovery with no problems	174 (67.2%)	200 (78.1%)	189 (69.5%)	563 (71.5%)
Full recovery, but problems reoccur	52 (20.1%)	29 (11.3%)	49 (18.0%)	130 (16.5%)
Partial recovery	14 (5.4%)	10 (3.9%)	18 (6.6%)	42 (5.3%)
Partial recovery, but problems reoccur	3 (1.2%)	2 (0.8%)	4 (1.5%)	9 (1.1%)
No improvement	4 (1.5%)	5 (2.0%)	0 (0.0%)	9 (1.1%)
I don't know/not indicated	12 (4.7%)	10 (3.9%)	12 (4.4%)	34 (4.3%)

Table 7.12: Chances of recovery *without* professional help

Prognosis	Vignette, n (%)			
	Depression	Schizophrenia	Alcohol Dependency	Total
Full recovery with no problems	45 (17.4%)	46 (18.0%)	52 (19.1%)	143 (18.2%)
Full recovery, but problems reoccur	11 (4.2%)	15 (5.9%)	12 (4.4%)	38 (4.8%)
Partial recovery	4 (1.5%)	4 (1.6%)	2 (0.7%)	10 (1.3%)
Partial recovery, but problems reoccur	4 (1.5%)	5 (2.0%)	2 (0.7%)	11 (1.4%)
No improvement	178 (68.7%)	168 (65.6%)	181 (66.5%)	527 (67.0%)
I don't know/not indicated	17 (6.6%)	18 (7.1%)	23 (8.4%)	58 (7.4%)

7.1.4.2. Views on prognosis over time.

Participants were asked to indicate their views of the mentally ill person in the long term from a list of possible prognostic behaviours. They were required to choose an option from a five-point Likert scale of: more likely, just as likely, less likely, depends, and don't know. As the results in Table 7.13 show, participants had good prognostic views of mental illness over time. In general, more participants ($n = 504$, 64.0%) believed that someone with mental illness is 'more likely' to be understanding of other people's feelings, and 500 (63.5%) held the view that the person would be a caring parent. 478 (60.7%) of the participants thought that someone with mental illness would have a good marriage. Nearly two-thirds ($n = 169$, 65.3%) of respondents who completed the questionnaire depicting the depression vignette thought that the person with depression would be a caring parent, and about 160 (61.8%) thought this person would be a productive worker.

This is followed by 157 (60.6%) participants who thought that a person depicted as depressed would be understanding of other people's feelings in the long term. About 161 (62.9%) of those who completed the vignette depicting schizophrenia were of the opinion that a schizophrenic patient would be a caring parent and understanding of other people's feelings, and 152 (59.4%) thought they would have a good marriage and be creative or artistic in the long term. Regarding long term prognostic view of alcohol dependency, more respondents ($n = 186$, 68.4%) believed that the person with this condition would be understanding of other people's feelings, while 173 (63.6%) and 170 (62.5%) thought that someone with alcohol dependency would have a good marriage and be a caring parent, respectively, in the long term.

Table 7.13: Perceptions of mental illness in the long term representing "more likely"

Prognosis	Vignette, n (%)			
	Depression	Schizophrenia	Alcohol Dependency	Total
Be violent	64 (24.7%)	68 (26.6%)	76 (27.9%)	208 (26.4%)
Drink too much alcohol	60 (23.2%)	55 (21.5%)	76 (27.9%)	191 (24.3%)
Take illegal drugs	50 (19.3%)	66 (25.8%)	83 (30.5%)	199 (25.3%)
Have poor friendships	54 (20.8%)	73 (28.5%)	68 (25.0%)	195 (24.8%)
Attempt suicide	64 (24.7%)	80 (31.3%)	69 (25.4%)	213 (27.1%)
Be understanding of other people's feelings	157 (60.6%)	161 (62.9%)	186 (68.4%)	504 (64.0%)
Have a good marriage	153 (59.1%)	152 (59.4%)	173 (63.6%)	478 (60.7%)
Be a caring parent	169 (65.3%)	161 (62.9%)	170 (62.5%)	500 (63.5%)
Be a productive worker	160 (61.8%)	149 (58.2%)	168 (61.8%)	477 (60.6%)
Be creative or artistic	148 (57.1%)	152 (59.4%)	169 (62.1%)	469 (59.6%)

7.1.4.2.1. Predictors of prognostic views.

To determine predictors of prognostic views, ordinal regression analysis was performed on items measuring participants' prognostic views of mental illness using demographic variables as predictors. The findings presented in Table 7.14 show that only age, gender and district variables were significant predictors of prognostic views. With participants aged 56 and above as a reference category, the results indicated that participants aged 50 – 64 associated people with mental illness as having a good marriage (OR = .35, 95% CI = -2.02 - -.05), and being a caring parent (OR = .32, 95% CI = -2.15 - -.11). Regarding gender, with males as a reference category, there was an association between females and the

perception that people with mental illness would be understanding of other people's feelings (OR = .65, 95% CI = -.72 - -.12).

The reference category for district is Kwa Sani, and the results show that there was an association between Kokstad and participants viewing the mentally ill as: violent (OR = .35, 95% CI = -1.36 - -.70), drinking too much alcohol (OR = .31, 95% CI = -1.50 - -.82), attempting suicide (OR = .32, 95% CI = -1.49 - -.80), being understanding of other people's feelings (OR = 3.75, 95% CI = .88 - 1.75), having a good marriage (OR = 4.77, 95% CI = 1.12 - 2.00), being a caring parent (OR = 4.74, 95% CI = 1.10 - 2.01), being a productive worker (OR = 5.53, 95% CI = 1.26 - 2.16), being creative or artistic (OR = 4.37, 95% CI = 1.05 - 1.89) in the long run.

Table 7.14: Ordinal logistic regression analysis of prognostic views and demographic variables

	Be violent	Drink too much alcohol	Take illegal drugs	Have poor friendships	Attempt suicide	Be understanding of other people's feelings	Have a good marriage	Be a caring parent	Be a productive worker	Be creative or artistic
Variable	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)
Age										
18 - 34	.457 (-.36/1.27)	.639 (-.19/1.47)	.093 (-.74/.92)	.453 (-.37/1.28)	.356 (-.48/1.19)	-.469 (-1.33/.40)	-.528 (-1.41/.35)	-.351 (-1.24/.54)	.033 (-.85/.92)	.241 (-.64/1.13)
35 - 49	.150 (-.67/.97)	.480 (-.35/1.31)	-.031 (-.86/.80)	.218 (-.61/1.04)	.303 (-.54/1.14)	-.076 (-.94/.79)	-.249 (-1.13/.63)	-.091 (-.99/.80)	.211 (-.68/1.10)	.492 (-.40/1.38)
50 - 64	-.092 (-.97/.79)	.287 (-.60/1.18)	-.075 (-.97/.82)	.028 (-.86/.91)	.158 (-.74/1.06)	-.763 (-1.72/.20)	-1.037 (-2.02/-.05) *	-1.138 (-2.15/-.11) *	-.747 (-1.74/.25)	-.198 (-1.17/.77)
65+	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Gender										
Female	-.131 (-.40/.14)	-.187 (-.46/.09)	-.254 (-.53/.02)	-.320 (-.59/-.04)	-.196 (-.47/.08)	-.425 (-.72/-.12) **	-.111 (-.40/.18)	-.060 (-.36/.24)	-.089 (-.38/.20)	-.130 (-.42/.16)
Male	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
District										
Kokstad	-1.036 (-1.36/-.70) ***	-1.160 (-1.50/-.82) ***	-1.062 (-1.39/-.72)	-.770 (-1.09/-.44)	-1.151 (-1.49/-.80) ***	1.322 (.88/1.75) **	1.564 (1.12/2.00) ***	1.557 (1.10/2.01) ***	1.714 (1.26/2.16) ***	1.477 (1.05/1.89) ***
Kwa Sani	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Education										
No schooling	.244 (-.66/1.15)	.300 (-.62/1.22)	.317 (-.60/1.24)	.692 (-.22/1.60)	.299 (-.63/1.23)	-.033 (-1.04/.97)	-.966 (-2.02/.09)	-.764 (-1.86/.33)	-.076 (-1.07/.91)	.174 (-.78/1.13)
Primary	.161 (-.38/.70)	-.010 (-.56/.54)	.058 (-.49/.61)	.395 (-.15/.94)	.038 (-.52/.59)	.350 (-.25/.95)	-.283 (-.86/.29)	.009 (-.58/.59)	-.032 (-.61/.55)	.043 (-.53/.62)
Secondary	-.048 (-.50/.41)	-.028 (-.49/.44)	.035 (-.43/.50)	.075 (-.38/.53)	-.194 (-.66/.27)	.099 (-.41/.61)	-.219 (-.69/.25)	-.102 (-.59/.39)	-.004 (-.49/.48)	-.042 (-.52/.44)
Tertiary	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Vignette										
Depression	.155 (-.16/.47)	.210 (-.11/.53)	.271 (-.05/.59)	.165 (-.15/.48)	-.046 (-.37/.28)	.302 (-.05/.66)	.113 (-.23/.46)	-.044 (-.40/.31)	.044 (-.30/.39)	.254 (-.09/.59)
Schizophrenia	.138 (-.18/.45)	.320 (-.01/.64)	.182 (-.14/.50)	.014 (-.30/.33)	-.302 (-.63/.02)	.188 (-.17/.55)	.037 (-.31/.39)	-.014 (-.37/.34)	.140 (-.21/.49)	.105 (-.24/.45)
Alcohol	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Dependency										

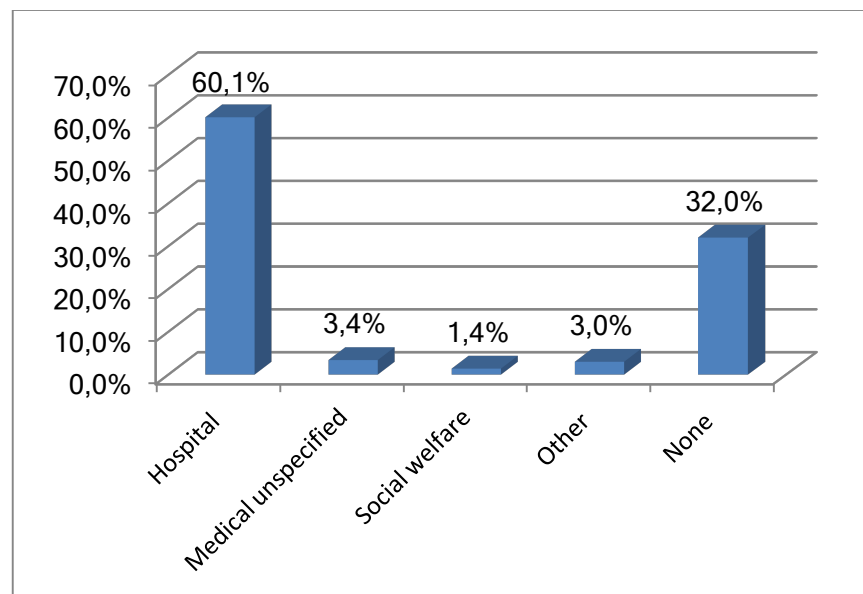
E = Estimate. 95% CI = 95% Confidence interval. *p < 0.05, **p < 0.01, ***p < 0.001

^a = This parameter is set at zero because it is redundant.

7.1.5. Awareness of institutions providing mental healthcare.

Participants' awareness of institutions that provide mental healthcare was also explored in this section. To assess their awareness, participants were asked to name the nearest place in their area they knew of that provides treatment to people with mental health problems. Their answers to this question contained a wide range of responses and the responses were clustered into the following five categories for easy analysis: 1) hospital/clinic (e.g. all hospitals or clinics that could be identified by their names or geographical areas where they are located); 2) medical unspecified (e.g. places or people that provide medical or psychological care but were not specified by name or geographical area, such as simply stating 'a doctor', 'a counsellor', or 'a psychologist', etc.); 3) social welfare (e.g. social workers or any mention of a social welfare institution, etc.); 4) other (e.g. special schools, churches, and non-specific responses like 'some place in Durban', etc.); and 5) none (e.g. responses like 'I don't know', 'can't think of any', etc.). Of the total sample, more than half ($n = 473$, 60.1%) responded that the hospital/clinic was the nearest place they knew of that provides treatment for people with mental health problems. This was followed by 27 (3.4%) participants who stated the category of medical unspecified, with only 24 (3.0%) participants' responses classified in the category of *other*. It is disconcerting to note that almost one in three ($n = 252$, 32.0%) of the total participants did not know of the nearest place that provides treatment for people with mental health problems. Figure 7.4 below is a graphical presentation of these results in further detail. The only significant difference that could be found with this question when using Chi-square analysis was related to district variable. More participants in Kokstad ($n = 390$, 64.4%), when compared to participants from Kwa Sani, rated the hospital/clinic as a place that they knew to provide treatment for people with mental health problems, $\chi^2(4, N = 390) = 23.86, p < 0.001$.

Figure 7.4: Institutions known to provide mental healthcare



7.1.5.1. Specific hospitals/clinics providing care for the mentally ill.

All responses that were categorised as 'hospital/clinic' when participants were asked about the places they know to provide care for the mentally ill were further analysed to identify specific hospitals or clinics that they referred to. For an easy analysis, these results are presented according to the districts where participants reside. Results presented in Table 7.15 show that, on the one hand, more than half ($n = 207$, 53.1%) of the participants from Kokstad knew Embizweni Hospital as the nearest place providing treatment for people with mental illness. Another 158 (40.5%) and 12 (3.1%) participants from Kokstad mentioned Kokstad Hospital and hospitals in Pietermaritzburg, respectively. On the other hand, 24 (28.9%) of the participants from Kwa-Sani Municipality stated that Underberg Clinic was the nearest place that they know that provides treatment for people with mental illness. Their second and third known places fell into the category of 'other' ($n = 19$, 22.9%) and Riverview Rehabilitation Centre ($n = 17$, 20.5%), respectively.

Table 7.15: Hospitals/clinics known to provide treatment for mental illness

Hospital/clinic	Kokstad	Kwa Sani	Total
Embizweni Hospital	207 (53.1%)	5 (6.0%)	212 (44.8%)
Kokstad Hospital	158 (40.5%)	3 (3.6%)	161 (34.0%)
Underberg Clinic	0 (0.0%)	24 (28.9%)	24 (5.1%)
Riverview Rehabilitation Centre	1 (0.3%)	17 (20.5%)	18 (3.8%)
Hospitals in Pietermaritzburg	12 (3.1%)	15 (18.1%)	27 (5.7%)
Hospitals in Eastern Cape	7 (1.8%)	0 (0.0%)	7 (1.5%)
Other	5 (1.3%)	19 (22.9%)	24 (5.1%)

7.1.5.1.1. *Predictors of awareness of institutions providing mental healthcare.*

Multinomial regression analysis was performed to determine demographic variables that predict participants' awareness of institutions providing mental healthcare. The findings, as detailed in Table 7.16 below, indicate that the type of mental illness predicts knowledge of institutions that provide care for the mentally ill among the current study participants. The odds of participants who completed a depression vignette identifying Kokstad Hospital, than those who could not identify any institution, were almost 0.5 times greater than those who completed the alcohol dependency vignette (OR = .46, 95% CI = .21 to .98). For participants who completed vignettes depicting schizophrenia, the odds of knowing Kokstad Hospital, than those who could not identify an institution, were 0.4 times more likely (OR = .41, 95% CI = .19 to .90) and almost 0.2 times more likely for Pietermaritzburg Hospital (OR = .15, 95% CI = .03 to .63), compared to those who completed the alcohol dependency vignette.

Table 7.16: Multinomial logistic regression analysis of participants' awareness of institutions providing mental healthcare and demographic variables

	Embizweni Hospital		Kokstad Hospital		Underberg Clinic		Riverview Rehabilitation		Pietermaritzburg Hospitals		Eastern Cape Hospitals		Other	
	B	OR (95% CI)	B	OR (95%/CI)	B	OR (95%/CI)	B	OR (95%/CI)	B	OR (95%/CI)	B	OR (95%/CI)	B	OR (95%/CI)
Gender														
Female	.188	1.20 (.68/2.13)	.355	1.42 (.78/2.5)	.317	1.37 (.52/3.60)	.029	1.02 (.35/2.95)	.856	2.35 (.86/6.36)	-.482	.61 (.12/2.99)	.904	2.47 (.86/7.06)
Male	0 ^b		0 ^b		0 ^b		0 ^b		0 ^b		0 ^b		0 ^b	
Vignette														
Depress.	-.376	.68 (.32/1.43)	-.768	.46 (.21/.98)*	.887	2.42 (.58/9.99)	-.803	.44 (.10/1.94)	-.580	.56 (.19/1.57)	-.174	.84 (.12/5.64)	-.898	.40 (.13/1.2)
Schizoph.	-.320	.72 (.34/1.53)	-.871	.41 (.19/.90)*	.484	1.62 (.36/7.15)	.091	1.09 (.30/3.93)	1.883	.15 (.03/.63)**	-.496	.60 (.07/4.82)	1.285	.27 (.07/.96)
Alc. Dep.	0 ^b		0 ^b		0 ^b		0 ^b		0 ^b		0 ^b		0 ^b	

Note: Reference category is None (n = 381). B = Logistic coefficient. SE = Standard Error. OR= Odds Ratio. 95% CI = 95% Confidence interval.

*p < 0.05, **p < 0.01, ***p < 0.001

Depress. = Depression. Schizoph. = Schizophrenia. Alc. Dep. = Alcohol Dependency

^b = This parameter is set at zero because it is redundant

7.1.6. Conclusion.

To conclude, the focus for this section was on participants' knowledge of and attitudes toward help-seeking for mental illness. Seeking professional help and referring the mentally ill to members of the family appeared to be the most preferred sources of help or support. Specific professional help preferred was a consultation with a social worker and going for counselling. When participants were asked to select a source of help or support from a list containing both professionals and non-professionals, they rated family GPs, followed by counsellors and psychologists as more preferred for the treatment of mental illness. Next, participants' opinions of medication they would consider helpful or appropriate for mental illness was assessed. The results indicated that more participants considered vitamins, minerals and tonics as likely to be helpful, followed by antidepressants and antipsychotics.

Participants' own willingness to seek help was assessed and the results indicate that approximately nine in ten participants would be willing to consult should they have mental illness. Many of them indicated that they would consult with a professional, followed by consulting relatives/family members and friends/neighbours. Hospitals/clinics, social workers and medical doctors were specific professionals that participants indicated that they themselves would consult. This section also examined prognostic views of mental illness, and found that most participants have positive prognostic views, with about 71.5% of participants believing that people with mental illness are likely to recover if professional help is received. Lastly, results regarding participants' awareness of institutions that provide mental healthcare concluded this section. The results show that more than half of participants (60.1%) know the hospital/clinic as the nearest place that provides care for the mentally ill. Specifically, more participants from Kokstad know Embizweni Hospital as the nearest place, on the one hand. On the other hand, Underberg Clinic was known as the nearest place by most participants from Kwa Sani. The next section presents the results on perceptions and attitudes toward mental illness.

7.2. Attitudes Toward Mental Illness

Results regarding participants' perceptions and attitudes towards mental illness are presented in this section, starting with stigmatising attitudes. Thereafter, the results regarding perceptions of discrimination by others, as well as participants' own friendly or cooperative attitudes should they come into contact with a person who suffers from mental illness will be outlined. Results related to perceptions of dangerousness and social distance attitudes will be presented next in this section, followed by results in respect of familiarity with mental illness. The last part of this section reports on the results on the public's sources of information related to mental illness.

7.2.1. Stigmatising attitudes.

To assess participants' attitudes toward mental illness, they were given nine stereotypical characteristics that are generally associated with people who are mentally ill. Participants were asked to rate them on a six-point Likert-scale ranging from 1 (strongly agree), 2 (agree), 3 (neither agree nor disagree), 4 (disagree), 5 (strongly disagree) to 6 (I don't know). Specifically, participants were asked, "What do you think or believe about these statements?" Table 7.17 contains the results of these questions, as well as the exact wording of these statements. In general, more than half of the participants (56.3%) strongly agreed that they would not vote for a politician if they knew he had suffered a problem like the one depicted in any of the three vignettes. The second and third stigmatising attitudes were that participants would not employ someone if they knew he had suffered a problem like the one in any of the vignettes (50.6%), and that people with a problem like the one in any of the three vignettes are dangerous (38.2%), respectively.

A Chi-square test was used to test if there are significant differences between stigmatising attitudes and the three disorders presented in the vignettes. The results indicated that participants had more stigmatising attitudes toward alcohol dependence than to depression and schizophrenia. Significant differences were noted on the following stigmatising attitudes toward alcohol dependence: not voting for a politician if it was known he suffered from a problem depicted in a vignette, $\chi^2 (12, N = 178) = 40.08, p < 0.001$; not employing someone they knew had a problem like the person in a vignette, $\chi^2 (10, N = 159) = 26.85, p <$

0.01; the problem depicted in a vignette is not a real medical illness, $\chi^2 (10, N = 113) = 28.74, p < 0.01$; it is best to avoid people with a problem like the one in a vignette so you don't develop this problem, $\chi^2 (10, N = 105) = 31.70, p < 0.001$; and people with a problem like the one in the vignette could come out of it if they wanted to, $\chi^2 (10, N = 83) = 19.00, p < 0.05$. When looking at the other two disorders separately (depression and schizophrenia), although responses are not statistically significant, the pattern of stigmatising attitudes were the same. For these disorders, respondents strongly agreed that they would not vote for a politician if they knew he suffered from mental illness, they would not employ someone if they knew he had a mental illness, and people with mental illness are dangerous. Table 7.17 presents these results more fully. Interestingly, in general, very few participants strongly agreed that if they had a problem like Bheki's that they would *not* tell anyone. This means that the majority of participants *would* openly talk about their condition should they suffer from mental illness.

Table 7.17: Respondents' stigmatising attitudes showing "strongly agree"

Attitudes towards mental illness	Disorder N (%)			Total	Pearson Chi-square test		
	Depression	Schizophrenia	Alcohol dependence		χ^2 value	df	P-value
People with a problem like Bheki's could come out of it if they wanted to	73 (28.2%)	73 (28.5%)	83 (30.5%)	229 (29.1%)	19.005	10	.040*
A problem like Bheki's is a sign of personal weakness	92 (35.5%)	63 (24.6%)	92 (33.8%)	247 (31.4%)	14.402	10	.155
Bheki's problem is not a real medical illness	73 (28.2%)	76 (29.7%)	113 (41.5%)	262 (33.3%)	28.745	10	.001**
People with a problem like Bheki's are dangerous	96 (37.1%)	82 (32.0%)	123 (45.2%)	301 (38.2%)	16.851	12	.155
It is best to avoid people with a problem like Bheki's so that you don't develop this problem	81 (31.3%)	58 (22.7%)	105 (38.6%)	244 (31.0%)	31.706	10	.000***
People with a problem like Bheki's are unpredictable	93 (35.9%)	73 (28.5%)	104 (38.2%)	270 (34.3%)	15.862	10	.104
If I had a problem like Bheki's I would not tell anyone	60 (23.2%)	62 (24.2%)	66 (24.3%)	188 (23.9%)	18.532	12	.100
I would not employ someone I knew if he had a problem like Bheki's	124 (47.9%)	115 (44.9%)	159 (58.5%)	398 (50.6%)	26.851	10	.003**
I would not vote for a politician if I knew he suffered a problem like Bheki's	143 (55.2%)	122 (47.7%)	178 (65.4%)	443 (56.3%)	40.088	12	.000***

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

7.2.2. Perceptions of discrimination by others.

Participants were also asked if they think the person depicted in a vignette would be discriminated against by others in the community if they knew about his problems. When the three disorders are combined, more than half of the participants ($n = 404$, 51.3%) thought that a person with mental illness would be discriminated against by others in the community if they knew about his problem. 312 (39.6%) participants did not think so, and 71 (9.0%) did not know if this person would be discriminated against by others in the community. When analysing this question according to specific disorder, most participants ($n = 153$, 56.3%) thought that the person suffering from alcohol dependency would be discriminated against more by others if they know of his condition. Almost half of the participants thought so for depression ($n = 129$, 49.8%) and schizophrenia ($n = 122$, 47.7%). Detailed results are presented in Table 7.18. A Chi-square analysis shows that these differences are statistically significant, $\chi^2 (4, N = 404) = 10.47, p < 0.05$; suggesting that participants thought that a person with alcohol dependency is more likely to be discriminated against when compared to a person suffering from depression or schizophrenia. There was also a significant difference when this item was analysed according to district, suggesting that participants from Greater Kokstad Municipality, when compared to their counterparts from Kwa Sani Municipality, were more likely to think that a person with mental illness would be discriminated against by others, $\chi^2 (2, N = 320) = 8.50, p < 0.05$. An analysis by age also indicates that more participants (64.3%) who are 65 years old and older thought that this person would be discriminated against, $\chi^2 (6, N = 18) = 12.51, p < 0.05$. Significant differences according to level of education were also found, with 64.4% of participants who have a tertiary level of education thinking that a mentally ill person would be discriminated against by others if they know about his condition, $\chi^2 (6, N = 47) = 16.88, p < 0.01$.

Table 7.18: Participants' perceptions of the public's discriminating attitudes

	Would the mentally ill be discriminated by others in the community?			Would your contact with the mentally ill be friendly & cooperative?		
	Yes	No	I don't know	Yes	No	I don't know
Vignette*				Vignette		
Depression	129 (49.8%)	114 (44.0%)	16 (6.2%)	183 (70.7%)	38 (14.7%)	38 (14.7%)
Schizophrenia	122 (47.7%)	102 (39.8%)	32 (12.5%)	179 (69.9%)	42 (16.4%)	35 (13.7%)
Alcohol dependency	153 (56.3%)	96 (35.3%)	23 (8.5%)	191 (70.2%)	33 (12.1%)	48 (17.6%)
District*				District***		
Kokstad	320 (52.8%)	225 (37.1%)	61 (10.1%)	394 (65.0%)	101 (16.7%)	111 (18.3%)
Kwa Sani	84 (46.4%)	87 (48.1%)	10 (5.5%)	159 (87.8%)	12 (6.6%)	10 (5.5%)
Gender				Gender*		
Male	154 (51.9%)	112 (37.7%)	31 (10.4%)	196 (66.0%)	54 (18.2%)	47 (15.8%)
Female	250 (51.0%)	200 (40.8%)	40 (8.2%)	357 (72.9%)	59 (12.0%)	74 (15.1%)
Age**				Age**		
18-34	232 (47.9%)	210 (43.3%)	42 (8.7%)	349 (72.1%)	72 (14.9%)	63 (13.0%)
35-49	110 (52.6%)	76 (36.4%)	23 (11.0%)	131 (67.7%)	30 (14.4%)	48 (23.0%)
50-64	44 (66.7%)	18 (27.3%)	4 (6.1%)	53 (80.3%)	9 (13.6%)	4 (6.1%)
65+	18 (64.3%)	8 (28.6%)	2 (7.1%)	63 (13.0%)	48 (23.0%)	4 (6.1%)
Education*				Education		
No schooling	13 (46.4%)	14 (50.0%)	1 (3.6%)	20 (71.4%)	4 (14.3%)	4 (14.3%)
Primary	93 (60.0%)	51 (32.9%)	11 (7.1%)	104 (67.1%)	21 (13.5%)	30 (19.4%)
Secondary	251 (47.3%)	229 (43.1%)	51 (9.6%)	373 (7.02%)	81 (15.3%)	77 (14.5%)
Tertiary	47 (51.3%)	312 (39.6%)	71 (9.0%)	56 (76.7%)	7 (9.6%)	10 (13.7%)

*p < 0.05, **p < 0.01, ***p < 0.001

7.2.2.1. Predictors of perceptions of discrimination of the mentally ill by others.

Multinomial logistic analysis to predict participants' perceptions of discrimination against the mentally ill by others, using demographic variables as predictors, was performed. The results are presented in Table 7.19 below. These results show that location and education predicted perception of discrimination by others. In particular, the odds of participants from Kokstad thinking that mentally ill people would be discriminated against by others, than those who do not think so, are almost 1.5 times (OR = 1.47, 95% CI = 1.04 to 2.08) higher as compared to those of participants from Kwa Sani. In addition, participants with no schooling and those with a secondary level of education are 0.65 (OR = .35, 95% CI = .14 to .90) and 0.58 (OR = .42, .23 to .74) times more likely, respectively, to think that people

with mental illness would be discriminated against by others if their condition is known to others.

Table 7.19: Multinomial logistic regression analysis of participants' perceptions of discrimination of the mentally ill by others and demographic variables

Variable	Yes		Don't know	
	B	OR (95% CI)	B	OR (95% CI)
Age				
18 - 34	-.711	.49 (.20/1.15)	-.223	.80 (.16/3.90)
35 - 49	-.441	.64 (.26/1.55)	.191	1.2 (.24/6.10)
50 - 64	.083	1.08 (.40/2.94)	-.118	.88 (.13/5.88)
65+	0 ^b		0 ^b	
Gender				
Female	-.095	.90 (.66/1.23)	-.325	.72 (.42/1.21)
Male	0 ^b		0 ^b	
District				
Kokstad	.387	1.47 (1.04/2.08)*	.858	.35 (.15/.81)
Kwa Sani	0 ^b		0 ^b	
Education				
No schooling	-1.034	.35 (.14/.90)*	-1.828	.16 (.01/1.44)
Primary	-.359	.69 (.36/1.32)	-.723	.48 (.16/1.39)
Secondary	-.868	.42 (.23/.74)**	-.691	.50 (.20/1.21)
Tertiary	0 ^b		0 ^b	
Vignette				
Depression	-.342	.71 (.49/1.01)	-.535	.58 (.29/1.17)
Schizophrenia	-.287	.75 (.52/1.08)	.270	1.30 (.71/2.39)
Alcohol Dependency	0 ^b		0 ^b	

Note: Reference category is No (n = 312).

B = Logistic coefficient. SE = Standard Error. OR = Odds Ratio. 95% CI = 95% Confidence interval.

*p < 0.05, **p < 0.01, ***p < 0.001

^b = This parameter is set at zero because it is redundant

7.2.3. Participants' friendly or cooperative contact.

In addition to asking participants whether they think someone would be discriminated against by others in the community if these others knew about their mental illness, participants were asked whether their own contact would be friendly or cooperative if they were to come into contact with someone having a problem like Bheki's. The overwhelming majority of participants (n = 553, 70.3%) responded that their contact would be friendly and cooperative. An inferential statistical analysis showed statistically significant differences when analysing this question in terms of the following three demographic variables: district, gender and age. Chi-square analysis indicated that more participants from Kwa Sani Municipality (n = 159, 87.8%) than Greater Kokstad Municipality (n = 394, 65%) reported that they would have more friendly and cooperative contact with people suffering from mental illness, $\chi^2 (2, N = 394) = 34.94, p < 0.001$. Furthermore, the majority of female participants (n = 357, 72.9%) as compared to their male counterparts (n = 196, 66.0%), were more likely to have a friendly and cooperative

attitude towards a person suffering from a mental illness, $\chi^2 (2, N = 357) = 6.16, p < 0.05$. Lastly, more participants ($n = 53, 80.3\%$) between the ages of 50 to 64 also reported that their contact with the mentally ill person depicted in the vignette would be friendly or cooperative, $\chi^2 (6, N = 53) = 18.00, p < 0.01$. See Table 7.20, below, for a detailed outline of these results.

7.2.3.1. Predictors of friendly contact.

A multinomial logistic regression analysis of participants' beliefs about their own friendly contact toward the mentally ill and demographic variables was conducted and the results are presented in Table 7.20. These results show that gender and district predict friendly contact toward the mentally ill. Specifically, the odds of females who would have more friendly contact than those who would not are almost 1.7 times (OR = 1.66, 95% CI = 1.10 to 2.50) higher than those of males. Regarding district, the results show that participants from Kokstad are 0.71 times (OR = .29, 95% CI = .15 to .55) less likely to have friendly contact with the mentally ill when compared to their counterparts from Kwa Sani.

Table 7.20: Multinomial logistic regression analysis of participants' beliefs about their own friendly contact toward the mentally ill and demographic variables

Variable	Yes		Don't know	
	B	OR (95% CI)	B	OR (95% CI)
Age				
18 - 34	-.724	.48 (.11/2.12)	1.099	.29 (.05/1.49)
35 - 49	-.829	.43 (.09/1.97)	-1.232	.53 (.10/2.81)
50 - 64	-.530	.58 (.11/2.96)**	-.629	.14 (.02/1.08)
65+	0 ^b		0 ^b	
Gender				
Female	.511	1.66 (1.10/2.50)**	.365	1.44 (.85/2.42)
Male	0 ^b		0 ^b	
District				
Kokstad	-1.223	.29 (.15/.55)***	.277	1.31 (.54/3.18)
Kwa Sani	0 ^b		0 ^b	
Education				
No schooling	-.470	.62 (.16/2.36)	-.357	.70 (.12/3.79)
Primary	-.480	.61 (.21/1.54)	.000	1.00 (.32/3.05)
Secondary	-.552	.57 (.25/1.30)	-.407	.66 (.24/1.83)
Tertiary	0 ^b		0 ^b	
Vignette				
Depression	-.184	.83 (.50/1.38)	-.375	.68 (.36/1.29)
Schizophrenia	-.306	.73 (.44/1.21)	-.557	.57 (.30/1.07)
Alcohol Dependency	0 ^b		0 ^b	

Note: Reference category is No ($n = 113$).

B = Logistic coefficient. SE = Standard Error. OR = Odds Ratio. 95% CI = 95% Confidence interval.

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

^b = This parameter is set at zero because it is redundant

7.2.4. Dangerousness.

To examine the participants' perceptions and attitudes of dangerousness, they were asked to rate 5 stereotypical characteristics of dangerousness that are usually associated with mentally ill people on a six-point Likert scale of: 1 (strongly agree), 2 (agree), 3 (neither agree or disagree), 4 (disagree), 5 (strongly disagree), and 6 (I don't know). The results, as depicted in Table 7.21, indicate that in general, when the three disorders are combined, more participants (61.6%) strongly agree that a mentally ill person lacks self-control. Another 59.5% and 58.6% of participants perceived the mentally ill as frightening and aggressive, respectively. Chi-square analysis shows significant differences regarding perceptions of dangerousness between the three disorders. This analysis shows that most perceptions of dangerousness were attributed to alcohol dependency more than to depression and schizophrenia. People suffering from alcohol dependency were mostly perceived as: lacking self-control $\chi^2 (12, N = 199) = 43.55, p < 0.001$; aggressive $\chi^2 (12, N = 195) = 45.54, p < 0.001$; frightening $\chi^2 (12, N = 184) = 33.91, p < 0.01$; unpredictable $\chi^2 (12, N = 139) = 32.54, p < 0.01$; and dangerous $\chi^2 (12, N = 130) = 32.04, p < 0.01$. When looking at specific disorders, 57.5% of participants perceived a depressed person as: lacking self-control, frightening (55.2%) and aggressive (52.5%). For schizophrenia, attitudes of dangerousness were: frightening (55.1%), lack of self-control (53.5%), and aggressive (50.8%). Apart from significant differences found between vignettes, significant differences were also found between the variable of gender. Chi-square analysis shows significant differences between gender and perception of dangerousness, with more females perceiving the mentally ill as dangerous $\chi^2 (6, N = 206) = 15.63, p < 0.05$, and aggressive $\chi^2 (6, N = 297) = 15.68, p < 0.05$.

Table 7.21: Participants' dangerousness attitudes toward mental illness

Dangerousness attitudes towards mental illness	Disorder %			Total %	Pearson Chi-square test		
	Depression	Schizophrenia	Alcohol dependence		χ^2 value	df	<i>P</i> -value
Dangerous	100 (38.6%)	100 (39.1%)	130 (47.8%)	330 (41.9%)	32.046	12	.001**
Unpredictable	108 (41.7%)	107 (41.8%)	139 (51.1%)	354 (45.0%)	32.549	12	.001**
Lacking self-control	149 (57.5%)	137 (53.5%)	199 (73.2%)	485 (61.6%)	43.558	12	.000***
Aggressive	136 (52.5%)	130 (50.8%)	195 (71.7%)	461 (58.6%)	45.548	12	.000***
Frightening	143 (55.2%)	141 (55.1%)	184 (67.6%)	468 (59.5%)	33.917	12	.001**

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

7.2.4.1. Predictors of attitudes of dangerousness.

Ordinal logistic regression analysis was performed to determine predictors of dangerousness using demographic variables. The findings, as presented in Table 7.22, indicate that all variables, with the exception of age, predict different perceptions of dangerousness. The results of gender analysis, with males set as a reference category, show an association between females and perception of aggressiveness (OR = .72, 95% CI = -.62 to -.04). With regard to district, a significant association exists between Kokstad and the perceptions dangerous (OR = 1.50, 95% CI = .09 to .71), unpredictable (OR = 1.49, 95% CI = .08 to .71), aggressive (OR = .59, 95% CI = -.84 to -.20), and frightening (OR = .64, 95% CI = -.76 to -.12), when Kwa Sani was set as a reference category.

Analysis according to the level of education, with tertiary level of education set as a reference category, found an association between primary level of education and the perception of the mentally ill as being unpredictable (OR = 1.81, 95% CI = .04 to 1.14). Regarding analysis according to vignette, the results indicate that both depression and schizophrenia were associated with all dependent variables, with alcohol dependency set as a reference category. To be specific, an association was found between depression and being dangerous (OR = 1.60, 95% CI = .15 to .78), unpredictable (OR = 1.63, 95% CI = .17 to .81), lacking self-control (OR = 2.05, 95% CI = .36 to 1.07), aggressive (OR = 2.40, 95% CI = .52 to 1.22), and frightening (OR = 1.71, 95% CI = .19 to .87). For schizophrenia, an association was found between being dangerous (OR = 1.62, 95% CI = .16 to .80), unpredictable (OR = 1.67, 95% CI = .18 to .83), lacking self-control (OR = 2.22, 95% CI = .43 to 1.15), aggressive (OR = 2.47, 95% CI = .55 to 1.25), and frightening (OR = 1.55, 95% CI = .09 to .78).

Table 7.22: Ordinal logistic regression analysis of perceptions of dangerousness and demographic variables

Variable	Dangerous	Unpredictable	Lacking self-control	Aggressive	Frightening
	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)
Age					
18 – 34	.436 (-.39/1.26)	.018 (-.79/.83)	.379 (-.54/1.29)	.273 (-.66/1.21)	.085 (-.82/.99)
35 – 49	.409 (-.42/1.2)	-.198 (-1.01/.622)	.239 (-.68/1.16)	.332 (-.61/1.27)	.117 (-.78/1.02)
50 - 64	.532 (-.35/1.4)	-.229 (-1.10/.65)	-.124 (-1.12/.89)	.282 (-.72/1.28)	-.417 (-1.41/.57)
65+	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Gender					
Female	-.057 (-.32/.21)	.089 (-.18/.36)	-.104 (-.39/.18)	-.334 (-.62/-.04)*	-.120 (-.40/.16)
Male	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
District					
Kokstad	.403 (.09/.71)*	.399 (.08/.71)*	.105 (-.23/.44)	-.522 (-.84/-.20)***	-.442 (-.76/-.12)**
Kwa Sani	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Education					
No schooling	.666 (-.22/1.55)	.118 (-.79/1.03)	.018 (-.99/1.03)	-.026 (-1.09/.95)	-.515 (-1.52/.49)
Primary	.334 (-.20/.87)	.596 (.04/1.14)**	.467 (-.11/1.05)	.067 (-.51/.64)	-.072 (-.63/.49)
Secondary	.288 (-.17/.74)	.233 (-.23/.69)	.139 (-.36/.63)	.091 (-.39/.57)	-.175 (-.65/.30)
Tertiary	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Vignette					
Depression	.469 (.15/.78)**	.491 (.17/.81)**	.719 (.36/1.07)***	.873 (.52/1.22)***	.537 (.19/.87)**
Schizophrenia	.481 (.16/.80)**	.508 (.18/.83)**	.796 (.43/1.15)***	.906 (.55/1.25)***	.436 (.09/.78)*
Alcohol	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Dependency					

E = Estimate. 95% CI = 95% Confidence interval. *p < 0.05, **p < 0.01, ***p < 0.001

^a = This parameter is set at zero because it is redundant.

7.2.5. Social distance attitudes.

To assess participants' social distance attitudes, they were given 10 statements that contain attitudes towards someone and asked to rate them on a 5-point Likert scale ranging from: 1 (definitely willing), 2 (probably willing), 3 (probably unwilling), 4 (definitely unwilling), to 5 (don't know). From these statements, participants were asked how willing would they be to have a range of personal relationships and to engage in certain activities with a person depicted in a vignette. Table 7.23 provides the results, as well as specific statements posed to participants. The results show that in general, or when the three disorders are combined, participants showed willingness to have a closer social distance with a person showing symptoms of mental illness when the relationship or engagement was perceived to be less intimate, on the one hand. For example, of the total sample, 70.6% of participants indicated that they would be definitely willing to move next door to a mentally ill patient, and 60.9% would spend an evening socialising with a mentally ill patient. Another 58.8% of participants reported that they were definitely willing to make friends with and have the person depicted in

a vignette live in their neighborhood. On the other hand, a wider social distance was noticed when the relationship or engagement with a mentally ill person was perceived to be more intimate. Only 26.9% and 31.8% of participants were definitely willing to have someone with mental illness look after their children, or have a relationship with the people depicted in the vignettes, respectively.

When looking at specific disorders, an overwhelming majority of participants showed willingness for a closer social distance to someone with depression. Most of these participants (79.5%) were definitely willing or probably willing to move next door to the depressed person. However, the least desire for a greater social distance was recorded toward someone suffering from alcohol dependency, with only 26.9% of participants indicating that they would be definitely willing to have this person look after their children.

Table 7.23: Participants' social distance attitudes

Definitely willing to:	Disorder %			Total %	Median	Chi-square value	df	P-value
	Depression	Schizophrenia	Alcohol dependency					
Move next door to Bheki?	79.5%	66.4%	66.2%	70.6%	1	14.712	2	.001
Spend an evening socialising with Bheki?	69.1%	54.7%	58.8%	60.9%	1	11.973	2	.003
Make friends with Bheki?	66.0%	54.3%	56.3%	58.8%	1	8.453	2	.015
Have a relationship with Bheki?	36.3%	35.9%	23.5%	31.8%	2	24.632	2	.000
Have Bheki start working closely with you on a job?	56.0%	53.9%	43.8%	51.1%	1	9.160	2	.010
Have Bheki looking after your children?	32.8%	28.1%	20.2%	26.9%	4	1.577	2	.455
Have Bheki marry in your family?	42.1%	38.3%	28.3%	36.1%	2	17.615	2	.000
Live in the same room with Bheki?	51.7%	44.5%	37.9%	44.6%	2	18.375	2	.000
Eat food cooked by Bheki?	54.8%	44.9%	40.8%	46.6%	2	9.116	2	.010
Have people like Bheki living in your neighborhood?	69.1%	58.2%	49.6%	58.8%	1	20.847	2	.000

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

7.2.5.1. Predictors of social distance.

Ordinal logistic regression analysis was conducted to determine predictors of social distance attitudes using demographic variables as predictors. Age and gender were not significant predictors of social distance attitudes. The results, as presented in Table 7.24, show that district, level of education and the type of disorder (vignette) predicted social distance attitudes. To be specific, an analysis according to district, with Kwa Sani as predictor variable, shows an association between Kokstad and making friends with Bheki (OR = 1.63, 95% CI = .14 to .83), having a relationship with Bheki (OR = .73, 95% CI = -.62 to -.01), as well as having people like Bheki living in your neighbourhood (OR = 1.41, 95% CI = .00 to .68). For education, with tertiary level of education set as reference category, an association is found between having no schooling and moving next door to Bheki (OR = .29, 95% CI = -2.44 to .00), and making friends with Bheki (OR = .34, 95% CI = -2.14 to .02).

An analysis according to vignette, with alcohol dependency set as reference category, indicates that both depression and schizophrenia were significantly associated with all dependent variables. To be specific, depression was significantly associated with moving next door to Bheki (OR = .50, 95% CI = -1.07 to -.30), spending an evening socialising with Bheki (OR = .67, 95% CI = -.74 to -.05), making friends with Bheki (OR = .63, 95% CI = -.81 to -.12), having a relationship with Bheki (OR = .54, 95% CI = -.93 to -.31), having Bheki start working closely with you on a job (OR = .59, 95% CI = -.84 to -.20), having Bheki look after your children (OR = .53, 95% CI = -.95 to -.30), having Bheki marry in your family (OR = .54, 95% CI = -.92 to -.29), living in the same room with Bheki (OR = .51, 95% CI = -.99 to .35), eating food cooked by Bheki (OR = .57, 95% CI = -.88 to -.24) and having people like Bheki living in your neighbourhood (OR = .44, 95% CI = -1.16 to -.47). Schizophrenia is significantly associated with moving next door to Bheki (OR = .92, 95% CI = -.44 to .27), spending an evening socialising with Bheki (OR = 1.07, 95% CI = -.27 to .40), making friends with Bheki (OR = .92, 95% CI = -.41 to .25), having a relationship with Bheki (OR = .53, 95% CI = -.94 to -.31), having Bheki start working closely with you on a job (OR = .60, 95% CI = -.83 to -.18), having Bheki look after your children (OR = .57, 95% CI = -.89 to -.23), having Bheki marry in your family (OR = .59, 95% CI = -.84 to -.21), living in the same room with Bheki (OR = .67, 95% CI = -.72 to -.08), eating food cooked by Bheki (OR = .123, 95% CI = -.52 to .11) and

having people like Bheki living in your neighbourhood (OR = .65, 95% CI = -.75 to -.09).

Table 7.24: Ordinal logistic regression analysis of social distance and demographic variables

	Move next door to Bheki	Spend an evening socialising with Bheki	Make friends with Bheki	Have a relationship with Bheki	Have Bheki to start working closely with you on a job	Have Bheki looking after your children	Have Bheki marry in your family	Live in the same room with Bheki	Eat food cooked by Bheki	Have people like Bheki living in your neighbourhood
Variable	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)	E (95% CI)
Age										
18 - 34	-.541 (-1.50/.42)	-.520 (-1.38/.34)	-.562 (-1.42/.30)	-.255 (-1.06/.55)	-.606 (-1.43/.21)	-.579 (-1.42/.27)	-.736 (-1.56/.09)	-.388 (-1.21/.44)	-.965 (-1.79/-.13) *	-.963 (-1.80/-.12) *
35 - 49	-.059 (-1.02/.90)	-.059 (-.92/.80)	-.187 (-1.05/.67)	-.138 (-.94/.67)	-.341 (-1.16/.48)	-.490 (-1.34/.36)	-.677 (-1.51/.15)	-.162 (-.99/.66)	-.617 (-1.44/.21)	-.537 (-1.37/.30)
50 - 64	-.501 (-1.02/.90)	-.812 (-1.76/.14)	-.903 (-1.85/.04)	-.737 (-1.61/.13)	-.867 (-1.76/.02)	-.822 (-1.73/.08) *	-1.034 (-1.93/-.13) *	-.719 (-1.61/.17)	-.887 (-1.77/.01) *	-1.261 (-2.19/-.33) **
65+	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Gender										
Female	.050 (-.27/.37)	-.124 (-.41/.16)	-.046 (-.33/.24)	-.080 (-.34/.18)	.025 (-.25/.30)	-.228 (-.50/.05)	-.197 (-.46/.07)	-.023 (-.29/.24)	-.153 (-.42/.12)	-.135 (-.42/.15)
Male	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
District										
Kokstad	.046 (-.32/.41)	.207 (-.13/.55)	.488 (.14/.83) **	-.320 (-.62/-.01) *	.293 (-.03/.61)	-.433 (-.75/-.11)	-.179 (-.48/.13)	.083 (-.23/.39)	.013 (-.30/.32)	.344 (.00/.68) *
Kwa Sani	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Education										
No schooling	-1.222 (-2.44/.00) *	-.831 (-1.87/.21)	-1.082 (-2.14/-.02) *_	-.651 (-1.54/.24)	-.623 (-1.57/.32)	-.678 (-1.59/.24)	-.890 (-1.81/.03)	-.723 (-1.65/.20)	-.568 (-1.50/.36)	-.643 (-1.63/.35)
Primary	-.290 (-.90/.32)	.129 (1.43/.69)	-.072 (-.63/.48)	-.093 (-.62/.44)	.071 (-.47/.61)	-.450 (-1.00/.10)	-.258 (-.79/.28)	-.134 (-.67/.40)	.058 (-.60/.48)	-.044 (-.61/.52)
Secondary	-.335 (-.84/.17)	-.223 (-.70/.25)	-.237 (-.70/.23)	-.219 (-.66/.23)	-.184 (-.64/.27)	-.182 (-.65/.29)	-.143 (-.60/.31)	-.254 (-.71/.20)	.018 (-.44/.48)	-.176 (-.65/.30)
Tertiary	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a
Vignette										
Depression	-.690 (-1.07/-.30) ***	-.399 (-.74/-.05) *	-.468 (-.81/-.12) **	-.625 (-.93/-.31) ***	-.523 (-.84/-.20) ***	-.627 (-.95/-.30) ***	-.610 (-.92/-.29) ***	-.671 (-.99/.35) ***	-.567 (-.88/-.24) *	-.820 (-1.16/-.47) ***
Schizophrenia	-.082 (-.44/.27)	.064 (-.27/.40)	-.079 (-.41/.25)	-.627 (-.94/-.31) ***	-.509 (-.83/-.18) **	-.564 (-.89/-.23) ***	-.530 (-.84/-.21) ***	-.401 (-.72/-.08) **	-.204 (-.52/.11)	-.423 (-.75/-.09) *
Alcohol Dependency	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a	0 ^a

E = Estimate. 95% CI = 95% Confidence interval. *p < 0.05, **p < 0.01, ***p < 0.001

^a = This parameter is set at zero because it is redundant.

7.2.6. Familiarity with mental illness.

Prior to exploring if there is a relationship between familiarity with mental illness and stigmatising attitudes, analysis to explore participants' familiarity with mental illness was conducted. Familiarity was measured by participants either knowing someone who has suffered from a mental illness, or having experienced mental illness themselves. Participants were asked if anyone in their family or close circle of friends had ever had problems similar to the person depicted in any of the three vignettes. As can be seen in Table 7.25 below, 339 (43.1%) of the participants admitted that their family member or close friend had experienced a similar mental health problem. About 70.8% ($n = 240$) of them knew one family member or a friend with mental illness, and 29.8% ($n = 99$) knew more than one such person. More participants knew a family member or a close friend with alcohol dependency ($n = 135$, 39.8%) as compared to depression ($n = 116$, 34.2%) and schizophrenia ($n = 88$, 26.0%). These differences were found to be significant when analysed using a Chi-square test, $\chi^2(4, N = 135) = 16.14, p < 0.01$. Another significant difference was found between gender, with more females ($n = 227$, 46.3%) than males ($n = 112$, 37.7%) knowing someone with mental illness, $\chi^2(2, N = 227) = 6.49, p < 0.05$. When district variable was computed, more participants from Greater Kokstad ($n = 277$, 45.7%) compared to participants from Kwa Sani Municipality ($n = 62$, 34.3%) reported knowing a family member or close friend with mental illness, $\chi^2(2, N = 277) = 7.55, p < 0.05$. Other demographic variables did not show significant differences on this question.

Participants were further asked if they ever had problems similar to Bheki's. Just over one in four ($n = 206$, 26.2%) participants reported that they had experienced problems similar to that of the person presented in any of the three vignettes. Of those who indicated that they had experienced problems similar to the person in a vignette, 36.9% ($n = 76$) were responding to the depression vignette, while 34.0% ($n = 70$) and 29.1% ($n = 60$) were responding to vignettes depicting alcohol dependency and schizophrenia, respectively. Only a Chi-square analysis by district reflected statistical differences when this question was analysed in terms of demographic variables. This analysis shows that more participants from Kokstad ($n = 179$, 86.9%) than Kwa Sani ($n = 27$, 13.1%) reported to have had problems similar to that of the person presented in the vignette, $\chi^2(2, N = 179) = 17.89, p < 0.001$.

Although not statistically significant, more women than men reported ever having experienced mental illness. These results are presented in detail in Table 7.25 below.

Table 7.25: Familiarity with mental illness

	Has anyone in your family or close friends ever had similar problems to the person in a vignette?			Vignette	Ever had similar problems to the person in a vignette?		
	Yes	No	I don't know		Yes	No	I don't know
Vignette**							
Depression	116 (44.8%)	137 (52.9%)	6 (2.3%)	Depression	76 (29.3%)	171 (66.0%)	12 (4.6%)
Schizophrenia	88 (34.4%)	162 (63.3%)	6 (2.3%)	Schizophrenia	60 (23.4%)	184 (71.9%)	12 (4.6%)
Alcohol dependency	135 (49.6%)	136 (50.0%)	1 (0.4%)	Alcohol dependency	70 (25.7%)	198 (72.8%)	4 (1.5%)
District*				District***			
Kokstad	277 (45.7%)	319 (52.6%)	10 (1.7%)	Kokstad	179 (29.5%)	403 (66.5%)	24 (4.0%)
Kwa Sani	62 (34.3%)	116 (64.1%)	3 (1.7%)	Kwa Sani	27 (14.9%)	150 (82.9%)	4 (2.2%)
Gender*				Gender			
Male	112 (37.7%)	178 (59.9%)	7 (2.4%)	Male	75 (25.3%)	209 (70.4%)	13 (4.4%)
Female	227 (46.3%)	257 (52.4%)	6 (1.2%)	Female	131 (26.7%)	344 (70.2%)	15 (3.1%)
Age				Age			
18-34	208 (43.0%)	266 (50.0%)	10 (2.1%)	18-34	122 (25.2%)	345 (71.3%)	17 (3.5%)
35-49	86 (41.1%)	120 (57.4%)	3 (1.4%)	35-49	56 (26.8%)	145 (69.4%)	8 (3.8%)
50-64	34 (51.5%)	32 (48.5%)	0 (0.0%)	50-64	23 (34.8%)	42 (63.6%)	1 (1.5%)
65+	11 (39.3%)	17 (60.7%)	0 (0.0%)	65+	5 (17.9%)	21 (75.0%)	2 (7.1%)
Education schooling				Education			
No schooling	7 (25.0%)	21 (75.0%)	0 (0.0%)	No schooling	5 (17.9%)	20 (71.4%)	3 (10.7%)
Primary	67 (43.2%)	85 (54.8%)	3 (1.9%)	Primary	51 (32.9%)	99 (63.9%)	5 (3.2%)
Secondary	236 (44.4%)	286 (53.9%)	9 (1.7%)	Secondary	129 (24.3%)	385 (72.5%)	17 (3.2%)
Tertiary	339 (43.1%)	43 (58.9%)	1 (1.4%)	Tertiary	21 (28.8%)	49 (67.1%)	3 (4.1%)

*p < 0.05, **p < 0.01, ***p < 0.001

7.2.6.1. Predictors of familiarity with mental illness

A multinomial logistic regression analysis to determine the predictors of familiarity with mental illness using demographic variables was performed. The results, as depicted in Table 7.26, show that the odds of females being familiar with mental illness, than those who are not familiar, are 1.4 times (OR = 1.40, 95% CI = 1.04 to 1.88) greater compared to males. The odds of participants from Kokstad being familiar with mental illness are 1.6 times (OR = 1.62, 95% CI = 1.14 to 2.30) greater compared to participants from Kwa Sani. Furthermore, participants who completed the vignette depicting schizophrenia are 0.46 times (OR = .54, 95% CI = .38 to .77) less likely to be familiar with mental illness compared to those who completed the alcohol dependency vignette.

Table 7.26: Multinomial logistic regression analysis of participants' familiarity with mental illness and demographic variables

Variable	Yes		Don't know	
	B	OR (95% CI)	B	OR (95% CI)
Gender				
Female	.339	1.40 (1.04/1.88)*	-.521	.59 (.19/1.79)
Male	0 ^b		0 ^b	
District				
Kokstad	.485	1.62 (1.14/2.30)**	.192	1.21 (.32/4.48)
Kwa Sani	0 ^b		0 ^b	
Vignette				
Depression	-.159	.85 (.60/1.20)	1.784	5.95 (.70/50.13)
Schizophrenia	-.603	.54 (.38/.77)***	1.617	5.03 (.59/42.35)
Alcohol Dependency	0 ^b		0 ^b	

Note: Reference category is No (n = 435).

B = Logistic coefficient. SE = Standard Error. OR = Odds Ratio. 95% CI = 95% Confidence interval.

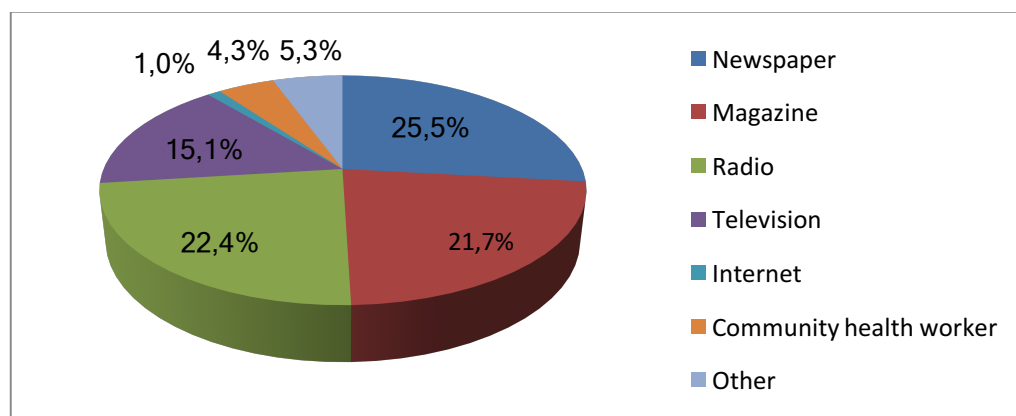
*p < 0.05, **p < 0.01, ***p < 0.001

^b = This parameter is set at zero because it is redundant

7.2.7. Public's source of information for mental illness.

This section aims to explore the public's sources of information regarding mental health issues and also to determine whether there is a relationship between these sources of information and attitudes toward mental illness. Firstly, participants were asked if they have seen, read, or heard any news or stories about mental health in the last six months. Less than half of total participants (n = 366, 46.5%) responded affirmatively to this question. These participants were then asked to select their source from 6 possible options that included the newspaper, magazine, radio, television, internet, community worker, and other. As can be seen from Figure 7.5, the newspaper (25.5%), radio (22.4%), and magazine (21.7%) were the most identified sources of information for the public regarding mental illness.

Figure 7.5: Participants' sources of information for mental illness



Chi-square analysis shows significant differences between district, suggesting that more people from Kokstad than Kwa Sani received their information about mental illness from newspapers, $\chi^2 (1, N = 190) = 46.82, p < 0.001$; magazines, $\chi^2 (1, N = 170) = 61.97, p < 0.001$; radio, $\chi^2 (1, N = 162) = 28.97, p < 0.001$; and television, $\chi^2 (1, N = 106) = 11.54, p < 0.001$. Significant differences between gender show that more males (18.9%) than females (12.9%) received information about mental illness from television, $\chi^2 (1, N = 56) = 5.18, p < 0.05$. The same analysis also found significant differences between the use of the internet as a source of information for mental illness and level of education, thus suggesting that more participants (6.8%) with a tertiary level of information received their information about mental illness from the internet, $\chi^2 (3, N = 5) = 27.63, p < 0.001$. Results showing full percentages are reflected in Table 7.27 below.

Table 7.27: Participants' source of information for mental illness

	Source of information						
	Newspaper	Magazine	Radio	Television	Internet	Community Health Worker	Other
District							
Kokstad	31.4%	28.1%	26.7%	17.5%	1.2%	4.1%	4.1%
Kwa Sani	6.1%	0.6%	7.7%	7.2%	0.6%	5.0%	9.4%
	***	***	***	***			
Gender							
Male	24.2%	19.2%	21.9%	18.9%	1.7%	4.7%	6.4%
Female	26.3%	23.3%	22.7%	12.9%	0.6%	4.1%	4.7%
				*			
Age							
18-34	24.2%	21.1%	20.9%	14.9%	1.4%	4.5%	5.2%
35-49	24.9%	19.1%	24.4%	16.3%	0.5%	3.3%	6.2%
50-64	36.4%	34.8%	25.8%	16.7%	0.0%	7.6%	6.1%
65+	28.6%	21.4%	25.0%	7.1%	0.0%	0.0%	0.0%
		*					
Education							
No schooling	21.4%	17.9%	10.7%	3.6%	0.0%	3.6%	7.1%
Primary	28.4%	23.2%	24.5%	14.2%	0.0%	3.2%	3.2%
Secondary	24.9%	21.3%	21.8%	15.1%	0.6%	4.3%	5.8%
Tertiary	26.0%	23.3%	26.0%	21.9%	6.8%	6.8%	5.5%

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

7.2.8. Conclusion.

Participants' perceptions and attitudes toward mental illness were analysed in this section. More than half of the total participants indicated that they would not vote for a politician if they knew he suffered from mental illness, they would also not employ the mentally ill person, and that mentally ill people are dangerous. Participants showed more negative attitudes toward patients with alcohol dependency compared to those with depression or schizophrenia. Interestingly, the results show that most participants believe that other people have more stigmatising attitudes than themselves. They believe that a person with mental illness would be discriminated against by others in the community if they knew about his problem. However, participants themselves believe that they would have a friendly contact with the mentally ill person.

Regarding perceived dangerousness, most participants perceived the mentally ill as lacking self-control, frightening, and aggressive. More perceptions of dangerousness were attributed to alcohol dependency when compared to depression and schizophrenia. Interestingly, despite these perceptions of dangerousness, most participants showed some willingness to have a closer social distance with the mentally ill person, more so when that contact was perceived as less intimate. However, a closer social distance was seen as less desirable when that contact was perceived to be intimate. For example, more participants indicated that they would be willing to move next door to a mentally ill person. However, very few participants indicated their willingness to have the mentally ill person look after their children or to have a relationship with them. An analysis of the results regarding familiarity with mental illness shows that less than half of the participants admitted to ever having had a family member or a friend who had experienced one of the conditions presented in the vignettes. Lastly, when participants' sources of information regarding mental illness were assessed, it appeared that the newspaper and radio were the most common sources of information for the public in this regard. The results presented in this chapter are discussed in greater depth in the next chapter.

Chapter 8

Discussion

The main objective of this study was to investigate the mental health literacy of African residents of Sisonke District in the province of KwaZulu-Natal, with a focus on Greater Kokstad and Kwa Sani Municipalities. In particular, views regarding mental health literacy factors such as conceptions, aetiology, attitudes and treatment of mental illness were investigated. Although studies investigating mental health literacy have been conducted in South Africa (Hugo et al., 2003; Sorsdahl, Flisher, Wilson & Stein, 2010; Sorsdahl & Stein, 2010), there is very little research of this nature conducted in the province of KwaZulu-Natal. To the best knowledge of the researcher of the current study, in an extensive search for literature using search engines such as SABINET, Medline, Ebscohost, Google Scholar, Academic Search Complete, and so forth, no studies of mental health literacy that had previously been conducted in Sisonke District were found. The main objective of the study was investigated using three secondary objectives. These were: the respondents' conceptions of mental disorders; their knowledge and attitudes toward help-seeking and interventions; as well as their perceptions and attitudes toward mental illness. The results of the study are discussed in this chapter, firstly by examining participants' conceptions of mental illness and their aetiological beliefs. This is followed by a consideration of their knowledge and attitudes towards help-seeking and interventions for mental health problems. Finally, a discussion of participants' perceptions and attitudes toward mental illness will be presented. The findings of this study are discussed and contextualised in relation to relevant research studies and the broader literature that was reviewed in earlier chapters. Implications derived from the results of this study also form an integral part of the discussion.

Firstly, it is important to highlight that while the terms *conceptualise*, *understand*, and *view* carry different meanings in their own right, they are used in this discussion interchangeably because they broadly convey the meaning of interpreting something in a particular way. Secondly, in respect to people who participated in this research, a reference to *subjects* will not be used, but the terms *participants* or *respondents* will be used interchangeably. Thirdly, the concepts *urban* and *rural* areas will be used to refer to Kokstad and Kwa Sani Municipalities, respectively.

8.1. Conceptions and Aetiological Beliefs of Mental Illness

This study uncovered a number of important findings regarding conceptions and aetiological beliefs of mental illness among participants in the study. Firstly, the results show an endorsement of multiple explanatory models of mental illness, thus suggesting an embracement of both Western and indigenous influences. Secondly, participants did not use standard psychological nomenclature to describe mental illness, but instead used very broad, over-encompassing terms such as family crisis, low self-esteem, stress and so forth, and traditional labels like ancestral calling, bewitchment, *ukuthwasa*, and so on, which may be indicative of their worldview.

8.1.1. Views about mental illness.

This study investigated participants' conceptualisations or understandings of mental illness based, not necessarily on Western psychiatric nosology, but participants' own explanatory models of illness. Jorm (2012) cautions that mental health literacy has, thus far, largely represented a Western scientific conceptualisation, which may conflict with indigenous traditional beliefs. Evidence already exists (Angermeyer & Dietrich, 2006; Das & Phookun, 2013; Furnham & Hamid, 2014) which shows that a large number of members of the lay public have difficulty recognising many mental disorders in accordance with labels used by scientific classification when they are described in a vignette. The same has also been found in a South African study by Sorsdahl & Stein (2010). Therefore, it becomes imperative to interpret a community's use of over-encompassing labels that are different from standard psychological nomenclature in studies of mental illness with care, as it may not necessarily imply a lack of knowledge. This is so for a number of reasons.

Firstly, Furnham, Lee and Kolzeev (2015) argue that it is possible that people may have a good understanding of mental illnesses that are being studied, yet may not know the official diagnostic term for the illness. In spite of not knowing official terms for mental illness, people have their own way of referring to behavioural presentations that constitute some mental illnesses. In the current study, the interest lies in participants' own conceptualisations and labels that they themselves use to refer to mental illness; that is, in accordance with their explanatory models, the person's ideas about the nature of the illness (Kleinman, 1978; 1980). Secondly, community members who are often recruited to participate in mental health surveys

are lay people who generally have no professional qualifications in psychology, psychiatry or any field of study related to mental illness. Therefore, an expectation for lay participants to have accumulated knowledge that is usually acquired through years of formal training, and consequently referring to them as ignorant when they do not show evidence of such knowledge, would be unfair and unreasonable. Thirdly, the participants in this study are indigenous South Africans who mainly speak isiZulu and isiXhosa as their first languages. These languages do not employ the labels that are used to refer to many medical illnesses as they are commonly used by medical professionals.

Furthermore, Mohamed-Kaloo and Laher (2014) argue that mental health literacy should extend beyond the Western conceptualisation and they call for a greater awareness and inclusion of the influence of cultural values. Literature has already documented that culture influences mental illness in terms of perceptions, conceptions, classification, labelling and treatment of mental illness (Honwana, 1998; Mohamed-Kaloo & Laher, 2014). There is also literature showing that conceptualisations of mental illness are based on an individual's explanatory models of illness (Littlewood, 1990). Moreover, evidence exists to show that there is a discrepancy between professionals' and the public's conceptualisations of mental illness (Link et al., 1999). Because of the potential consequences of such discrepancies, the need to understand the public's own conceptualisation of mental disorder, not from professionals' perspective, but their own, is of paramount significance. This is not in any way an attempt to dismiss the current scientific understanding of mental illness, but to try to update and incorporate new knowledge into the field. Failure to do so, according to Matoane (2012), is likely to result in inadequate understanding of local people, with the possibility of misinterpretation of their mental health literacy.

8.1.1.1. Conceptualisation.

The results in this study related to how the participants conceptualise mental disorders are very interesting. In general, the findings show an endorsement of multiple explanatory models of mental illness, and suggest an embracement of both Western and indigenous influences. When participants were specifically asked what they would say is wrong with the person depicted in the vignettes used in the questionnaires, their responses showed dominance of the psychological, social and

medical models of explaining mental illness. It is interesting to note that many respondents were of the view that people presented in these vignettes were experiencing stress. This finding confirms the work of Hugo et al. (2003) in South Africa, Lauber, Falcató, Nordt and Rössler (2003) in Switzerland, as well as Link et al. (1999) in the United States, and shows that cases of mental illness are often conceptualised as psychosocial and representing a variety of stress-related factors. This may reflect the reality of a stressful life which people across the globe are experiencing to varying degrees. Consistent with previous research (Furnham & Telford, 2012), this study shows that the public's conceptualisation of mental illness is not haphazard; it is classified into categories such as social, psychological and medical, almost in a similar fashion to how health professionals would classify mental illness. The findings of this study suggest that the public is not ignorant of mental illness, but instead employs an understanding which may be informed by their own worldview and is different from a Western scientific view.

When looking at specific mental illnesses in the current study, it is important to note that while respondents used a variety of descriptions to conceptualise mental illness, many similar descriptions were used across the three disorders. For example, labels such as HIV/ AIDS, depressed, being sick, stress, mental illness and family problems were used in the conceptualisation of all three disorders investigated in this study. A few implications from this could be hypothesised. Firstly, this may reflect the public's awareness that a certain state of an illness is present. Secondly, the respondents' understanding of mental illness may largely be driven by a particular symptom that they themselves commonly associate with or recognise as reflecting the experience of being ill. Thirdly, this may also imply that participants' understanding of mental illness is not limited to social or psychological suffering, but is viewed as holistic and as encompassing social, psychological and physical factors.

When differences in participants' understandings of individual disorders were investigated, the findings in this study indicate that depression is conceptualised more in psychological and medical terms, on the one hand. On the other hand, both schizophrenia and alcohol dependency are conceptualised in psychological and social terms. Regarding the differences between the conceptualisation of the three disorders, the results of this study indicate that 91.9% of participants who were assigned the alcohol dependency vignette were significantly more likely to

conceptualise alcohol dependency as a psychological problem. This finding is encouraging as it reflects a higher level of understanding of alcohol dependency when compared to the results of other studies. In their review of population studies located in Europe, North America, New Zealand, Brazil and Ethiopia, it was found that people suffering from alcohol dependency were less frequently regarded as mentally ill and were held much more responsible for their illness (Schomerus et al., 2010). Examples of commonly-used psychological explanations for alcohol dependency in the current study include abusing alcohol, difficulty in controlling alcohol drinking, facing some depressing situation, being mentally disturbed, and so forth. This finding may have positive implications for the treatment of alcohol dependency because more people in indigenous communities in South Africa could be referred for professional help if their condition is viewed as a psychological problem.

Results of the current study may also reflect a complex understanding among respondents that psychosis is both a mental and traditional illness. An interesting finding in this study is that only schizophrenia, among the three disorders investigated in this study, was conceptualised traditionally using supernatural descriptions such as being troubled by ancestors, as an ancestral spirit entering the person, as a result of bewitchment, or *ukuthwasa*, and so on. This reflects participants' holistic worldview, whereby the person is not an encapsulated, self-contained entity, but a relational being that continues to have an ongoing, spiritual relationship with entities beyond the physical realm. Other researchers also show that explanations that are indigenous of mental illness, especially psychosis, are very common in many indigenous African communities (Sorsdahl, Flisher, Wilson & Stein, 2010). Most importantly, this study indicates that the use of traditional conceptualisations of mental illness is based on individuals' own indigenous explanatory models which are informed by their worldviews.

When examining explanations of mental illness in general and demographic variables in this study, when compared to other age groups, participants between the ages of 50 and 60, tended to conceptualise mental illness using traditional explanations. Furthermore, the results of this study illustrate that males and females understand mental illness differently. For example, more females conceptualised mental illness using medical explanations, while more males used traditional explanations to conceptualise mental illness. These results may imply that strategies

or messages designed to improve mental health literacy must take these age and gender differences into account. To lend support to this implication, Dogra et al. (2011) are also of the opinion that gender-specific interventions may be more appropriate to improve mental health literacy than whole population approaches.

An unexpected finding of this study relates to an understanding of mental illness by geographical location. It was found that 38.7% of participants from a more rural area viewed depression as a problem that is medical in nature. This has a positive implication, according to Furnham and Telford (2012), as it suggests that people with mental illness may not be viewed differently than those with a physical illness by traditional people from rural areas. Perceiving mental illness as similar to any other illness is also likely to reduce stigma and to foster improved help-seeking among the general public.

8.1.1.2. Labelling.

It is important to note that when labelling of a mental disorder was investigated in this study, the aim was not to determine whether participants provided a specific diagnostic label for disorders presented in the vignettes. Although it might be the case that they have a different understanding altogether as to what the disorders are, previous studies have already reported that many South Africans are generally unable to correctly identify common mental disorders (Hugo, et al., 2003; Sorsdahl, Mall, Stein & Joska, 2010; Sorsdahl & Stein, 2010). This phenomenon is not only limited to South Africans; some studies conducted abroad (Furnham, Daoud & Swami, 2009; Furnham & Wincelous, 2012; Jorm et al., 1997) have found similar results where most of their participants were unable to provide correct labels for mental illness. Nevertheless, the current study is interested in labels that participants use based on their own explanatory models of behaviours which could be scientifically classified as mental illness. The results of the present study revealed two important findings regarding labelling of conditions by participants.

Firstly, the results of this study confirm Jorm's (2012) assertion that when people do not make use of mental disorder labels such as depression, they often use normalising labels such as stress or life problems. Over one-fourth of the total participants (29.5%) called mental disorders presented in any of the three vignettes 'stress', and the majority of them were responding to the vignette depicting

depression. Secondly, a number of labels for common medical problems, psychological and social stressors, such as mental disturbance, depression, stress, mental illness, and not being well were used to refer to any of the three disorders. It can be hypothesised that participants did not use these medical or psychological labels exclusively to denote an illness in a proper medical sense. To lend support to this hypothesis, Schomerus, Matschinger and Angermeyer (2006) argue that it is possible that those respondents who labelled the depression vignette as depression may not have thought of an illness, but, for example, may have associated the symptoms with sadness.

In particular, while depression in the current study was also named using psychosocial terms such as family crisis, low self-esteem, stress, hopelessness, abuse, and so forth, it was labelled more often using medical terms such as AIDS, HIV, general sickness, TB, cancer, fever, fatigue, not being well, etc. This may reflect participants' familiarity with these illnesses, which tends to invoke the feeling of compassion or sadness in others when a person is reported to suffer from one of these ailments. However, traditional labels such as the calling to become a traditional healer, possession by ancestral spirits, bad luck, ancestral calling, bewitchment, *ukuthwasa*, and so on were used by more participants to refer to schizophrenia. Alcohol dependency was labelled using more concrete terms that reflect the experience of heavy alcohol consumption such as alcohol addiction, alcohol abuse, alcoholic, drunkard, drinking too much, and the like.

Relevant to mental health literacy research is the point noted in this study that people use certain labels based on their sociocultural influence to distinguish between human differences such as having an illness and being in good health. Such labelling may, unfortunately, have undesirable effects on people suffering from mental illness and may hinder or prevent their ability or motivation to seek professional help. Schulze and Angermeyer (2003) argue that labelling is seen as a prerequisite for the very existence of deviance that could justify stigmatisation because labelled people are often linked to undesirable characteristics. Jorm (2012) has cautioned that the use of labels, more so the normalising labels such as stress, bad luck, and so on, is less likely to facilitate professional help-seeking. For instance, in another study, the same author and his colleagues found that people who labelled depression with a label other than depression were likely to believe that it would be helpful to deal with the problem on their own (Jorm et al., 2006).

8.1.2. Aetiology of mental illness.

Information regarding respondents' aetiological views of mental illness was obtained in two different ways and yielded distinct patterns of results. Participants were initially asked an open-ended question to ascertain their aetiological beliefs. Then they were given a list of possible aetiological factors on a Likert-scale and were asked to select the one that they think is most likely to be the cause of a condition presented in a vignette. Similar to another South African study conducted among university students (Samouilhan & Seabi, 2010), the results of the current study revealed that respondents' conceptions of mental illness are significantly related to their aetiological beliefs. The findings also show a consistency between respondents' aetiological views that were assessed using an open-ended question and Likert-scale, which largely reflects that participants predominantly attribute psychosocial causation to mental illness. However, for the vignette representing schizophrenia, respondents consistently endorsed traditional aetiological factors.

8.1.2.1. Aetiological views

In accordance with their conceptions of mental illness, respondents in this study hold the view that mental illness is caused by factors that are psychological, social and medical in nature. This finding is consistent with other studies that have reported psychosocial factors, especially stress and other day-to-day problems, to be perceived as the major causes of mental disorders (Angermeyer & Matschinger, 1994; Angermeyer & Matschinger, 1996; Furnham et al., 2015; Jorm et al., 2005; Link et al., 1999; Mohamed-Kaloo, & Laher, 2014). This also affirms the view expressed by Angermeyer and Dietrich (2006) that lay beliefs about the causes of mental disorders are distinct from the results of psychiatric research in that psychosocial factors predominate in comparison with biological factors. The predominant belief in this study, that mental illness is caused by psychological and social factors, is encouraging as it may suggest that the public is becoming more open to different aetiological views.

Although medical causation ranked third in the present study, it predominates in some studies conducted in developed countries. For example, two-thirds of respondents who recognised schizophrenia in a Canadian study identified a biological cause, usually a brain disease (Stuart & Arboleda-Florez, 2001). Interestingly, some participants in the current study considered some form of illness to be the cause of mental illness. For example, descriptions such as HIV, sickness, sexually transmitted diseases, TB, and so forth were given as the causes of disorders being investigated. The results of a study conducted by Lauber et al. (2003) in Switzerland are also in line with the findings of this study, in which their respondents also considered *some kind of an illness* to be responsible for mental illness. Lauber et al. (2003) attributed these discrepancies to methodological differences, in that other studies had used closed questions to ask about the causes whereas their study had used open-ended questions to explore aetiological beliefs. It is possible that closed questions by their nature limit the range of responses, on the one hand, and open-ended questions afford an expression of individuals' beliefs, on the other hand.

In general, the respondents' use of psychological, social and medical causation in the current study affirms an earlier speculation that their knowledge of mental illness is based on a distinct and consistent understanding that is sensible to them. This understanding is sensible to them in that, for example, their use of medical causation differs from professionals' knowledge about the medical causation of mental illness because it includes, for instance, their beliefs about factors such as TB, AIDS, loss of appetite, not cleansing the body system, and so on. This translates into a significant practical implication. Literature has already indicated that many psychiatric patients consult a medical practitioner before seeing a mental health practitioner (Mohamed-Kaloo & Laher, 2014; Pillay et al, 2009; Seedat et al., 2008). This, once more, cautions general practitioners to always explore the patient's explanatory model of illness and to screen for mental illness in spite of a physical illness being reported as a reason for consultation.

Consistent with the view of Furnham and Telford (2012), beliefs about the causes of a mental disorder in this study also vary depending on the particular disorder. Interestingly, the leading causal factors given for both schizophrenia and alcohol dependency, when participants were asked an open-ended question, were psychological factors, with stress, drugs, too much thinking and depression as

predominating examples. The finding that more participants in this study believe that alcohol dependency, when compared to other mental disorders, is caused by factors that are psychological in nature coheres with previous research, such as a study by Furnham and Thomson (1996). However, for depression, social factors such as family problems, financial difficulties and lack of social support were the leading aetiological factors identified by participants in this study. The view that stressful life events are associated with the onset of episodes of major depression has already been confirmed by Kendler, Karkowski and Prescott (1999). Research conducted in South Africa and Germany also reported that social factors are often seen as the cause of depression (Hugo et al., 2003; Schomerus et al., 2006). It is possible that participants' views of psychosocial causal factors may be attributed to their life experiences. Based on this, the need for awareness campaigns addressing the effects of psychosocial stressors and the onset of mental illness is of paramount importance.

This study shows that beliefs in supernatural causes of illness, specifically with regard to schizophrenia, are widespread. Of the three disorders investigated in this study, only schizophrenia was viewed to have traditional aetiological factors such as ancestors wanting something, bewitchment, *ukuthwasa*, failure to perform certain cultural rituals, and possession by ancestral spirits, amongst other factors. The belief in supernatural causes of mental illness is a well-known phenomenon among indigenous populations. This is congruent with a study conducted in Nigeria that reported participants' endorsement of supernatural causes of mental illness (Adebowale & Ogunlesi, 1999). South African studies confirm that indigenous South Africans often attribute mental health problems to cultural causes such as witchcraft or the ancestors, more so than to genetic or biological causes (Mohamed-Kaloo & Laher, 2014; Sorsdahl, Flisher, Wilson & Stein, 2010). A consistent trend found in this study of schizophrenia being most likely to be associated with indigenous factors is probably due to the nature of the symptoms of this condition such as hearing of voices and an interaction with other 'entities' beyond one's bodily experience. To substantiate, Fabrega (1989) argues that schizophrenia disturbs an individual's sense of self and others and the ability of the self to relate meaningfully to the cultural world. This is consistent with Kleinman's (1978, 1980) assertion that illness is culturally constructed.

The results of this study show that there is a significant relationship between conceptualisation of mental illness and aetiological beliefs. In this study, more than

half of participants (51.3%) who conceptualise mental illness as a psychological illness also believe that it is caused by psychological factors. In clinical practice, this compels the need for mental health practitioners to elicit their patients' explanatory models of illness as it informs their aetiological beliefs. This also implies that, while respondents may not have used *psychiatric labels* to describe their understanding of mental illness, they have constructed their own sound and consistent understanding of mental illness which coheres with that of professionals.

The findings of this study show a consistency between respondents' aetiological views assessed using an open-ended question and Likert-scale. The findings from the Likert-scale questions confirm previous research showing a predominant belief in both psychosocial and traditional causes of mental disorders (Bener & Ghuloum, 2010; Sorsdahl & Stein, 2010; Trump & Hugo, 2006) and also confirm findings indicating that genetic factors are less frequently endorsed by the public (Jorm et al., 2005). The findings in this study show that participants believe that mental illness is caused by stressful circumstances in life, by a person's own bad character and by ancestral anger. An endorsement of both psychosocial and traditional aetiological factors may suggest that respondents are becoming more open to different ways of understanding and interpreting their reality, by their belief that both have a role. In practice, this may suggest that some patients are likely to seek treatment from traditional healers before seeking Western professional help, or vice versa.

Consistent with other studies (Bener & Ghuloum, 2010; Ganesh, 2011; Link et al., 1999), when looking at specific disorders, respondents in the current study believe that schizophrenia, when compared to other disorders, is caused largely by stressful circumstances in life and supernatural forces such as ancestral anger, failure to perform certain cultural rituals, evil spirits or sorcery, as well as God's will. Adopting a supernatural view of aetiology of mental illness may, according to Gureje et al. (2005) as well as Adewuya and Oguntade (2007), imply that orthodox medical care would be futile and that help would be more likely to be obtained from traditional healers.

The findings of this study from the Likert-scale items also affirms the hypothesis made earlier that interventions aimed at increasing mental health literacy must take the public's demographic variables into account. In this study, more participants over the age of 65 when compared to their counterparts from other age groups viewed traditional factors, such as ancestral anger and failure to perform certain cultural

rituals, as very likely to be the cause of mental illness. Furthermore, the results in this study show that more participants in middle adulthood, than their counterparts in other age categories, believe that stressful circumstances in life are the causes of mental illness. An analysis of the results according to the level of education attained shows that more participants who have never been to school believe in traditional aetiological factors, such as failure to perform certain cultural rituals, ancestral anger, as well as punishment for sins that might have been committed.

In general, the implications resulting from the predominant view that respondents' aetiological beliefs in this study are not biologically orientated, but are shaped by psychosocial factors, are important in many respects. Firstly, the endorsement of the psychosocial model implies that support for treatment of mental illness should be based in the community rather than in hospitals (Lauber et al., 2003). According to Ganesh (2011), this would also be in line with the international trend, which is to have fewer in-patient facilities and instead to focus on a community-based model of mental health service delivery. Secondly, the need for educating the public about both the psychosocial and biological causes of mental illness is highlighted by this finding. This, according to Sorsdahl et al. (2010), may improve the acceptability and compliance of biological treatments. Thirdly, endorsement of traditional causal factors shows that many members of the public, more so those that are much older, explained schizophrenia in terms of supernatural causation such as ancestral anger. This finding affirms an earlier speculation that interventions geared toward improving mental health literacy must take demographic factors into account, especially gender, age and level of education.

8.2. Knowledge and Attitudes Toward Interventions and Help-Seeking

The current study also investigated participants' knowledge of and attitudes toward interventions and help-seeking for mental illness. In general, the results highlighted the strong preference among the respondents for professional help-seeking, particularly from social workers and medical practitioners, for the treatment of depression and alcohol dependency. However, traditional healing was seen as more helpful for treating schizophrenia. The endorsement of vitamins, minerals and tonics over antidepressants and antipsychotics was found when looking at specific medicines that participants perceived as helpful.

8.2.1. Sources of support.

Initially, to assess their preferred sources of support for mental illness, participants in this study were asked an open-ended question - how do they think that the person depicted in the vignette could best be helped? The results in this study indicate that encouraging professional help-seeking and referral to a family member or friend were seen as participants' preferred sources of support for addressing mental health problems. Starting with encouraging a mentally ill person to consult with their family member or friend, this practice may reflect the ideological view which supports the principle of interdependence as reflected by the indigenous African worldview, on the one hand. On the other hand, this may highlight the importance of ensuring that both families and community members are equipped with appropriate knowledge of mental illness.

There is also research showing that those that are closest to the sick individual may be useful in encouraging the person to seek professional help. Research conducted by Vogel, Wade, Wester, Larson and Hackler (2007) found that most of their respondents who sought mental health services were specifically prompted to seek help by someone close to them and, in addition, the respondents who sought these services also knew someone who had previously sought treatment. The finding of the current study in this regard reflects the need and importance of educating members of the community about how best to assist and refer people suffering from mental illness. This is very important because many people experiencing a mental disorder may fail to seek professional help or may delay help-seeking as they may not correctly recognise what is happening to them (Jorm, 2012).

The finding that most respondents would encourage professional help-seeking is consistent with previous research conducted in Cape Town, South Africa (Sorsdahl & Stein, 2010). Social workers, medical doctors and hospitals/clinics in particular were sources that most participants in this study indicated that they would encourage a person who may be mentally ill to seek help from. The preference to consult social workers concurs with Furnham and Telford (2012), Angermeyer and Matschinger (1996), as well as Sorsdahl and Stein (2010) who found that the public and some people with mental illness generally prefer counselling or psychotherapy over medication. This may also reflect the public's level of familiarity and comfort with social workers because their work often requires them to conduct home visits.

Furthermore, the finding that medical doctors and hospitals/clinics were also sources of help to be consulted is supported by literature indicating that general practitioners are often the first point of entry when people with mental health problems seek assistance (Mohamed-Kaloo & Laher, 2014) and they are mainly consulted from public hospitals/clinics. What is disconcerting, however, is that detection of mental illness by general practitioners is generally low, as evidenced by studies in South Africa (Hugo et al., 2003), in other countries such as Nigeria (Ogunsemi et al., 2010) and also in Taiwan (Liu, Mann, Cheng, Tjung & Hwang, 2004). Apart from a significant problem of low detection rate, general practitioners' ability to manage depression is also a concern. In their study of knowledge and attitudes toward depression among non-psychiatric physicians in Taiwan, Liu, Lu and Lee (2008) found that their respondents were not confident in managing depressed patients, and the majority of them reported that incomplete knowledge was a major barrier that limited their care of patients with depression. This implies that efforts to improve mental health literacy should not only focus on the general public, but also on primary healthcare workers.

A rather concerning finding in this study is that very few respondents (1.1%) indicated that psychiatrists would best help people with mental illness. A similar finding has also been reported by Mickus, Colenda and Hogan (2000) in a study conducted in Michigan where only 13% of their respondents selected psychiatrists for mental health services. Although the reason for this finding was not investigated in this study, it was speculated that, apart from stigma attached to consulting a psychiatrist, respondents may be unfamiliar with psychiatrists, given their shortage in the country.

The results of this study also show that when participants were asked to rate the likely helpfulness of 14 professionals and non-professionals on a Likert-scale, they rated family doctors, counsellors and psychologists as likely to be helpful. This finding, as well as the previous finding where respondents were asked an open-ended question about how the mentally ill could be helped, shows that participants are consistent and confident in their belief that medical doctors can treat mental illness. A finding related to the significant differences between mental disorders indicated that more participants in this study considered getting help from close friends as beneficial for the treatment of depression, on the one hand. On the other hand, psychiatrists, psychologists and *sangomas* were seen as helpful for the treatment of schizophrenia. A speculation is that schizophrenia is perceived as a more serious form

of mental illness and warrants treatment by highly specialised professionals. To lend support to this speculation, Ganasen et al. (2008), as well as Sorsdahl, Flisher, Wilson and Stein (2010) also argue that it is possible that symptoms of schizophrenia are more distinctly perceived as abnormal, while depressive symptoms are largely viewed as part of normal life experience. This explains the likelihood that depression may have been perceived by respondents as a benign condition that could be dealt with by, for example, just talking to a friend. A variation of treatment preference based on perceived severity of a mental disorder has also been documented by Furnham and Telford (2012). They reported that medication and specialised interventions are often believed to be most effective for disorders with a high perceived severity, rather than psychotherapy.

The finding that a *sangoma* is seen as helpful for the treatment of schizophrenia is of great significance given that respondents in this study also viewed this condition to be due to traditional causes. This confirms an argument by Ganasen et al. (2008) that cultural beliefs are closely linked with causal attributions to mental illness and may influence pathways to care. The relationship between beliefs in traditional or supernatural causes and treatment of mental illness has been documented. Literature has already indicated that cultural factors do not only influence the meanings attached to different health conditions and beliefs regarding causation, but are also likely to determine the persons who are consulted to restore health and well-being (Ross & Deverell, 2010). Given that patients with mental illness in South Africa consult with traditional healers before consulting general practitioners, the results of this study highlight the significance of collaboration between Western-trained practitioners and traditional healers. Skilling traditional healers, and encouraging their recognition and referral to them for treatment of mental illness, would benefit this collaboration because traditional healers' explanatory models of mental illness vary from the scientific models. Sorsdahl, Flisher, Wilson and Stein (2010) reported that traditional healers in their study did not believe that a patient with schizophrenia was suffering from a mental illness, but rather that their symptoms were a result of the patient being called by ancestors to become a traditional healer.

8.2.2. Medicines perceived as helpful.

From a list of 8 possible medicines/pharmacological treatments, the majority of participants in this study perceived vitamins, minerals and tonics as more helpful

for the treatment of mental illness, followed by antidepressants and anti-psychotics. However, when testing for significant differences in participants' perceived helpfulness between these medicines, the results indicate that vitamins, minerals and tonics, pain relievers, antibiotics as well as tranquilisers were considered more helpful for the treatment of depression. Previous research in South Africa and abroad has uncovered similar findings. Findings of a national South African survey among psychiatric patients to determine factors mitigating their recovery indicated that the majority of respondents (62%) took vitamin/mineral supplements to self-medicate (Trump & Hugo, 2006). In the same study, 20% and 22% of participants had tried homeopathic medicine and herbal products, respectively, for the same reason of self-medicating. A study conducted in Australia and Japan found a low level of endorsement for standard pharmacological interventions, with only around half of their respondents endorsing antidepressants for depression, and around a third endorsing antipsychotics for schizophrenia (Jorm et al., 1997; Jorm et al., 2005).

The endorsement of vitamins, minerals and tonics for the treatment of mental disorders over psychotropic medication found in this study arguably indicates that misinformation about treatment of mental disorders is a problem that requires urgent attention. Such misinformation, according to Hugo et al. (2003), presumably contributes to under-treatment of mental disorders. To compound the picture, Lauber, Nordt and Rossler's (2005) argument that the belief among the general population that depressive states are not illnesses but rather normal psychological states, commonly called life crises, may correspond with the endorsement of non-psychopharmacological treatments. Consulting a professional for prescription of psychopharmacological treatment may not be considered necessary if depression is not perceived as an illness, but could consequently encourage the use of over the counter medication for self-treatment. A low level of endorsement of pharmacological interventions may also limit the willingness to accept some recommended interventions, and may consequently reduce treatment compliance.

Furthermore, this study also found that more participants endorsed traditional medicine as significantly more helpful for treating schizophrenia than other mental illnesses. Given that respondents' conceptualisation and aetiological beliefs about schizophrenia were based on traditional understandings, this study shows that both the cultural conceptions and aetiological beliefs of mental illness are related to treatment preference. The findings of this study in this regard point to the need for treatment that is holistic in its approach and is in accordance with the patient's

beliefs. This may imply that, while Western pharmacological and psychotherapeutic interventions may address the physical and emotional wellbeing of patients (Trump & Hugo, 2006), emotional and spiritual wellbeing should be addressed through traditional healing. To substantiate this claim, it would have been expected to find more people in more rural areas showing preference for traditional medicine. However, the finding of this study that more participants in the urban area endorsed traditional medicine as helpful suggests that the practice of traditional healing remains widespread even in urban areas and both treatments, most likely, satisfy different aspects of patients' needs. It has already been indicated that some patients who seek professional Western treatment would have seen a traditional healer before consulting with a general practitioner. Therefore, the argument that traditional healers should also be included and considered as an integral part of mental healthcare providers, and specific training should be designed to ensure their harmonious inclusion into the mainstream mental healthcare, seems relevant.

The finding of this study that more females than men were likely to consider anti-depressants, antibiotics and sleeping pills more helpful for the treatment of depression may reflect the influence of their personal experience. It is possible that this could be due a number of reasons, starting with women being more likely to visit their medical practitioners and to be given significantly more prescriptions for psychotropic medication than men (Mickus et al., 2000). This could also be due to an assumed greater gender role-specific interest of women in health topics (Gaebel, Baumann, Witte & Zaeske, 2002). To substantiate this, a study conducted by Llovera, Ward, Ryan, LaTouche & Sama, (2003) found that women are more interested in the more typically female health issues than men are in more typically male health issues. Interestingly, more males than females perceived traditional medicine as helpful for the treatment of mental illness in the current study. It is unclear what could be the possible explanation for these gender differences found in this study.

Younger participants in this study, between the ages of 18 to 34, compared to other ages groups, considered anti-depressants to be a more helpful treatment for mental illness, on the one hand. On the other hand, more of their older counterparts, those who are 65 years and older, considered sleeping pills and tranquilisers as helpful to treat mental illness. This may reflect the influence of personal experience as people of an older age are more concerned with somatic illnesses requiring more medical attention (Lauber et al., 2003).

8.2.3. Willingness to seek help.

The willingness to seek healthcare depends on a number of factors including availability, proximity, reputation of the healthcare professional, and perceived quality (Asenso-Okyere, Anum, Osei-Akoto & Adukonu, 1998). The attitude toward seeking help is also a prominent factor affecting individuals' decision to accept professional mental healthcare (Atik & Yalcin, 2011). A strikingly positive finding in the present study is that an overwhelming majority of respondents (90.3%) reported a positive attitude regarding their willingness to seek help if they were to suffer from mental illness. This is a sharp contrast to the statistics related to the number of people who actually seek help for mental illness. Mickus et al. (2000) reported that only one in five people with mental illness in the United States seek help. Bayer and Peay (1997) also stated that relatively few Australians seek professional help for their psychosocial difficulties. A South African study found that a much lower rate (28%) of adult respondents with a severe or moderately severe disorder received professional treatment (Williams et al., 2008). The possibility that this lower rate could be attributed to lack of health facilities and trained mental health specialists, as well as the hidden statistics of those seen by traditional healers, should not be ignored. Nevertheless, although the assessment of people who actually seek help is beyond the scope of this research, the finding that the majority of participants in this study showed willingness to seek help prompts the need for future research to investigate whether there would be a discrepancy between potential intention and the actual help-seeking behaviour among the people of Sisonke District.

Apart from consulting professionals, the finding that respondents in this study showed willingness to seek help from their close relatives/friends coheres with the findings of a study by Atik and Yalcin (2011) who discovered that their participants preferred sharing their concerns with close friends. Locally, Trump and Hugo (2006) found that mentally ill respondents who participated in their study rated spouses, family and friends as significantly more supportive towards them than people in the workplace. The current study's finding has positive implications for treatment, according to Furnham and Telford (2012), as it advocates social and community support rather than hospitalisation. The role of the community in the prevention and care of mental illness is widely advocated, and is regarded by some researchers (Kabir, Iliyasu, Abubaker & Aliyu, 2004; Mpem, 2015) as the most appropriate basis for the development of mental health programmes. However, the effectiveness of this is

dependent upon the ability to recognise the seriousness of the presented complaint, as well as making appropriate referrals to professionals by those whom support is sought from.

The current study also revealed some interesting findings regarding gender and help-seeking. The results of this study are different from previous studies in that the majority of both male and female respondents, almost 9 in 10, reported willingness to seek help, and this is very commendable. Other studies mainly reported that females hold a more positive attitude than males toward professional help-seeking (Bayer & Peay, 1997; Masuda, Suzumura, Beauchamp, Howells & Clay, 2005; Turkum, 2004; Vogel et al., 2007). It may be speculated that the high level of willingness to seek help from both male and female participants may suggest that men are increasingly taking interest in matters affecting their health. This could also mean that the public in general has positive attitudes toward health facilities in their communities. An unusual finding regarding help-seeking and gender, however, was found in a study conducted by Mickus et al. (2000) which showed that women were less likely to utilise psychiatric help than men. These authors could not establish an explanation for their finding which contradicted national trends.

Although more respondents in this study further indicated they would seek professional help or consult with a close relative or family member, this is also in contrast to doctors' experience of patients' willingness for disclosure. A South African study of perceptions of mental illness among general practitioners reported that doctors also indicated that their patients tended to keep mental illness a secret from their families and were even reluctant to disclose their mental status to their general practitioners (Mohamed-Kaloo & Laher, 2014). Mental illness is often presented as psychosomatic complaints such as headaches, hypertension and abdominal pain, which are more acceptable because they carry less stigma. Unfortunately, concealing mental illness exacerbates the problem of general practitioners' failure to detect mental illness timeously.

Nevertheless, the finding that respondents also reported the willingness to consult with close relatives or family members is consistent with the cultural practice of *ubuntu* which places emphasis on co-dependency. Family, among the indigenous African nations, is regarded as the most important structure in caring for sick family members.

In the current study, hospitals or clinics, social workers and medical doctors were professionals that respondents endorsed as being willing to seek help from, which provides insight into the possible patterns of help-seeking behaviour of the public in Sisonke District. This finding shows that assistance would first be sought at a primary level, which has important training and development implications for all professionals involved with patient care at this level. The implication of this finding is that in order to improve treatment of mental disorders, efforts to educate and ensure continued professional development in mental healthcare for all health professionals, especially nurses, general practitioners and social workers, must be prioritised.

Despite evidence that pharmacotherapy and psychotherapeutic interventions are helpful (Sorsdahl, Mall, Stein & Joska, 2010) and the willingness of participants to seek help, barriers that could deter people from seeking help should be considered. This study's findings also suggest that financial constraints may represent a deterrent from seeking professional help. Despite the fact that a great number of participants in the current study indicated their willingness to seek professional help, there were those that indicated that their efforts to consult a health professional might be affected by lack of money for consultation or transport, as well as by fear of being judged or stigmatised. A number of factors are known to affect access to mental health services. Previous studies have also identified factors such as income, fear of stigma, resource insufficiency, cost of treatment and transport as constituting barriers to the public's ability or willingness to gain access to mental health services (Asenso-Okyere et al., 1998; Ganasen et al., 2008). In turn, according to Mickus et al. (2000), all these impediments to access unfortunately may contribute to lack of timely and appropriate specialised mental healthcare.

8.2.4. Prognostic views.

The findings in this study, that the majority of participants (71.5%) reported a positive prognostic view for mental illness if appropriate professional help is received, and that more than half (67%) reported a negative prognostic view if professional help is withheld, demonstrate their understanding of the importance of treatment of mental illness. Similar results have also been found in a Nigerian study where 91.7% of respondents agreed that people can recover from mental illness (Dogra et al., 2011). In particular, as also found in a study conducted by Jorm et al. (2005), this conveys

the impression that there is a general belief among respondents that professional help would be beneficial. The belief that mental illness is curable, with appropriate treatment, can be very encouraging and can have a positive impact on referral for appropriate mental healthcare.

Of concern however is that while the general public hold a positive prognostic view about mental illness when appropriate help is received, on the one hand, there is evidence to suggest that medical doctors hold a pessimistic prognostic view, on the other hand. In their study of doctors' attitude towards people with mental illness in Western Nigeria, Adewuya and Oguntade (2007) found that only 9% of doctors believed mental illness could be cured, with most anticipating partial remission and persistence of the disorder even when appropriate treatment is received. The authors of that study speculated that this pessimistic view may stem from doctors' disappointing professional experience with chronic mentally ill patients. Given the respondents' endorsement of doctors for the treatment of mental disorders found in this study, having doctors who are pessimistic about prognosis of mental illness would be discouraging for many patients. This implies that efforts to improve mental health literacy should not only be limited to the public, but should include doctors too.

The finding that respondents in this study had good prognostic views of mental illness over time shows encouraging concordance with the general importance of treating mental illness. Many of the respondents held the view that people suffering from mental illness are more likely to be understanding of other people's feelings, to be a caring parent and to have a good marriage in the longer term.

8.2.5. Institutions providing help for mental illness.

When participants were asked to name the nearest place in their area that they know of which provides treatment for people with mental illness, 60.1% of them mentioned the hospital or clinic. More participants from Kokstad knew about Kokstad Hospital and Embizweni Hospital, on the one hand. Embizweni Hospital is a psychiatric hospital located at Mzimkhulu (about 90 km from Kokstad) and it is sometimes referred to as Umzimkhulu Hospital. On the other hand, more participants from Kwa Sani Municipality knew a state primary healthcare clinic called Underberg Clinic and a private psychiatric clinic located in Underberg called Riverview Manor Rehabilitation Centre. Of concern though is that some respondents reported that

they knew hospitals located as far as Pietermaritzburg and the Eastern Cape as the nearest institutions providing treatment for mental illness. This shows that people living in rural areas may have to travel unreasonable distances to access healthcare services. In a study of a profile of patients seen by fly-in clinical psychologists at Kokstad by Pillay et al. (2009) the findings indicated that some patients reported to have travelled from places further than 100 kms away to access mental health services. This highlights the question of the accessibility of mental health services to the people of Sisonke District in general. Taking into account the scarcity of mental health facilities in this country, it might be speculated that the likelihood of people in need of mental health services from Sisonke District receiving the required treatment is very low.

8.3. Attitudes Toward Mental Illness

Literature shows that a persistent negative attitude and social rejection of people with mental illness has prevailed throughout history (Poreddi, Blrudu, Thimmaiah & Math, 2015; Yongsi, 2015). Knowledge of community attitudes towards mental illness is of paramount importance because, according to Kabir et al. 2004), they play a role in determining help-seeking behaviour and successful treatment of the mentally ill. The key findings in this study regarding attitudes toward mental illness indicate that negative attitudes towards people with mental illness are widely maintained. Of the three disorders investigated in this study, most of the participants attributed stigmatising attitudes more toward alcohol dependency. Not only did the participants have stigmatising attitudes, they also thought that other people in the community would have stigmatising attitudes toward the mentally ill. Patients with mental illness were seen as lacking control, and as frightening and aggressive. Interestingly, in spite of these attitudes, respondents in this study showed some willingness for a closer social distance, more so when the relationship with the mentally ill was perceived as somewhat distant. Less than half of participants in this study were familiar with mental illness; familiarity being measured as knowing a family member or relative or close friend with mental illness. Lastly, the findings show that the media is the primary source of information regarding mental illness.

8.3.1 Stigmatising attitudes.

Despite their willingness to seek help and having positive prognostic attitudes toward mental illness, more than half of participants in this study held stigmatising attitudes. About 56.3% strongly agreed that they would not vote for a politician if they knew he suffered from mental illness, and 50.6% strongly agreed that they would not employ someone who suffered from mental illness. Levels of stigma associated with particular disorders differed. Previous studies reported more stigmatising attitudes toward schizophrenia than depression and alcohol dependency (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). However, the results of this study show a different pattern. The finding in this study is that respondents had more stigmatising attitudes toward alcohol dependency than to depression and schizophrenia. This is consistent with surveys conducted in South Africa (Sorsdahl & Stein, 2010; Sorsdahl, Mall, Stein & Joska, 2010), and Nigeria (Crisp et al., 2000) which reported that people with alcoholism are more frequently considered unpredictable and violent than people with depression. While this was not explored in this study, based on a previous study (Crisp et al., 2000), it is possible to speculate that these attitudes toward alcohol dependency are fuelled by the view that the disorder is self-inflicted. For example, some participants in this study thought that alcohol dependency was due to misbehaving, boredom, being silly, and so forth.

In addition to the afore-mentioned stigmatising attitudes also dominating for depression, participants in this study held the view that alcohol dependency is not a real illness, that it is best to avoid people with alcohol dependency, and that people with a problem like this could overcome their dependency if they wanted to. Unfortunately, the implication of stigmatising attitudes is that the public is likely to look at those suffering from mental illness with disdain, according to Mpem (2015). The same author (Mpem, 2005) also argues that the public may therefore be likely to withhold sympathy for and assistance that may have been offered to those with mental illness, believing that the afflicted person is responsible for their actions. In fact, 61.5% of respondents from an Indian survey agreed that people with mental health problems are largely to blame for their condition (Poreddi et al., 2015).

8.3.2. Discrimination.

Participants in this study did not only have stigmatising attitudes themselves, but they also thought that other people in the community would discriminate against the mentally ill if their condition were to become known. Interestingly, more than half of participants (51.3%) thought that others would have the same discriminating attitudes as their own toward the mentally ill, and these were largely directed to alcohol dependency more than to depression or schizophrenia. Furthermore, more respondents from urban areas than rural areas believe that the mentally ill would be more likely to be discriminated against by others in the community. This finding is contrary to that of Yongsu (2015) who reported that attitudes of participants residing in more urban neighbourhoods toward mental illness were more favourable as compared to those in rural areas.

Significantly more participants older than 65 and also those with a tertiary level of education thought that mentally ill persons would be discriminated against by others. While the reason for this is not clear, Gaebel et al. (2002) also found that older people in their study, conducted in Germany, often place more emphasis on negative characteristics and behaviour. A Canadian study reported that older respondents were significantly less knowledgeable and more distancing than their younger counterparts were (Stuart & Arboleda-Florez, 2001).

A striking contrast is noticed between respondents' perception of stigmatising attitudes by others and their own friendly or cooperative contact in this study. Almost 7 out of 10 of respondents believed that their contact with a mentally ill person would be friendly and cooperative. The results further indicate that more female participants, than males, believed that their contact with the mentally ill would be friendly. This is inconsistent with previous research conducted in Iran and Qatar. In their study of Iranian community attitudes and knowledge of mental illness, Ghanian, Nojomi and Jacobsson (2015) found that male participants seemed to be more accepting of mentally ill people than women. Similarly, a Qatari study (Bener, & Ghuloum, 2010) reported that male respondents had better attitude toward mental illness than women. While it is encouraging to notice respondents' willingness for friendly and cooperative contact in the present study, Angermeyer and Dietrich (2006) caution that little is known about the relationship between attitudes towards people with mental disorders and people's actual behaviour towards them. In

general, the findings of the present study highlight the need to address social discrimination toward people with mental illness.

8.3.3. Dangerousness.

Like previous research in South Africa (Hugo et al., 2003), Nigeria (Adewuya & Oguntade, 2007), India (Ganesh, 2011; Poreddi et al., 2015), Iran (Ghanean et al., 2015), and the United States of America (Link et al., 1999), the majority of the respondents in this study hold the perception that the mentally ill are dangerous. In this study, people with mental illness were seen as lacking control, frightening and aggressive. This is concerning because, according to Crisp et al. (2000), only a small minority of people with mental illness behave dangerously. Instead, Ghanean et al. (2015) argue that people with mental illness, including depression and schizophrenia, are silent and withdrawn. However, findings from a study conducted in northern Nigeria by Kabir et al. (2004) show that their respondents expect the mentally ill to display behaviour that is disruptive and attracts public attention, such as aggression, destructiveness, talkativeness, and so on. Attitudes of dangerousness toward people with mental illness have also been found in a study conducted by Sorsdahl, Flisher, Wilson and Stein (2010) among traditional healers in the province of Mpumalanga, South Africa. In their study, traditional healers initially reported that the patient with schizophrenia as presented in a vignette was simply being called to become a healer. However, when the symptoms were altered and they were told that patient in the vignette was also aggressive, Sorsdahl, Flisher, Wilson and Stein (2010) reported that traditional healers were more likely to diagnose the patient as mentally ill. This shows that people almost always hold attitudes of dangerousness toward the mentally ill. In order to change these attitudes, educational programmes should aim to educate the public about behaviours that are likely to provoke aggression in people in general, since aggression is also present in non-clinical populations.

Consistent with findings regarding stigmatising and discriminating attitudes in this study, the results also show that perceptions of dangerousness were once again attributed more to alcohol dependency than to depression and schizophrenia. These findings cohere with those of Angermeyer and Dietrich (2006) who found that people with alcoholism are more frequently considered as unpredictable and violent than people with depression. In the current study, people with alcohol dependency were seen as lacking self-control, aggressive, frightening, unpredictable and dangerous.

The possibility that such discriminating attitudes toward alcohol dependency may reflect respondents' frequent experiences of people using alcohol in their communities is acknowledged. Often people commit acts of violence and claim, as their defence, that they were under the influence of alcohol.

When looking at the other two disorders, 57.5% and 55.1% of respondents held the view that depressed patients lack self-control and that schizophrenic patients were frightening, respectively. While it is difficult to speculate why depressed people are perceived as lacking control, it is possible that perceptions of schizophrenia as frightening may result from the portrayal of schizophrenic patients in the media, as the effects of the media have already been discussed in this study.

It was also found in this study, when comparing attitudes of dangerousness according to gender, that more females hold the attitude that the mentally ill are dangerous and aggressive. Bener and Ghuloum (2010), as well as Kabir et al. (2004) have also found that fear of the mentally ill was more prevalent among their female respondents than men. They argue that this could be due to the fact that men are traditionally expected to be outwardly brave and less submissive towards aggression than women.

It is disconcerting to note that attitudes of dangerousness toward the mentally ill are generally difficult to change and rather than diminishing, are actually increasing. Despite there being large-scale public education efforts in the United States focused on the nature, causes, and treatment of mental illness, the dangerousness attitudes have endured and are increasing, argue Link et al. (1999). A direct and radical confrontation is required if this perception of dangerousness is to be addressed. Mpem (2015) cautions that if confrontation of these attitudes does not occur then these attitudes may promote social distance from people that have mental illness, thus worsening their plight. While large scale community interventions using public media may be useful to eradicate stigmatising attitudes, on the one hand, a radical change is required by media in terms of its portrayal of mental illness, on the other hand. For example, people are well aware that the public image of mental illness in the media is dominated by the view that patients suffering from mental illness are violent and dangerous (Schulze & Angermeyer, 2003). Thus, it can be argued that the portrayal of mentally ill persons must be altered in the media, to counteract people's perceptions of these patients as dangerous.

8.3.4. Social distance.

The present study also sought to investigate participants' social distance attitudes towards mentally ill individuals. Judging from participants' attitudes of dangerousness, strikingly different results regarding social distance were found in this study. The results suggest a general willingness to have a closer social distance with mentally ill individuals, especially when the relationship is perceived as less intimate. However, this finding was converse when the relationship was perceived to be more intimate such as having a relationship with or having the mentally ill person marry into the participant's family. Nigerian studies also found that the closer the intimacy required for the interaction with the mentally ill, the stronger the respondents' desire to keep the distance (Dogra et al., 2011; Gureje et al., 2005). Similarly, Stuart and Arboleda-Florez (2001) found that social distance increased with level of intimacy required in Canada.

When looking at specific disorders, more respondents in this study showed willingness for a closer social distance to someone with depression than other disorders. Similarly, a review of population studies conducted by Angermeyer and Dietrich (2006) found that rejection is most pronounced towards people with drug abuse and alcoholism, followed by those with schizophrenia, and is less pronounced towards people with depression and anxiety disorders. There are a number of possible explanations for this. Firstly, according to Marie and Miles (2008), this could be due to the view of depression as a behaviourally benign disorder because of its stronger associations with social withdrawal and sadness. Secondly, depression is more common in most communities and has received much public attention due to its increasing incidence and prevalence rates (Marie & Miles, 2008).

Consistent with a study conducted by Gaebel et al. (2002), the findings of the current study show that respondents had the least desire for closer social distance with someone who suffers from alcohol dependency or schizophrenia. The findings of this study show that perceptions of dangerousness may account for participants' need to maintain a greater social distance toward people with mental illness. People suffering from alcohol dependency were perceived as unpredictable and violent, and those with schizophrenia as frightening. Only 20.2% and 28.1% of respondents in this study were willing to have someone suffering from alcohol dependency and schizophrenia, respectively, look after their children.

Taking the above results into consideration, two issues for consideration could be highlighted. Firstly, it is possible to hypothesise that stigmatising attitudes may prevent people from seeking appropriate professional help. Secondly, stigmatisation, discrimination, fear, and distancing from people with mental illness should therefore be, according to Yongsu (2015), a concern for all people, rather than only for those who suffer from mental illness and their caregivers. Eradication of stigma, discrimination, and improved acceptance of people with mental illness is possible within a tolerant and supportive community environment reflective of the principle of *ubuntu* embodied in African philosophy.

8.4. Familiarity with Mental Illness

Results of this study show that less half of the respondents (43.1%) knew a family member or a friend with mental illness. This number is relatively lower when compared to that of studies conducted in Nigeria and Cameroon. In a recent study of public perception and attitudes towards mental illness in Otukpo town of Benue State, Nigeria, Mpem (2015) found that 70% of respondents know people that have mental illness around them. In another study, Yongsu (2015) reported that 67.7% of respondents from Cameroon had known someone who had suffered or is suffering from mental illness. This implies that contact with mentally ill patients is moderate among respondents in the current study when compared to other studies.

Of those who know someone close with mental illness in the current study, more respondents (39.8%) know someone with alcohol dependency than depression or schizophrenia. This is most probably a reflection that the prevalence of alcohol dependency is much higher than that of depression and schizophrenia, on the one hand. On the other hand, despite government's efforts to discourage excessive alcohol drinking by raising the price of alcohol, access to alcohol remains easy and raising the cost of alcohol is proving ineffective. Females and participants from urban areas were found to be more familiar with mental illness. This may be due to women's gender roles as carers as compared to men's roles. Research showing that women are more likely than men to provide care to the sick already exists, such as the findings of a study by Umberson, Chen, House, Hopkins and Slaten (1996).

Since familiarity is also measured by the experience of oneself having suffered from mental illness in this study, just over a quarter of participants (26.2%) reported

familiarity through personal experience. Many of them were women, were from an urban area, and had had a personal experience of being depressed. Other studies conducted in South Africa and abroad documented that women report becoming mentally ill due to their extremely stressful lifestyles when they are expected to work, take care of the children, and do household chores (Mohamed-Kaloo & Laher, 2014). A high number of people who reported familiarity with mental illness through personal experience may also suggest the prevalence of mental conditions at community level that may presumably remain untreated.

A positive relationship exists between familiarity with mental illness and attitudes toward mental illness. This, according to Angermeyer and Dietrich (2006) implies that facilitating more contact with people who are mentally ill may prove effective in reducing negative attitudes.

8.5. Source of Information for Mental Illness

While it is likely that personal experiences and anecdotal evidence from family and friends are important sources of public information about mental illness (Das & Phookun, 2013), acquisition of knowledge from the mass media was also explored in the current study. According to the results of this study, less than half of participants (46.5%) had seen, read or heard news or stories about mental illness in the past six months, and newspapers, radio and magazines were the primary sources of such information. This is consistent with literature that argues that members of the public are more likely to receive information about mental illness from the mass media than from mental health professionals (Borinstein, 1992). For example, the participants of a study conducted in Germany by Schulze and Angermeyer (2003) cited newspapers, television broadcasts and feature films as their main sources of information about mental illness. It may be speculated that negative attitudes toward the mentally ill found in this study may also be as a result of the media's influence. It has been argued earlier in this research that the public image of mental illness in the media is dominated by the view that patients suffering from mental illness are violent and dangerous.

More respondents from urban areas than rural areas had received information from the afore-mentioned sources. The internet was significantly the main source of information for respondents with a tertiary level of education, and television was the main source for women. Although this finding may suggest that information is more

easily accessible in urban areas than in rural communities, access to the internet in developing countries still remains limited. However, due to better access, the internet is rapidly becoming a major source of health information, including information on mental disorders, for the public in developed countries (Jorm, 2012).

Television is most probably a more influential source of information regarding mental illness for respondents in this study since the number of households with television sets in developing countries outweighs those with access to the internet. According to Statistics South Africa (2013), more than 80.2% of South African households own a television set as compared to only 10% that has access to the internet at home. In this study, it is contended that, if the media can be so influential in fuelling the negative attitudes toward mental illness, it may also be a powerful tool to reverse these attitudes if a concerted effort is made to report and provide correct information to the public. Furthermore, even though access to the internet is still limited in South Africa, especially in urban areas, Ganasen et al. (2008) argue that the internet may also be used as a vehicle to develop mental health literacy, particularly amongst the youth who may access the internet from their mobile telephones. The findings of this study imply and highlight the fact that the media has an enormous influence on the public regarding their knowledge of mental illness, more so if the media is involved in a carefully planned and studied manner, warns Ganesh (2011).

8.6. Conclusion

The results that were found regarding the mental health literacy of Sisonke District participants were discussed in this chapter, and they were presented according to the main objectives of the study. It has been shown that even though conceptualisations of mental illness were based on psychological, social and medical explanations, they did not conform neatly to the Western medical use of these concepts. It became apparent that participants have a good understanding of mental disorders that were being investigated and have their own ways of referring to these disorders. Respondents' beliefs about the causes of mental illness were also presented and found to be related to their conceptualisation of mental illness. This affirmed an earlier speculation that respondents' knowledge of mental illness is based on a certain kind of consistent understanding that is sensible to themselves.

Participants' knowledge and attitudes toward interventions and help-seeking were also discussed. Seeking help from social workers, medical practitioners or from a family member or a friend predominated for depression and alcohol dependency. However, for the treatment of schizophrenia, traditional healing practices dominated. The same was presented regarding conceptualisation and beliefs about the causation of schizophrenia. This led to the speculation that, of the three disorders investigated, schizophrenia was attributed more to traditional explanatory models. A discussion around the finding regarding the endorsement of vitamins, minerals and tonics over antidepressants and antipsychotics was presented, followed by a discussion regarding the respondents' willingness to seek help, as well as their prognostic views regarding mental illness.

The last section of this chapter discussed respondents' attitudes toward mental illness. It was shown in this section that while negative attitudes toward people with mental illness are widely maintained, they were more pronounced toward people with alcohol dependency than to depression and schizophrenia. Respondents' views that they would have friendly contact with a mentally ill person, in spite of their negative attitudes towards the mentally ill were also discussed. A presentation around the participants' familiarity and sources of information about mental illness followed last. Less than half of respondents were familiar with mental illness, and the media, especially television, was their primary source of information regarding mental illness.

Chapter 9

Conclusion

The prevalence of mental illness is on the rise across the globe. The problem of poor mental health literacy is a major concern in both developed and developing countries. There are many people with mental illness who are unaware that they have a diagnosable disorder or that effective treatment is available due to poor mental health literacy. Furthermore, stereotypes about and prejudice against patients with mental illness are widespread. As a result, the need to understand the public's conceptualisation of and beliefs about mental illness and their treatment is crucial to initiatives aimed at improving mental health literacy.

Conceptualisation and attitudes toward mental illness and beliefs about treatment among African residents of Sisonke District in KwaZulu-Natal, in particular from Kokstad and Kwa Sani Municipalities, have been investigated in this study.

The first chapter introduced the topic and the study as whole and defined the concept *mental health literacy*. The four major consequences of a lack of mental health literacy were presented to highlight the importance of this study. This was followed by a presentation of the aims and objectives of the study, and the definitions of terms used in the study concluded the first chapter.

The second chapter, the literature review, presented a brief historical background of mental illness illustrating how the conceptualisation of mental illness has evolved over the centuries from the prehistoric era to date. Focus then shifted to the current global state of mental illness looking at epidemiological issues with a particular reference to a selected few countries, including South Africa.

In the third chapter, culture and its influence on the construction of mental illness was presented, demonstrating how the notions and attitudes toward mental illness are generally informed by the worldviews upheld within a particular society. Indigenous African views of illness, mental illness in particular, were also presented in the third chapter and this discussion highlighted the fact that the manner in which people understand their afflictions is connected to their beliefs about their origins, and such beliefs inform what they consider to be appropriate therapeutic strategies for their alleviation.

The theoretical framework employed to underpin the study was presented in the fourth chapter. The framework selected in this study draws from a number of

theories or models of healthcare, beginning with the explanatory models of illness, followed by contact theory and the health belief model. The concepts grounding the explanatory models of illness were used to demonstrate how the meanings attached to mental illness are important in shaping how mental illness is experienced, expressed and dealt with. The main argument presented using contact theory is that contact, equated to familiarity, leads to decreased stigma of mental illness. The health belief model was presented to demonstrate how psychosocial constructs explain the individual's decision-making linked to health-related behaviours.

The fifth chapter presented the methodology used to conduct this study. It started with a presentation of the study location followed by the research design, particularly, a quantitative approach with cross-sectional and correlational designs. The research instrument used, namely a questionnaire, its adaptation, pre-testing and piloting also formed part of this chapter. The ethical considerations taken into account throughout the study were presented last in Chapter 5.

The results of this study were presented in Chapters 6 and 7. Chapter 6 begins with the demographic characteristics of the sample followed by the presentation of the results regarding the conceptions of mental illness. Knowledge and attitudes toward help-seeking as well as attitudes toward mental illness are presented in Chapter 7.

Chapter 8 presented a discussion of the findings of this study, firstly by examining respondents' conceptions and aetiological beliefs about mental illness. This was followed by a consideration of the knowledge and attitudes of participants toward help-seeking for mental illness. The findings were discussed and contextualised in relation to available literature. The implications derived from the results of this study were also presented alongside the discussion in general.

The current chapter presents a summary of the research results, the unique contribution of the study and recommendations for practice with regard to mental illness. The limitations of this study and suggestions for further research conclude this chapter.

9.1. Summary of the Results

This study was conducted to investigate the conceptions and attitudes toward mental illness and beliefs about treatment among African residents of Sisonke District, with a particular focus on Greater Kokstad and Kwa Sani Municipalities. The

results have been presented in the sixth and seventh chapters of this thesis. In addressing the objectives of this study, which were stated in the first chapter, the key findings derived from the results of the study are presented in summation accordingly below.

9.1.1. Conceptualisation, labelling and beliefs about the causes of mental illness.

Regarding participants' conceptualisation of mental illness, the results show that participants use multiple explanatory models of mental illness. Although participants conceptualised mental illness using a wide array of descriptions such as HIV/AIDS, TB, feeling unwell, being abused, feeling suicidal, experiencing stress, thinking too much, having family problems or financial problems, their responses show the use of psychological, social and medical models of explaining mental illness. Participants used many similar descriptions across the three disorders investigated in this study. For example, depression and alcohol abuse were both described as *TB*, *being sick* and *AIDS*, *financial problems*, and so forth, on the one hand. On the other hand, schizophrenia and alcohol abuse were described as *being stressed*, *lost the mind*, *financial problems*, and so on.

Traditional conceptions of mental illness were only applied to schizophrenia using descriptions such as *being troubled by ancestors*, *ancestral spirits entering the person*, *bewitchment*, *ukuthwasa*, and so forth, and this was more prevalent among participants between the ages of 50 to 60, who conceptualised mental illness using traditional explanatory models of illness as compared to the other age groups. Gender differences regarding conceptualisation of mental illness were also found, with more females using medical explanations, while more males used traditional explanations of mental illness.

Regarding labelling, the study found that over one-fourth of participants named any of the three disorders investigated in this study *stress*. The results also indicate that common medical and psychological problems and social stressors were used to label mental disorders. However, these labels were not used exclusively to denote an illness in proper medical terms, but instead were used to indicate the presence of an illness. Similar descriptive labels that were used to conceptualise mental illness such as *HIV/AIDS*, *TB*, *general sickness*, and the like were also used to label mental illness. Once again, traditional labels such as *possession by ancestral*

spirits, ancestral calling, bewitchment, ukuthwasa and so on were used by more respondents in reference to schizophrenia.

With regard to the causes of mental illness, the results of this study show a consistency between respondents' conceptualisation, labelling and aetiological beliefs. Mental illness was found to be understood as caused by factors that are psychological, social and medical in nature. However, the use of these aetiological factors was found to differ from how medical professionals would use them. For example, in this study, medical causation included factors such as *TB, AIDS, loss of appetite*, and the like. Consistent with earlier findings reported in the current study, more respondents in this study believe that schizophrenia, more than other disorders, is caused by stressful circumstances in life and supernatural forces. The findings of this study show a significant relationship between conceptualisation of mental illness and aetiological beliefs.

9.1.2. Knowledge and attitudes toward interventions and help-seeking.

The findings of this study regarding participants' preferred sources of support for mental illness indicate that participants preferred professional help-seeking and referral to a family member or a friend. Specifically, social workers, medical doctors and hospitals or clinics were professionals where help would be sought from. When participants were asked to rate the helpfulness of 14 professionals and non-professionals on a Likert-scale, family doctors, counsellors and psychologists were rated as likely to be helpful. Receiving help from a close friend was endorsed by more respondents for depression, and endorsement of a psychiatrist, psychologist or *sangoma* was made for helping someone suffering from schizophrenia.

Regarding specific medicines or pharmacological treatments, the results of this study show that vitamins, minerals and tonics, pain relievers, antibiotics as well as tranquilisers were perceived as helpful for the treatment of mental illness. Most of these medicines were perceived as more helpful for the treatment of depression than for schizophrenia or alcohol dependency, and were perceived as such by more females than males. However, traditional medicines were, significantly, seen as more helpful for the treatment of schizophrenia than for depression and alcohol dependency by more males than females. On a more positive note, this study found that the overwhelming majority (90.3%) of respondents reported a willingness to seek help should they suffer from mental illness. Participants indicated that they were

willing to consult professionals (in particular hospitals or clinics, social workers and medical doctors) and close relatives or family members.

The findings regarding prognosis indicate that the majority of participants have a good prognostic view of mental illness if appropriate professional help is received. Participants also maintained a good prognostic view over time, and held the view that people with mental illness are more likely to be understanding of others' feelings, and are more likely to be a caring parent and have a good marriage in the long run.

The results regarding knowledge of institutions that provide mental health services show that participants know that hospitals or clinics are such places. In particular, participants from Kokstad knew about Kokstad Hospital and Embizweni Hospital, on the one hand. On the other hand, Underberg Clinic and Riverview Manor Rehabilitation Centre were regarded by respondents from Kwa Sani as the nearest institutions providing services for people with mental illness. Of concern is that some respondents mentioned places as far away as Pietermaritzburg and the Eastern Cape as the nearest institutions providing treatment for illness.

9.1.3. Perceptions and attitudes toward mental illness.

In spite of the willingness to seek treatment for mental illness and good prognostic views, this study found that negative attitudes toward people with mental illness are widely maintained. Most stigmatising attitudes were attributed more to alcohol dependency than to depression and schizophrenia. Participants were of the view that alcohol dependency is not a real illness, that it is best to avoid people with this problem, and that people with alcohol dependency could overcome their dependency if they wanted to.

The findings of this study also show that not only did participants have stigmatising attitudes, but they also thought that other people in the community would discriminate against the mentally ill if their condition were to become known. Interestingly, more participants in this study believed that they would have friendlier or more cooperative contact with the mentally ill.

Regarding perceptions of dangerousness, the results of this study show that people with mental illness were seen as lacking control, and were perceived as frightening and aggressive. Of the three disorders studied here, more perceptions of dangerousness were attributed to alcohol dependency. In this study, people with this condition were seen as lacking self-control, and were viewed as aggressive,

frightening, unpredictable and dangerous. However, for depression and schizophrenia, people with these conditions were only seen as lacking self-control and as frightening, respectively. More females in this study viewed the mentally ill as dangerous and aggressive than male participants.

When investigating social distance, this study found that participants had a general willingness to have a closer social distance with the people suffering from mental illness, especially when the relationship was considered less intimate, in spite of having been stigmatised and perceived as dangerous. A willingness for a closer social distance towards someone with depression than schizophrenia and alcohol dependency was found.

The results regarding familiarity with mental illness show that less than half of the respondents knew a family member or a friend with mental illness. More respondents knew someone with alcohol dependency than with depression or schizophrenia. Just over a quarter of participants reported familiarity through a personal experience of mental illness. Many of them were women, from an urban area, with a personal experience of depression.

Lastly, participants' sources of information about mental illness were investigated and the results show that less than half of participants reported to have seen, read or heard news or stories about mental illness in the past six months. Newspapers, the radio and magazines were their primary sources of information. However, significantly more people from Kokstad than Kwa Sani reported to have received such information from newspapers, magazines and television. Participants with a tertiary level of education were more likely to receive information about mental illness from the internet.

9.2. Unique Contribution of the Study

Investigating mental health literacy among the African residents of Sisonke District led to the discovery of two unique and key contributions to knowledge and practice of mental healthcare. Many studies conducted abroad and in sub-Saharan Africa on the public's mental health literacy reported that the public has a poor level of mental health literacy, and this may be due to a number of reasons. For example, most of these studies have found that the public's predominant views regarding conceptualisation and causation of mental illness were not attributed to biopsychosocial explanatory models of illness. In some studies, respondents were not

able to correctly label or identify a mental disorder being investigated. It can be argued that most of these studies view mental illness as universal and they measure public knowledge based on their own conceptualisation informed by mainstream Western psychopathology.

The current study found, however, that respondents' mental health literacy may not be regarded as poor in spite of them not being able to provide a biopsychosocial explanatory model of illness or being able to correctly label or identify mental disorders that were studied because they have their own indigenous explanatory models which are equally valid. This study sought to investigate mental health literacy not on the basis of mainstream Western psychopathology, but from participants' own understandings of the presentation of mental illness as informed by their own explanatory models of illness. Although participants used a variety of descriptions and labels such as *TB*, *HIV*, *sickness*, *loss of appetite*, *stress*, *losing the mind*, *financial problems* and so on, that were classified as medical, psychological and social, these were not applied in the strict Western scientific form. However, respondents did not use these concepts haphazardly, but applied them consistently to denote their conceptualisation, naming and beliefs about the causes of mental illness. This implies that even though participants lack the use of professional or scientific vocabulary of mental illness, they have a basic and consistent understanding that a state of an *illness* is in question. This led to an understanding that mental health professionals' and the public's naming or labelling of mental illness may be different, yet may be used similarly at a deep conceptualisation level. This simply means that the manner in which the public use different concepts to refer to mental illness or the causes of mental illness may differ from that of mental health professionals, and at times some of these concepts may be used across the board to refer to different mental illnesses. However, the participants' understanding of the *nature of an illness* carries almost the same weight as that of professionals. This study adds to the field of mental health literacy, especially from the South African context, in that it has shown that failure to attribute conceptualisation, causation and labels in the same way as health professionals would, in terms of strict biopsychosocial models of illness, does not necessarily indicate a lack of mental health literacy. The lack of medical vocabulary in indigenous languages must be taken into account as a factor that may have led to the participants' usage of their own valuable ways of understanding the same mental illness being investigated.

In clinical practice, this finding cautions health professionals not to take patients' initial presenting complaints at face value when they articulate their reason/s for consultation. Clinicians need to be aware that it is very possible that patients could complain about *fever, TB, not feeling well*, and so forth, while they are actually trying to communicate that they suffer from depression, schizophrenia or alcohol dependency.

Another unique contribution of this study to knowledge and practice is that, of the three disorders investigated, the conceptualisation, causation and treatment of schizophrenia is likely to be influenced by indigenous explanatory models of illness, particularly the indigenous African worldview. This study shows that while members of the community have made progress in their understanding of mental illness using biopsychosocial models, there are a significant number of people in Sisonke District who may describe the clinical presentation of mental illness to a health practitioner, particularly schizophrenia, in traditional terms. Mental health practitioners, therefore, need to be aware that some patients may use traditional medicine concurrently with psychopharmacological treatment. As a result, enquiring about this must be a standard practice when consulting with African residents in Sisonke District, particularly those presenting with psychotic disorders.

9.3. Recommendations

Based on the literature reviewed, the actual experience of conducting the study, analysing the findings and compiling the discussion, the following recommendations can be made:

9.3.1. Awareness campaigns.

This study was able to highlight the need for interventions or awareness campaigns designed to improve mental health literacy among the residents of Sisonke District. It is recommended that these interventions must aim to educate members of the public about the nature of mental illness, stigma and its effects, causation, treatment implications and the importance of prescribed medications as the finding that 'tonics and vitamins' are preferred over psychotropic medication can only harm compliance and the therapeutic impact of treatment modalities.

Reducing stigma and fostering community acceptance of people who are mentally ill should also be the goal of these interventions. This must be done by taking into account the multicultural nature of the population in the province of KwaZulu-Natal. It is recommended that designing these interventions should take into consideration and should respect the cultural differences of the people. For example, communities' cultural conceptualisations and aetiological beliefs should not be discarded, but should be accepted as alternative explanations of mental illness containing rich complementary knowledge that could be presented alongside scientific views. Therefore, cultural experts, such as various traditional healers in the communities, community leaders, and all people who are custodians of the African tradition in the communities, must be part of these interventions.

It is also recommended that these interventions should not be generic and applicable to all, but should be tailored to address varying needs based on identified demographic variations. For example, in this study schizophrenia was likely to be seen as a traditional illness by males and depression as medical by females, older participants were more likely to use traditional explanations of mental illness and educated respondents were more likely to have received their information about mental illness from the internet.

9.3.2. The role of the media.

The findings of this study and the implications thereof have also identified the powerful role that media plays as a source of information for the public. If media is known to influence the public's negative view of mental illness, the media thus has the potential to reverse these negative views if a concerted effort is made to report and provide the correct information to the public. Mental health messages based on appropriate information presented through media platforms such as television, radio, internet and newspapers can be a powerful means to increase the public's mental health literacy. It is acknowledged that media producers may not be experts in mental health issues and are consequently likely to be unfamiliar with material relevant for improved mental illness. It is therefore recommended that health policy planners, researchers and health practitioners make a concerted effort to partner with the media, be it as content advisors or informants for published material related to mental illness, or as guests in popular talk shows. Accurate information and positive

messages about mental illness must predominate in the media for a real change to occur.

9.3.3. Collaboration between traditional and medical practitioners.

For policy developers, the findings of this study suggest that there is a need for collaboration between Western medical practitioners and traditional healers. Participants' conceptualisation of mental illness, especially psychosis, and their endorsement of traditional causation and treatment of mental illness supports this recommendation. This collaboration will promote a focus on holistic healing, which is central to the African worldview and which seeks to promote physical, psychological and spiritual well-being. Skilling traditional healers to recognise and refer patients to appropriate professionals would benefit this collaboration. For this to happen smoothly, it is recommended that an integration of Western and traditional practices to healing should be implemented without any one practice being imposed as superior over the other. An atmosphere of trust and respect should prevail between all parties involved in this collaboration.

9.3.4. Training of general practitioners and social workers.

The finding that more people are likely to consult general practitioners and social workers when confronted with mental illness motivates for the following training and practice recommendations:

1) While mental health is an integral part of both general practitioners' and social workers' training, it is recommended that their training in this area should be intensified to equip them with sufficient skills to provide necessary interventions at primary level.

2) For practitioners who are already providing service to the public, continued professional development training initiatives in mental healthcare should be prioritised.

3) For clinical practice, it is recommended that every practitioner should explore every patient's explanatory model of illness and should screen for mental illness in spite of a physical illness being reported as a reason for consultation. Not only should general practitioners be encouraged to explore patients' explanatory models of illness, they should also play a role in improving patients' mental health literacy. In

clinical practice, this can be realised by informing and discussing with patients their diagnosis, the cause of their illness as well as suitable treatment for them and the implications of this treatment.

9.3.5. Taking mental health services to the communities.

While there is an effort to provide mental health services at primary care level through CHCs, implementation of these initiatives has been slow, and some communities do not have CHCs. Most communities have ordinary local clinics, and the provision of mental health services at these local clinics is virtually non-existent. It is recommended that policymakers and officials responsible for the planning and provision of health services make mental health services at CHCs more available to all communities. Initially, each clinic could be staffed with a nurse with a specialisation in mental health, and psychologists and psychiatrists providing services at CHCs and hospitals could provide on-going support to these clinics. This would also address a concern raised in the finding in this study that some people in Sisonke District only knew about institutions that provide services for mental illness that are located far away from them.

Taking into consideration the realistic shortage of health service providers in the South African health system, an expectation for current staff to provide mental health services in addition to catering for the physical health needs of patients may not be realistic. It is therefore recommended that additional people who will function as community mental health workers be trained and employed within the public health sector. These are people who would educate and disseminate appropriate knowledge of mental health to communities, and would provide basic screening for mental illness and counselling for patients in remote areas and local clinics. Through these community mental health workers, appropriate referrals to professionals would be encouraged and improved.

9.4. Limitations of the Study

It is acknowledged that the present study has numerous limitations. The following limitations must be taken into account when interpreting the results of this study:

1) Although vignettes are used in several studies of mental health literacy, they are not without shortcomings. The vignettes used in this study did not present a full psychiatric history of the characters, but only a scenario depicting salient features relevant to make a diagnosis. It is possible that this information may be sufficient to mental health professionals but not to lay community members.

2) It would have been desirable to conduct individual interviews alongside the use of vignettes. Much more detailed information about participants' understanding of and attitudes toward mental illness could have been gained in this way. Condensing participants' responses to open-ended questions into single categories to enable quantitative analysis may have resulted in the loss of rich information. Moreover, participants were not asked to provide reasons for their responses, thus making interpretation of the findings speculative. Therefore, findings of this study must be interpreted with an understanding that they are limited to quantitative data collected using vignettes.

3) Another limitation that should be taken into account when interpreting the results of this study relates to representativeness and generalisability. Even though the sample was selected randomly to be representative of the adult African residents who reside in the two selected municipalities of Sisonke District, data gathered in this study does not represent the whole population of this district. Sisonke District comprises five municipalities, and only two were included, thus making this study representative of only Greater Kokstad and Kwa Sani Municipalities.

4) Sisonke District is in a racially and culturally diverse province, and only African participants were included in this study. As a result, views of other racial groups regarding mental illness are not represented in this study. Thus, the results may not be applicable to people from other racial groups. Moreover, this study was conducted during the day when most people were at work. The possibility that the views of the working group about mental illness may be different cannot be ignored.

5) Although the questionnaire used in this study was designed to be self-administered, many respondents completed it in the presence of the researcher or research assistants and those who could not read or write were assisted to complete the questionnaire. In addition, the findings are based entirely on self-reporting. Therefore, a bias due to social desirability and reporting cannot be excluded, more so for items which were designed to elicit attitudinal beliefs. For example, the study only measured attitudes and willingness for help-seeking, not the actual use of such help.

6) A further limitation of this study concerns the problem of familiarity with items included in the questionnaire. For example, some of the medicines that were used on Likert-scale questions such as anti-psychotics and tranquilisers may not be commonly available and may have been foreign to participants. In such situations, respondents may not have had prior knowledge to base their responses on. Similarly, another limitation of this study is that it only assessed subjective understanding of mental illness and knowledge and attitudes towards mental illness and help-seeking, without looking into respondents' actual experiences of stigma and utilisation of treatment facilities. Recruiting mentally ill individuals and their family members in this study would have been ideal.

These limitations notwithstanding, the present study provided useful information regarding respondents' conceptualisation of, and attitudes and beliefs toward mental illness and its treatment.

9.5. Suggestions for Future Research

The findings of this study have demonstrated that African residents of Sisonke District have a certain way of conceptualising mental illness that is different from professionals' biopsychosocial models. Therefore, a further discourse analytic study that would explore indigenous communities' constructions of mental illness and their beliefs about its causes and treatment is recommended. This study should examine the influence of language and culture in the construction of illness narratives among indigenous communities, not only in Sisonke District, but the whole province of KwaZulu-Natal. Exploring sociocultural meanings and terminology of illnesses would be important in understanding mental health literacy of indigenous people.

Further, in-depth, mixed methods studies are called for. It is recommended that future studies should explore communities' mental health literacy not only through making use of surveys, but by using both qualitative and quantitative research methods. Constructing a set of open-ended questions that would elicit how mental illness is socially or culturally constructed with categories of illness not being pre-defined as in the vignettes that were used in this study would be useful for future studies. In particular, the effects of language, culture, gender and education in shaping the constructions of mental illness should be explored in these studies. It is recommended that these studies should also include interviews with and

participation of indigenous mental health experts such as *izangoma*, *izinyanga* and so forth.

It is also recommended that more studies of mental health literacy in the province of KwaZulu-Natal that are inclusive of all racial groups be conducted because the problem of poor mental health literacy is not limited to certain populations, but is a global issue. Failure to do so is likely to exclude other people who equally need to have their mental health literacy improved, which may result in mental health literacy *gaps* among people of the same nation.

The current study investigated mental health literacy using a cross-sectional design. It is recommended that future longitudinal studies be conducted after suggested recommendations made in this study have been implemented to assess their influence over time. Similarly, replicating the current study in Sisonke District using the same municipalities is also recommended.

9.6. Conclusion

Given the high prevalence of mental illness across the globe, it is likely that the emotional and financial burden on the patients, their family and society as a whole are enormous. Further, mental disorders are a major contributor to the global burden of disease worldwide. Lack of mental health literacy may lead to delays and inappropriate help-seeking, as well as attitudes and stigma toward those who suffer from mental illness and their families. The main objective of this study was to investigate mental health literacy among African residents of Sisonke District in KwaZulu-Natal. A correlational and cross-sectional research design using a quantitative survey among 787 participants from Kokstad and Kwa Sani Municipalities was used to achieve the objective of this research.

In consolidating the findings of this study, it is plausible to conclude that respondents in this study demonstrated a certain level of mental health literacy, although their conceptualisation is not neatly aligned with the Western biopsychosocial understanding of mental illness. Most participants conceptualised disorders investigated in this study using the *medical, social and psychological* explanations. However, it is only schizophrenia that was also conceptualised using traditional explanations. Conceptions of mental illness were significantly related to participants' aetiological beliefs. In relation to treatment, more participants were more inclined toward the use of professional help, in particular general practitioners

and social workers, as well as seeking assistance from family members or close friends. The encouraging finding is that the majority of respondents indicated their willingness to seek help should it be required. However, the study also found that negative attitudes toward the mentally ill are widely maintained. People with mental illness were viewed as lacking control, frightening and aggressive. In this study, media, particularly, newspapers, radio and magazines, were found to be participants' primary sources of information about mental illness. The results of this study highlight the need to improve mental health literacy and thus to change the public's attitudes toward mental illness among the African residents of Sisonke District, the need for greater collaboration between traditional healers and medical practitioners, as well as the need to improve training of general practitioners and social workers in mental health issues, and to extend mental health services more widely into communities.

It is hoped that this study will create an interest and encourage mental health practitioners, policy makers and researchers in KwaZulu-Natal and South Africa as a whole to conduct more studies of mental health literacy.

References

- Abbo, C. (2011). Profiles and outcome of traditional healing practices for severe mental illnesses in two districts of Eastern Uganda. *Global Health Action*, 4, 7117. doi: 10.3402/gha.v4i0.7117.
- Abegunde, D. O., Mathers, C. D., Adam, T., Ortegón, M., & Strong, K. (2007). The burden and costs of chronic diseases in low-income and middle-income countries. *Lancet*, 370, 1929-1938.
- Abraham, C. & Sheeran, P. (2005). The health belief model. In M Conner, & P Norman (eds.). *Predicting health behaviour* (2nd ed.) (pp. 28-80). London: YHT Ltd.
- Absolon, K. (2010). Indigenous wholistic Theory: a knowledge set of practice. *First Peoples Child & Family Review*, 5, 2, 74-87.
- Adams, J., & Scott, J. (2000). Predicting medication adherence in severe mental disorders. *Acta Psychiatrica Scandinavica*, 101, 119-124.
- Adebowale, T. O., & Ogunlesi, A. O. (1999). Beliefs and knowledge about aetiology of mental illness among Nigerian psychiatric patients and their relatives. *African Journal of Medicine and Medical Sciences*, 28, 1-2, 35-41.
- Adewuya, A., & Oguntade, A. A. (2007). Doctors' attitudes towards people with mental illness in Western Nigeria. *Social Psychiatry Psychiatric Epidemiology*, 42, 931-936.
- Adhikari, S. R. (2007). Mental illness and stigma. (Editorial). *Kathmandu University Medical Journal*, 5, 3, 293-294.
- Aidoo, M., & Harpham, T. (2001). The explanatory models of mental health amongst low-income women and health care practitioners in Lusaka, Zambia. *Health Policy and Planning*, 16, 2, 206-213.
- Alderson, P. (2007). Competent children? Minors' consent to health care treatment and research. *Social Science and Medicine*, 65, 2272-2283.
- Allport, G. W. (1954). *The nature of prejudice*. Garden City, NY: Doubleday.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. Washington, DC: American Psychiatric Association.
- Anderson, R. M. (1995). Revisiting the behavioral model and access to medical care: does it matter? *Journal of Health and Social Behaviour*, 36, 1, 1-10.
- Andrade, L., Caraveo-Anduaga, J., Berglund, P., Bijl, R. V., Graaf, R. D., Vollebergh, W., ... Wittchen, H. U. (2003). The epidemiology of major depressive episodes:

- results from the International Consortium of Psychiatric Epidemiology (ICPE) Surveys. *International Journal of Methods in Psychiatric Research*, 12, 1, 3-21.
- Andrews, G., Hall, W., Teesson, M., & Anderson, S. (1999). *The mental health of Australians*. Canberra: Department of Health and Aged Care.
- Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, 113, 163-179.
- Angermeyer, M. C., Dietrich, S., Pott, D., & Matschinger, H. (2005). Media consumption and desire for social distance towards people with schizophrenia. *European Psychiatry*, 20, 246-250.
- Angermeyer, M. C., & Matschinger, H. (1994). Lay beliefs about schizophrenic disorder: the results of a population survey in Germany. *Acta Psychiatrica Scandinavica*, 89, 382, 39-45.
- Angermeyer, M. C., & Matschinger, H. (1996). The effect of violent attacks by schizophrenic persons on the attitude of the public towards the mentally ill. *Social Science and Medicine*, 43, 1721-1728.
- Angermeyer, M. C., & Matschinger, H. (1997). Social distance towards the mentally ill: results of representative surveys in the Federal Republic of Germany. *Psychological Medicine*, 27, 131-141.
- Angermeyer, M. C., & Matschinger, H. (2003). The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder. *Acta Psychiatrica Scandinavica*, 108, 304-309.
- Angermeyer, M. C., Matschinger, H., & Corrigan, P. W. (2004). Familiarity with mental illness and social distance from people with schizophrenia and major depression: testing a model using data from a representative population survey. *Schizophrenia Research*, 69, 175-182.
- Arvaniti, A., Samakouri, M., Kalamara., E., Bochtsou, V. & Bikos, C. (2009). Health service staff's attitudes towards patients with mental illness. *Social Psychiatry and Psychiatric Epidemiology*, 44, 658-665.
- Asenso-Okyere, W. K., Anum, A., Osei-Akoto, I., & Adukonu, A. (1998). Cost recovery in Ghana: are there any changes in health care seeking behavior? *Health Policy and Planning*, 13, 2, 181-188.
- Atik, G., & Yalcin, I. (2011). Help-seeking attitudes of university students: the role of personality traits and demographic factors. *Psychological Society of South Africa*, 41, 3, 328-338.

- Atilola, O. (2015). Mental health service utilization in sub-Saharan Africa: is public mental health literacy the problem? Setting the perspective right. *Global Health Promotion, 23, 2*, 30-37.
- Austin, L. T., Ahmad, F., McNally, M., & Stewart, D. E. (2002). Breast and cervical cancer screening in Hispanic women: a literature review using the health belief model. *Women's Health Issue, 12, 3*, 122-128.
- Austin, T. (2009). Psychological assessments and psychodiagnostics. In A Burke (Ed.), *Abnormal psychology. A South African Perspective* (pp. 44-63). Cape Town: Oxford University Press, Southern Africa.
- Austin, T., & Burke, A. (2009). Introduction. In A Burke (Ed.), *Abnormal psychology. A South African Perspective* (pp. 2-42). Cape Town: Oxford University Press, Southern Africa.
- Ayuya, C., Ileri, N., Kimani, I., Mathenge, J., Muriithi, J., & Otieno, R. (2015). African worldview: an integrated psychological perspective. *International Journal of Humanities Social Sciences and Education, 2, 5*, 53-61.
- Babbie, E. (2011). *The basics of social research* (5th ed.). Australia: Wadsworth Cengage learning.
- Babbie, E. & Mouton, J. (2001). *The practice of social research: South African edition*. Cape Town: Oxford University Press Southern Africa.
- Baghramian, M., & Carter, J. A. (2015). Relativism. In *Stanford Encyclopedia of Philosophy*. Retrieved from <http://plato.stanford.edu/entries/relativism/>
- Baloyi, L., & Makobe-Rabothata, M. (2013). The African conception of death: A cultural implication. In L. Jackson., D. Meiring., F. Van der Vijver., & E. Idemudia. (Eds.) (pp. 232-243). *Towards sustainable development through nurturing diversity: Selected papers from Twenty-First Congress of the International Association for Cross-Cultural Psychology*, Melbourne, FL: International Association for Cross-Cultural Psychology.
- Barlow, D. H., & Durand, V. M. (2012). *Abnormal psychology. An integrative approach* (6th ed.). Australia: Wadsworth Cengage Learning.
- Barlow, D. H. & Durand, V. M. (2005). *Abnormal psychology: an integrative approach* (4th Ed.). Pacific Grove, CA: Thomson Wadsworth.
- Bartlett, H., Travers, C., Cartwright, C. & Smith, N. (2006). Mental health literacy in rural Queensland: results of a community survey. *Australian and New Zealand Journal of Psychiatry, 40*, 783-789.

- Baumann, S. E. (2007). Odd ideas, voices, disorganized behaviours and the loss of sight: the schizophrenias and other psychotic disorders. In S E Baumann (Ed.), *Primary health care psychiatry. A practical guide for southern Africa* (pp. 547-482). Cape Town: Juta & Co, Ltd.
- Bayer, J. K., & Peay, M. Y. (1997). Predicting intentions to seek help from professional mental health services. *Australian and New Zealand Journal of Psychiatry*, 31, 504-513.
- Benatar, S. R. (2002). Reflections and recommendations on research ethics in developing countries. *Social Science & Medicine*, 54, 1131-1141.
- Bener, A., & Ghuloum, S. (2010). Gender differences in the knowledge, attitude and practice towards mental health illness in a rapidly developing Arab society. *International Journal of Social Psychiatry*, 57, 5, 480-486.
- Berg, A. (2003a). Ancestor reverence and mental health in South Africa. *Transcultural Psychiatry*, 40, 2, 194-207.
- Berg, A. (2003b). Beyond the dyad: parent-infant psychotherapy in a multicultural society- reflections from a South African perspective. *Infant Mental Health Journal*, 24, 3, 265-277.
- Bergman, M. M., Bergman, Z., & Gravett, S. (2011). The development and application of the explanatory model of school dysfunctions. *South African Journal of Education*, 31, 4, 461-474.
- Betancourt, J. R. (2004). Cultural competence- marginal or mainstream movement? *New England Journal of Medicine*, 351, 10, 953-955.
- Bethlehem, J. (1999). Cross-sectional surveys. In H J Ader, & G J Mellenbergh (eds.), *Research methodology in the social, behavioural & life sciences* (pp.110-142). London: SAGE Publications.
- Bhagwanjee, A., Parekh, A., Paruk, Z., Petersen, I. & Subedar, H. (1998). Prevalence of minor psychiatric disorders in an adult African rural community in South Africa. *Psychological Medicine*, 28, 1137-1147.
- Bhugra, D. & Bhui, K. (1997). Cross-cultural psychiatric assessment. *Advances in Psychiatric Treatment*, 3, 103-110.
- Bhugra, D. & Gupta, S. (2010). Culture and its influence on diagnosis and management. In C Morgan & D Bhugra (eds.), *Principles of Social Psychiatry* (pp. 117-131). Singapore: A John Wiley & Sons, Ltd.
- Bhui, K., & Bhugra, D. (2002). Explanatory models for mental distress: Implications for clinical practice and research. *British Journal of Psychiatry*, 181, 6-7.

- Blazer, D. G., Kessler, R. C., McGonagle, K. A., Swartz, M. S. (1994). The prevalence and distribution of major depression in a national community sample: the national comorbidity survey. *The American Journal of Psychiatry*, 151, 7, 979-986.
- Boddington, P., & Raisanen, U. (2009). Theoretical and practical issues in the definition of health: insights from Aboriginal Australia. *Journal of Medicine and Philosophy*, 34, 49-67.
- Bootzin, R. R., Acocella, J. R., & Alloy, L. B. (1993). *Abnormal psychology, current perspectives*. New York: McGraw-Hill, INC.
- Borinstein, A. B. (1992). Public attitudes toward persons with mental illness. *Health Affairs*, 11, 3, 186-196.
- Botha, K., & Moletsane, M. (2012). Western and African aetiological models. In A Burke (Ed.), *Abnormal psychology: a South African perspective* (pp. 56-83). Cape Town: Oxford University press- Southern Africa.
- Bourdon, K. H., Rae, D. S., Locke, B. Z., Narrow, W. E., & Regier, D. A. (1992). Estimating the prevalence of mental disorders un U.S. adults from the Epidemiological Catchment Area Survey. *Public Health Reports*, 107, 6, 663-668.
- Bourget, B., & Chenier, R. (2007). Mental health literacy in Canada: phase one draft report. Mental health literacy project. Canadian Alliance on Mental Illness and Mental Health. Retrieved from http://camimh.ca/wp-content/uploads/2012/04/Mental-Health-Literacy_-_Full-Final-Report_EN.pdf
- Bournot-Trites, M., & Belanger, J. (2005). Ethical dilemmas facing action researchers. *Journal of Educational Thought*, 39, 2, 197-215.
- Bowyer, B. T. (2009). The contextual determinants of whites' racial attitudes in England. *British Journal of Political Science*, 39, 559-586.
- Boyd, K. M. (2000). Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts. *Medical Humanities*, 26, 9-17.
- Bradshaw, D. (1996). Is the DALY measurable in South Africa? *South African Medical Journal*, 86, 1483-1483.
- Bradshaw, D., Groenewald, P., Laubscher, R., Nannan, N., Nojilana, B., Norman, R., ... Johnson, L. (2003). Initial burden of disease estimates for South Africa, 2000. *South African Medical Journal*, 93, 9, 682-688.
- Bradshaw, D., Norman, R., & Schneider, M. (2007). A clarion call for action based on refined DALY estimates for South Africa. (editorial). *South African Medical Journal*, 97,6, 438-439.

- Brewer, N. T., & Rimer, B. K., (2008). Perspectives on health behavior theories that focus on individuals. In K Glanz, B K Rimer, & K Viswanath (Eds.). *Health behaviour and health education: Theory, research, and practice* (4th ed.) (pp. 149-165). San Francisco, CA: Jossey-Bass.
- Brown, J. D. (2004). Yates correction factor. *The JALT Testing & Evaluation SIG Newslater*, 8, 1, 22-27. Retrieved from <https://jalt.org/test/PDF/Brown19.pdf>
- Brown, K. W., Cozby, P. C., Kee, D. W., & Worden, P. E. (1999). *Research methods in human development* (2nd ed.). Toronto: Mayfield Publishing Company.
- Bryman, A. (2008). *Social research methods*. New York: Oxford University Press.
- Buhrmann, M. V., & Gqomfa, J. N. (1981). The Xhosa healers of southern Africa: the songs sung in a healing ceremony. *Journal of Analytical Psychology*, 26, 297-312.
- Bulger, R. E. (1994). Toward a statement of the principles underlying responsible conduct in biomedical research. *Academic Medicine*, 69, 2, 102-107.
- Burgess, P. M., Pirkis, J. E., Slade, T. N., Johnston, A. K., Meadows, G. N., & Gunn, J. M. (2009). Service use for mental health problems: findings from the 2007 National Survey of Mental Health and Wellbeing. *The Royal Australian and New Zealand College of Psychiatrists*, 43, 615-623.
- Burns, J. K. (2011). The mental health gap in South Africa- a human rights issue. *The Equal Rights Review*, 6, 99-113.
- Bussing, R., Gray, F. A. Mills, T. L., & Garvan, C. W. (2003). Parental explanatory models of ADHD: gender and cultural variations. *Social Psychiatry and Psychiatric Epidemiology*, 38, 563-575.
- Butcher, J. N., Mineka, S., & Hooley, J. M. (2011). *Abnormal Psychology, core concepts* (2nd ed.). Boston: Pearson.
- Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment*, 6, 65-72.
- Callaghan, P., Shan, C. S., Yu, L. S., Ching, L. W., & Kwan, T. L. (1997). Attitudes towards mental illness: testing the contact hypothesis among Chinese student nurses in Hong Kong. *Journal of Advanced Nursing*, 26, 33-40.
- Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., & Flisher, A. J. (2010). Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Transcultural Psychiatry*, 47, 4, 610-628.

- Canino, G. & Alegria, M. (2008). Psychiatric diagnosis- is it universal or relative to culture? *Journal of Child Psychology and Psychiatry*, 49, 3, 237-250.
- Carrillo, J. M., Green, A. R., & Betancourt, J. R. (1999). Cross-cultural primary care: a patient-based approach. *Annals of Internal Medicine*, 130, 829-834.
- Carson, R. C., & Butcher, J. N. (1992). *Abnormal psychology and modern life* (9th ed.). New York: HarperCollins Publishers Inc.
- Cartwright, D. (2008). Psychopathology. In L Swartz, C de la Rey, N Ducan, & L Townsend. *Psychology: an introduction* (2nd ed.) (pp 451-470). Cape Town: Oxford University Press, Sothern Africa.
- Casebeer, A. L., & Verhoef, M. J. (1997). Combining qualitative and quantitative research methods: considering the possibilities of enhancing the study of chronic disease. *Chronic Diseases in Canada*, 18, 3, 130-135.
- Cerkoney, K. A. B., & Hart, L. (1980). The relationship between the health belief model and compliance of persons with diabetes mellitus. *Diabetes Care*, 3, 5, 594-598.
- Champion, V. L., & Skinner, C. S. (2008). The health belief model. In K Glanz, B K Rimer, & K Viswanath (Eds.). *Health behaviour and health education: Theory, research, and practice* (4th ed.) (pp. 45-65). San Francisco, CA: Jossey-Bass.
- Chowdhury, A. N. (2012). Culture, psychiatry and cultural competence, mental illness- understanding, prediction and control. InTech, Croatia. Retrieved from www.intechopen.com/books/mental-illness-understanding-prediction-and-control/culture-psychiatry-and-cultural-competence
- Chu, C. (1998). Cross-cultural health issues in contemporary Australia. *Ethnicity & Health*, 3,1/2, 125-134.
- Clark, A. (2006). Anonymizing research data. *NCRM Working Paper Series*. ESRC National Centre for Research Methods. Retrieved from http://eprints.ncrm.ac.uk/480/1/0706_anonymising_research_data.pdf
- Clark-Carter, D. (2010). *Quantitative psychological research: the complete student's companion* (3rd ed.). Canada: Psychology Press.
- Cobbah, J. A. M. (1987). African values and the human rights debate: An African perspective. *Human Rights Quarterly*, 9, 309-331.
- Conner, M., & Norman, P. (2005). Predicting health behaviour: a social cognition approach. In M Conner, & P Norman (eds.). *Predicting health behaviour* (2nd ed.) (pp. 1-27). London: YHT Ltd.
- Coolican, H. (2004). *Research methods and statistics in psychology*. (4th ed.). London: Hodder & Stoughton

- Coon, D., & Mitterer, J. O. (2010). *Gateways to psychology: An introduction to mind and behaviour* (13th ed.). Australia: Wadsworth Cengage Learning.
- Corbin, J. M. (2003). The body in health and illness. *Qualitative Health Research*, 13, 2, 256-267.
- Corrigan, P. W., Edwards, A. B., Green, A., Diwan, S. L., & Penn, D. L. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia Bulletin*, 27, 2, 219-225.
- Corrigan, P. W., Green, A., Lundin, R., Kubiak, M. A., & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric Services*, 52, 7, 953-958.
- Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, 1, 16-20.
- Corrigan, P. W., Watson, A. C., & Barr, L. (2006). The self-stigma of mental illness: implications for the self-esteem and self-efficacy. *Journal of Social and Clinical Psychology*, 25, 875-884.
- Costello, E. J., Egger, H., & Angold, A. (2005). 10-year research update review: the epidemiology of child and adolescent psychiatric disorders: I. Methods and public health burden. *Journal of American Child and Adolescent Psychiatry*, 44, 10, 972-986.
- Council for International Organization of Medical Sciences. (1991). *International guidelines for ethical review of epidemiological studies*. Council for International Organizations of Medical Sciences. Geneva.
- Crawford, T. A. & Lipsedge, M. (2004). Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine. *Mental Health, Religion & Culture*, 7, 2, 131-148.
- Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O, J. (2000). Stigmatisation of people with mental illnesses. *British Journal of Psychiatry*, 177, 4-7.
- Czaja, R., & Blair, J. (2005). *Designing surveys: a guide to decisions and procedures*. London: Pine Forge Press.
- Das, S., & Phookun, H. R. (2013). Knowledge, attitude, perception and belief (K.A.P.B.) of patients' relatives towards mental illness: associations with clinical and sociodemographic characteristics. *Delhi Psychiatric Journal*, 16, 1, 98-109.
- De Craemer, W. (1983). A cross-cultural perspective on personhood. *Health and Society*, 61, 1, 19-34.

- Dell'Utri, M. (2009). Relativism and antirelativism: is full understanding between cultures possible? *Annali della Facoltà di Lingue e Letterature Straniere di Sassari*, 6, 29-36.
- Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, L., Kovess, V., Lepine, J. P. ... WHO World Mental Health Survey Consortium. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of American Medical Association*, 291, 2581-2590.
- de Vaus, D. (2002). *Surveys in social science research* (5th ed.). London: Routledge Taylor & Francis Group.
- Devlin, A. S. (2006). *Research methods: Planning, conducting and presenting research*. Australia: Tomson Wadsworth.
- de Villiers, L., & Herselman, S. (2004). Metatheoretical and theoretical perspectives on cultural studies. In A A Tjale., & L de Villiers (Eds.). *Cultural issues in health and health care* (pp. 12-29). Cape Town: Juta & Co, Ltd.
- de Witt, A. H., de Boer, J., & Boersema, J. J. (2014). Exploring inner and outer worlds: a quantitative study of worldviews, environmental attitudes, and sustainable lifestyles. *Journal of Environmental Psychology*, 37, 40-54.
- Diale, B., & Fritz, E. (2007). Indigenous knowledge and learning development. In N Duncan, B Bowman, A Naidoo, J Pillay & V Roos. *Community psychology: analysis, context and action* (pp. 309-322). Cape Town; UCT Press.
- Diener-West, M. (2008). *The use of Chi-square statistics*. Retrieved from <http://ocw.jhsph.edu/courses/FundEpiII/PDFs/Lecture17.pdf>
- Dixon, J., Durrheim, K. & Tredoux, C. (2007). Intergroup contact and attitudes towards the principle and practice of racial equality. *Psychological Science*, 18, 10, 867-872.
- Dogra, N., Omigbodun, O., Adedokun, T., Bella, T., Ronzoni, P., & Adesokan, A. (2011). Nigerian secondary school children's knowledge of and attitudes to mental health and illness. *Clinical Child Psychology and Psychiatry*, 17, 3, 336-353.
- Dohrenwend, B. P. & Dohrenwend, B. S. (1982). Perspectives on the past and future of psychiatric epidemiology. The 1981 Rema Lapouse Lecture. *American Journal of Public Health*, 72, 11, 1271-1279.
- Dovidio, J. F., Gaertner, S. L., & Kawakami, K. (2003). Intergroup contact: the past, present, and the future. *Group Process & Intergroup Relations*. 6, 1, 5-21.

- Drennan, G. (2001). Cultural psychiatry. In B Robertson, C Allwood, & C Gagiano. *Textbook of psychiatry for southern Africa* (pp. 397-406). Cape Town: Oxford University Press, Southern Africa.
- Dunn, D. S. (2010). *The practical researcher: a student guide to conducting psychological research* (2nd ed.). Singapore: A John Wiley & Sons, Ltd.
- Durrheim, K. (1999a). Quantitative analysis. In M. Terre Blanche, K Durrheim, & D Painter (Eds.). *Research in practice: Applied methods for the social sciences* (pp. 96-122). Cape Town: University of Cape Town Press.
- Durrheim, K. (1999b). Research design. In M. Terre Blanche, K Durrheim, & D Painter (Eds.). *Research in practice: Applied methods for the social sciences* (pp. 29-53). Cape Town: University of Cape Town Press.
- Durrheim, K. (1999c). Quantitative measurement. In M. Terre Blanche, K Durrheim, & D Painter (Eds.). *Research in practice: Applied methods for the social sciences* (pp. 72-95). Cape Town: University of Cape Town Press.
- Durrheim, K., & Wassenaar, D. (1999). Putting design into practice: writing and evaluating research proposals. In M. Terre Blanche, K Durrheim, & D Painter (Eds.). *Research in practice: Applied methods for the social sciences* (pp. 54-71). Cape Town: University of Cape Town Press.
- Eagle, G. T. (2005). Therapy at the cultural interface: implications of African cosmology for traumatic stress intervention. *Journal of Contemporary Psychotherapy*, 35, 2, 199-209.
- Eaton, W. W., Martins, S. S., Nestadt, G., Bienvenu, O. J., Clarke, D., & Alexandre, P. (2008). The burden of Mental Disorders. *Epidemiologic Reviews*, 30, 1-14.
- Edwards, S. D., Grobbelaar, P. W., Makunga, N. V., Sibaya, P. T., Nene, L. M., Kunene, S. T., & Magwaza, A. S. (1983). Traditional Zulu theories of illness in psychiatric patients. *The Journal of Social Psychology*, 121, 213-221.
- Edwards, S. J. L. (2005). Research participation and the right to withdraw. *Bioethics*, 19, 2, 112-130.
- Ehrlich, R., Katzenellenbogen, J., Tollman, S. & Gear, J. (2007). Why do epidemiological research? A South African perspective. In G Joubert & R Ehrlich. *Epidemiology: A research manual for South Africa* (pp. 2-11). Cape Town: Oxford University Press, Southern Africa.
- Elder, J. P., Ayala, G. X., & Harris, S. (1999). Theories and intervention approaches to health-behaviour change in primary care. *American Journal of Preventive Medicine*, 17, 4, 275-284.

- Elliott, M., Maitoza, R., & Schwinger, E. (2011). Subjective accounts of the causes of mental illness in the USA. *International Journal of Social Psychiatry*, 58, 6, 562-567.
- Emanuel, E. J., Wendler, D. & Grady, C. (2000). What makes a clinical research ethical? *The Journal of the American Medical Association*, 283 (20), 2701-2711.
- Emanuel, E. J., Wendler, D., Killen, J. & Grady, C. (2004). What makes clinical research in developing countries ethical? The benchmarks of ethical research. *The Journal of Infectious Diseases*, 189, 5, 930-937.
- Emsley, R. (2001). Focus on psychiatry in South Africa. *British Journal of Psychiatry*, 178, 382-286.
- Emsley, R., & Seedat, S. (2007). Psychiatry in the southern African context: problems and challenges. In S E Baumann (Ed.), *Primary health care psychiatry: A practical guide for southern Africa* (pp. 38-45). Cape Town: Juta & Co, Ltd.
- Ensink, K., & Robertson, B. (1999). Patient and family experiences of psychiatric services and African indigenous healers. *Transcultural Psychiatry*, 36, 1, 23-43.
- Estroff, S. E. (1989). Self, identity, and subjective experiences of schizophrenia: in search of the subject. *Schizophrenia Bulletin*, 15, 2, 189-196.
- Fabrega, H. (1989). The self and schizophrenia: a cultural perspective. *Schizophrenia Bulletin*, 15, 2, 277-290.
- Fabrega, H. (1992). The role of culture in a theory of psychiatric illness. *Social Science and Medicine*, 35, 91-103.
- Fisher, L. J., & Goldney, R. D. (2003). Differences in community mental health literacy in older and younger Australians. *International Journal of Geriatric Psychiatry*, 18, 33-40.
- Fisher, A. J. (2007). Psychiatric epidemiology. In G Joubert & R Ehrlich. *Epidemiology: A research manual for South Africa* (pp. 281-292). Cape Town: Oxford University Press, Southern Africa.
- Fisher, A. J., Ziervogel, C. F., Chalton, D. O., & Robertson, B. A. (1993). Risk-taking behaviour of Cape Peninsula high-school students. Part I. Introduction and methods. *South African Medical Journal*, 83, 469-473.
- Fox, N., Ward, K., & O'Rourke, A. (2005). Pro-anorexia, weight-loss drugs and the internet: an anti-recovery' explanatory model of anorexia. *Sociology of Health & Illness*, 944-971.

- Frankel, M. S. & Siang, S. (1999). *Ethical and legal aspects of human subjects research on the internet*. Washington DC: American Association for the Advancement of Science. doi: <http://www.aaas.org/spp/dspp/sfml/projects/intres/main.htm>
- Furnham, A., Daoud, Y., & Swami, V. (2009). How to spot psychopath: lay theories of psychopathology. *Social Psychiatry Psychiatric Epidemiology*, 44, 464-472.
- Furnham, A., & Hamid, A. (2014). Mental health literacy in non-western countries: a review of the recent literature. *Mental Health Review Journal*, 19, 2, 84-98.
- Furnham, A., Lee, V., & Kolzeev, V. (2015). Mental health literacy and borderline personality disorder (BPD): what do the public "make" of those with BPD? *Social Psychiatry Psychiatric Epidemiology*, 50, 317-324.
- Furnham, A., & Telford, K. (2012). Public attitudes, lay theories and mental health literacy: the understanding of mental health. In L. L'Abate (Ed.), *Mental Illness – Understanding, Prediction and Control* (pp. 3 – 22). InTech: Croatia.
- Furnham, A., & Thomson, L. (1996). Lay theories of heroin addiction. *Social Science & Medicine*, 43, 1, 29-40.
- Furnham, A., & Wincelous, J. (2012). Psychiatric literacy and the personality disorders. *Psychopathology*, 45, 29-41.
- Gaebel, W., Baumann, A., Witte, A. M., & Zaeske, H. (2002). Public attitudes towards people with mental illness in six German cities. *European Archives of Psychiatry and Clinical Neuroscience*, 252, 6, 278-287.
- Ganasean, K. A., Parker, S., Hugo, C. J., Stein, D. J., Emsley, R. A., & Seedat, S. (2008). Mental health literacy: focus on developing countries. *African Journal of Psychiatry*, 11, 23-28.
- Ganesh, K. (2011). Knowledge and attitude of mental illness among general public of Southern India. *National Journal of Community Medicine*, 2, 1, 175-178.
- Gangat, A. (2001). The history of psychiatry. In B Robertson, C Allwood, & C Gagiano. *Textbook of psychiatry for southern Africa* (pp. 1-6). Cape Town: Oxford University Press, Southern Africa.
- Gavin, H. (2008). *Understanding research methods and statistics in psychology*. London: SAGE Publications.
- Gegeo, D. W., & Watson-Gegeo, K. A. (2001). "How we know": Kwara'ae rural villagers doing indigenous epistemology. *The Contemporary Pacific*, 13, 1, 55-88.

- Ghanean, H., Nojomi, M., & Jacobsson, L. (2015). A community study on attitudes to and knowledge of mental illness in Tehram. *Open Journal of Psychiatry*, 5, 26-30.
- Goldney, R. D., Fisher, L. J., Dal Grande, E., & Taylor, A. W. (2005). Changes in mental health literacy about depression: South Australia, 1998-2004. *Medical Journal of Australia*, 183, 134-137.
- Goodwin, C. J. (2005). *Research in psychology: methods and design* (4th ed.). New York: John Wiley & Sons, Inc.
- Gravetter, F. J. & Wallnau, L. B. (2004). *Statistics for the behavioural sciences* (6th ed.). Australia: Thomson Wadsworth.
- Greater Kokstad Municipality. (2008). *Reviewed Integrated Development Plan 2008/2009*. Retrieved from http://www.ewisa.co.za/ewisawaterworks/misc/MunicipalDocuments/KZNDiSi sonke/LMGreater_Kokstad/GREATER%20KOKSTAD%20MUNICIPALITY.pdf
- Greater Kokstad Municipality. (2012). *Integrated Development Planning 2012 – 2017*. Retrieved from http://devplan.kzncogta.gov.za/idp_reviewed_2012_13/IDPS/KZ5a4/Adopted/Greater%20Kokstad%202012-2017%20IDP.pdf
- Greener, I. (2011). *Designing social research: a guide for the bewildered*. Los Angeles: SAGE Publications.
- Grills, C. T. (2003). Substance abuse and African Americans: the need for Africentric-based substance abuse treatment models. In D J Gilbert, & E M Wright (eds.), *African American women and HIV/AIDS: critical responses* (pp. 3-72). Westport, CT: Praeger Publishers.
- Grills, C. T. (2006). *African centered psychology: strategies for psychological survival & wellness*. Retrieved from [http://baatn.org.uk/resources/Documents/Cheryl+Grills+Powerpoint+2\[1\].pdf](http://baatn.org.uk/resources/Documents/Cheryl+Grills+Powerpoint+2[1].pdf)
- Grob, G. N. (1994). *The mad among us: A history of the care of America's mentally ill*. Cambridge MA: Harvard University Press.
- Gureje, O., & Alem, A. (2000). Mental health policy development in Africa. *World Health Organization*, 78, 475-482.
- Gureje, O., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *British Journal of Psychiatry*, 186, 436-441.

- Hadebe, J. M. B. (1986). An African view of psychopathology: A blueprint. *University of Zululand Journal of Psychology*, 2, 2, 1-25.
- Hakim, C. (2000). *Research design: successful designs for social and economic research* (2nd ed.). Canada: Routledge.
- Harrison, J. A., Mullen, P. D., & Green, L. W. (1992). A meta-analysis of studies of the health belief model with adults. *Health Education Research*, 7, 1, 107-116
- Harry Gwala District Municipality (2016, August 10). Retrieved from www.harrygwaladm.gov.za
- Harry Gwala Health District Plan (2014). *District Health Plan 2015/2016: Harry Gwala District (Sisonke) KwaZulu-Natal*. Retrieved from <http://www.kznhealth.gov.za/Strategic/DHP/2015-16/Harry-Gwala.pdf>
- Hart, M. A. (2010). Indigenous worldviews, knowledge, and research: the development of an indigenous research paradigm. *Journal of Indigenous Voices in Social Work*, 1, 1, 1-16.
- Hayden, J. (2009). *Introduction to health behaviour theory*. United States of America: Jones & Bartlett Learning.
- Havenaar, J. M., Geerlings, M. I., Vivian, L., Collinson, M., & Robertson, B. (2008). Common mental health problems in historically disadvantaged urban and rural communities in South Africa: prevalence and risk factors. *Social Psychiatry and Psychiatric Epidemiology*, 43, 3, 209-215.
- Henderson, S. (2000). Epidemiology of mental disorders: the current agenda. *Epidemiologic Review*, 22, 1, 24-28.
- Henderson, S., Andrews, G., & Hall, W. (1999). Australia's mental health: an overview of the general population survey. *Australian and New Zealand Journal of Psychiatry*, 34, 197-205.
- Henshaw, E. J., & Freedman-Doan, C. R. (2009). Conceptualizing mental health care utilization using the health belief model. *Clinical Psychology Science & Practice*, 16, 4, 420-439.
- Herselman, S. (2004). The anthropology of health. In A A Tjale., & L de Villiers (Eds.). *Cultural issues in health and health care* (pp. 134-158). Cape Town: Juta & Co, Ltd.
- Herselman, S., & Parry, L. (2004). Anthropological principles underlying health care. In A A Tjale., & L de Villiers (Eds.). *Cultural issues in health and health care* (pp. 63-77). Cape Town: Juta & Co, Ltd.

- Hewlett, S. (1996). Consent to clinical research – adequately voluntary or substantially influenced? *Journal of Medical Ethics*, 22, 232-237.
- Hirst, M. (2005). Dreams and medicines: the perspective of Xhosa diviners and novices in the Eastern Cape, South Africa. *Indo-Pacific Journal of Phenomenology*, 5, 2, 1-22.
- Hoff, W. (1992). Traditional healers and community health. *World Health Forum*, 13, 182-187.
- Hofmann, B. (2001). Complexity of the concept of disease as shown through rival theoretical frameworks. *Theoretical Medicine*, 22, 211-236.
- Holt, N., Bremner, A., Sutherland, E., Vliek, M., Passer, M., & Smith, R. (2012). *Psychology. The science of mind and behaviour* (2nd ed.). London: McGraw-Hill.
- Honwana, A. (1998). Discussion guide 4: Non-western concepts of mental health. *The Refugee Experience-Psychosocial Training Module*, 103-119
- Hugo, C. J., Boshoff, D. E. L., Traut, A., Zungu-Dirwayi, N., & Stein, D. J. (2003). Community attitudes and knowledge of mental illness in South Africa. *Social Psychiatry and Psychiatric Epidemiology*, 38, 715-719.
- Hyder, A., & Morrow, R. (2006). Culture, behaviour, and health. In M Merson, R Black, & A Mills (Eds.). *International public health: diseases, systems, and politics* (pp. 41-66). Sudbury, MA: Jones and Bartlett.
- Iancu, I., Spivak, B., Ratzoni, G., Apter, A., & Weizman, A. (1994). The sociocultural theory in the development of anorexia nervosa. *Psychopathology*, 27, 1-2, 29-36.
- Ikuenobe, P. (2016). Good and beautiful: a moral-aesthetic view of personhood in African communal traditions. *Essays in Philosophy*, 17, 1, 125-163.
- Insel, T. R. & Fenton, W. S. (2005). Psychiatric epidemiology: It's not just about counting anymore. *Archives of General Psychiatry*, 62, 590-592.
- Isotalo, J. (2009). *Basics of statistics*. Retrieved from <http://www.mv.helsinki.fi/home/jmisotal/BoS.pdf>
- Ivey, G., & Myers, L. J. (2008). The psychology of bewitchment (Part I): a phenomenological study of experience of bewitchment. *South African Journal of Psychology*, 38, 1, 54-74.
- Jackson, A. P., & Sears, S. J. (1992). Implications of an Africentric worldview in reducing stress from African American women. *Journal of Counselling & Development*, 71, 184-190.

- Jackson, S. L. (2012). *Research methods and statistics: a critical thinking approach* (4th ed.). Australia: Wadsworth Cengage Learning.
- Jackman, M. R., & Crane, 1986). "Some of my best friends are black...": interracial friendship and whites' racial attitudes. *Public Opinion Quarterly*, 50, 459-486.
- Jacob, K. S., Bhugra, D., Lloyd, K. R., & Mann, A. H. (1998). Common mental disorders, explanatory models and consultation behaviour among Indian women living in the UK. *Journal of the Royal Society of Medicine*, 91, 66-71.
- Jagdeo, A., Cox, B. J., Stein, M. B., & Sareen, J. (2009). Negative attitudes toward help seeking for mental illness in 2 population-based surveys from the United States and Canada. *The Canadian Journal of Psychiatry*, 54, 11, 757-766.
- Jaggi, S. (2003). Descriptive statistics and exploratory data analysis. *Indian Agricultural Statistics Research Institute*, 1-8. Retrieved from http://www.iasri.res.in/ebook/eb_smar/e-book_pdf%20files/Manual%20II/1-Descriptive%20Statistics.pdf
- Jahanlou, A. S., Lotfizade, M., & Karami, A. (2013). A new behavioral model (health belief model combined with two fear models): design, evaluation and path analysis of the role of variables in maintaining behavior. In O O Oguntibeju (ed.). *Diabetes Mellitus: Insights and Perspectives* (pp. 297-312). INTECH Open Access Publisher. doi: <http://dx.doi.org/10.5772/52966>
- Jamieson, S. (2004). Likert scales: how to (ab)use them. *Medical Education*, 38, 1212-1218.
- Janz, N. K., & Becker, M. H. (1984). The health belief model: a decade later. *Health Education Quarterly*, 11, 1, 1-47.
- Jefferson, A. (2014). Mental disorders, brain disorders and values. *Frontiers in Psychology*, 5, 130. Retrieved from <http://juser.fz-juelich.de/record/151782/files/FZJ-2014-01664.pdf>
- Jenkins, J. H., & Kleinman, A., & Good, B. J. (1991). Cross-cultural studies of depression. In J Becker., & A Kleinman (Eds.). *Psychosocial aspects of depression* (pp. 67-99). New Jersey: Lawrence Erlbaum Associates, Publishers.
- Jenkins, R. (1997). Reducing the burden of mental illness. (commentary). *The Lancet*, 349, 1340-1340.
- Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: a research paradigm whose time has come. *Educational Researcher*, 33, 7, 14-26.
- Jordaan, E. (2010). Schizophrenia. In A Burke (Ed.), *Abnormal psychology: A South African perspective* (pp. 160-195). Cape Town: Oxford University Press.

- Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*, 177, 396-401.
- Jorm, A. F. (2012). Mental health literacy: empowering the community to take action for better mental health. *American Psychologist*, 67, 3, 231-243.
- Jorm, A. F., Barney, L. J., Christensen, H., Highet, N. J., Kelly, C. M. & Kitchener, B. A. (2006). Research on mental health literacy: what we know and what we still need to know. *Australian and New Zealand Journal of Psychiatry*, 40, 3-5
- Jorm, A. F., Christensen, H., & Griffiths, K. M. (2006). The public's ability to recognize mental disorders and their beliefs about treatment: changes in Australia over 8 years. *Australian and New Zealand Journal of Psychiatry*, 40, 36-41.
- Jorm, A. F., Kelly, C. M., Wright, A., Parslow, R. A., Harris, M. G., & McGorry, P. D. (2006). Belief in dealing with depression alone: results from community surveys of adolescents and adults. *Journal of Affective Disorders*, 96, 56-65.
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., & Henderson, S. (1999). Attitudes towards people with a mental disorder: a survey of the Australian public and health professionals. *Australian and New Zealand Journal of Psychiatry*, 33, 77-83.
- Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., Pollitt, P. (1997). "Mental health literacy": a survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*, 166, 182-186.
- Jorm, A. F., Nakane, Y., Christensen, H., Yoshioka, K., Griffiths, K. M., & Wata, Y. (2005). Public beliefs about treatment and outcome of mental disorders: a comparison of Australia and Japan. *BMC Medicine*, 3, 12.
- Joska, J. (2007). The unhappy or depressed patient. In S E Baumann (Ed.), *Primary health care psychiatry. A practical guide for southern Africa* (pp. 423-445). Cape Town: Juta & Co, Ltd.
- Kaas, N.E., Hyder, A.A., Ajuwon, A., Appiah-Poku, J., Barsdorf, N., Elsayed, D.E., et al., (2007). The structure and function of research ethics committees in Africa: a case study. *Plos Medicine*, 4, 1, 26-31.
- Kabir, M., Iliyasu, Z., Abubakar, I. S., & Aliyu, M. (2004). Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. *BMC International Health and Human Rights*, 4, 3.

- Kahn, M. S., & Kelly, K. J. (2001). Cultural tensions in psychiatric nursing: managing the interface between Western mental health care and Xhosa traditional healing in South Africa. *Transcultural Psychiatry*, 38, 1, 35-50.
- Kale, R. (1995). Traditional healers in South Africa: a parallel health care system. *British Medical Journal*, 310, 1182-1185.
- Kaliski, S. (2001). The prevalence and aetiology of psychiatric disorders. In B Robertson, C Allwood, & C Gagiano. *Textbook of psychiatry for southern Africa* (pp. 14-34). Cape Town: Oxford University Press, Southern Africa.
- Kamsu-Foguem, B., Diallo, G., & Foguem, C. (2013). Conceptual graph-based knowledge representation for supporting reasoning in African traditional medicine. *Engineering Applications of Artificial Intelligence*, 26, 4, 1348-1365.
- Kamwaria, A., & Katola, M. (2012). The role of African traditional religion, culture and world-view in the context of post-war among the Dinka community of southern Sudan. *International Journal of Humanities and Social Science*, 2, 21, 49-55.
- Kanje, A. (1999). Assessment research. In M. Terre Blanche & K. Durrheim (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 287 - 306). University of Cape Town Press: Cape Town.
- Kanu, I. A. (2013). The dimensions of African cosmology. *Journal of African Philosophy, Culture and Religion*, 2, 533-555.
- Karanja, K. C. (2008). African studies and research methodology: revisiting the centrality of the Afrikan worldview. *The Journal of Pan African Studies*, 2, 2, 4-27.
- Karanja, K. C. (2010). A genealogical analysis of the worldview framework in African centered psychology. *The Journal of Pan African Studies*, 3, 8, 109-134.
- Kauchali, S., Rollins, N., Van Der Broeck, J. (2004). Local beliefs about childhood diarrhoea: importance for healthcare and research. *Journal of Tropical Pediatrics*, 50, 2, 82-89.
- Kawakami, K., Dovidio, J. F., Moll, J., Hermsen, S., & Russin, A. (2000). Just say no (to stereotyping): effects of training in trait negation on stereotype activation. *Journal of Personality and Social Psychology*, 78, 871-888.
- Kelly, K. (1999). From encounter to text: collecting qualitative data for interpretive research. In M. Terre Blanche, K Durrheim, & D Painter (Eds.). *Research in practice: Applied methods for the social sciences* (pp. 379-397). Cape Town: University of Cape Town Press.
- Kendler, K. S. (2008). Explanatory models for psychiatric illness. *American Journal of Psychiatry*, 165, 6, 695-702.

- Kendler, K. S., Karkowski, L. M., & Prescott, C. A. (1999). Casual relationships between stressful life events and the onset of major depression. *American Journal of Psychiatry*, 156, 837-841.
- Kessler, R. C. (2000). Psychiatric epidemiology: selected recent advances and future direction. *Bulletin of the World Health Organization*, 78, 4, 464-474.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 6, 593-602.
- Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, 62, 617-709.
- Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbid Survey. *Archives of General Psychiatry*, 51, 1, 8-19.
- Kessler, R. C., & Ustun (2004). The world mental health (WMH) survey initiative version of the World Health Organization (WHO) composite international diagnostic Interview (CIDI). *International Journal of Methods in Psychiatric Research*, 13, 2, 93-121.
- Kim, U. (2000). Indigenous, cultural, and cross-cultural psychology: a theoretical, conceptual, and epistemological analysis. *Asian Journal of Social Psychology*, 3, 265-287.
- King, N. M. P., & Churchill, L. R. (2000). Ethical principles guiding research on child and adolescent subjects. *Journal of Interpersonal Violence*, 15, 7, 710-724.
- King, R. (2000). Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa: a literature review. *UNIAIDS Best Practice Collection*. Geneva, Switzerland. Retrieved from http://www.hst.org.za/uploads/files/Collab_Lit_Rev.pdf
- Kleinman, A. (1978). Concepts and models for comparison of medical systems as cultural systems. *Social Science and Medicine*, 12, 85-93.
- Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine and psychiatry*. Berkeley, CA: University of California Press.

- Kleinman, A. (2004). Culture and depression. *New England Journal of Medicine*, 351, 10, 951-953.
- Kleinman, A., & Benson, P. (2006). Anthropology in the clinic: the problem of cultural competency and how to fix it. *Plos Medicine*, 3, 10, 1673-1676. doi: 10.1371/journal.pmed.0030294.
- Kleinman, A., Eisenberg, L., & Good, B. (2006). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *The Journal of Lifelong Learning in Psychiatry*. IV, 1, 140-149.
- Koen, L., Niehaus, D., & Muller, J. (2003). Use of traditional treatment methods in a Xhosa schizophrenia population. *South African Medical Journal (Scientific Letters)*, 93, 6, 443.
- Kometsi, K. (2004). *Unreal: AIDS review*. Pretoria: Centre for the Study of AIDS, University of Pretoria.
- Kothari, C. R. (2004). *Research methodology: methods and techniques* (2nd ed.). New Delhi: New Age International (P) Limited, Publishers.
- Kura, S. Y. B. (2012). Qualitative and quantitative approaches to the study of poverty: taming the tensions and appreciating the complementarities. *The Qualitative Report*, 17,34, 1-19.
- Kwa Sani Municipality. (2011). *Integrated Development Plan 2011/2012: Final Report*. Retrieved from <http://kwasani.co.za/upload/KWA%20SANI%20FINAL%20IDP%202011%202012.pdf>
- Kwa Sani Municipality. (2012). *Integrated Development Plan 2012 – 2016: Final Report*. Retrieved from <http://kwasani.co.za/upload/KWA%20SANI%20IDP%20-%202012%202016%20Final.pdf>
- Kwa Sani Municipality. (2016). *Draft Annual Report 2014/2015*. Retrieved from <http://www.kwasani.gov.za/images/Documents/Annual%20Reports/Annual%20Report%20-%20Semi-Final%2003-02-2016.pdf>
- Lauber, C., Falcato, L., Nordt, C., & Rossler, W. (2003) Lay beliefs about causes of depression. *Acta Psychiatrica Scandinavica*, 108, 418, 96-99.
- Lauber, C., Nordt, C., & Rossler, W. (2005). Recommendations of mental health professionals and the general population on how to treat mental disorders. *Social Psychiatry Psychiatric Epidemiology*, 40, 835-843.

- La Vertu, D. S., & Linares, A. M. (1990). Ethical principles of biomedical research on human subjects: their application and limitations in Latin America and the Caribbean. *Bulletin of PAHO*, 24, 4, 469-479.
- Lawrence, D. J. (2007). The four principles of biomedical ethics: a foundation for current bioethical debate. *Journal of Chiropractic Humanities*, 14, 34-40.
- Leclerc-Madlala, S. (2002). On the virgin cleansing myth: gendered bodies, AIDS and ethnomedicine. *African Journal of AIDS Research*, 1, 87-95.
- Leeman, E. (1998). Misuse of psychiatric epidemiology. *The Lancet*, 351, 1601-1602.
- Lennon, J. L. (2005). The use of the health belief model in dengue health education. *Dengue Bulletin*, 29, 217-219.
- Levav, I., Shemesh, A., Grinshopoon, A., Aisenberg, E., Shershevsky, Y., & Kohn, R. (2004). Mental health-related knowledge, attitudes and practices in two Kibbutzim. *Social Psychiatry and Psychiatric Epidemiology*, 39, 758-764.
- Levin, K. A. (2006). Study design III: cross-sectional studies. *Evidence-based Dentistry*, 7, 24-25.
- Lin, T. & Standley, C. C. (1962). *The scope of epidemiology in psychiatry*. Switzerland: World-Health Organization.
- Link, B. G., Phelan, J. C., Bresnahan, M., Stueve, A. & Pescosolido, B. A. (1999). Public conceptions of mental illness: Labels, causes, dangerousness and social distance. *American Journal of Public Health*, 89, 9, 1328-1333.
- Link, B. G., Struening, E. L., Neese-Todd, S., Asmussen, S., & Phelan, J. C. (2001). Stigma as a barrier to recovery: the consequences of stigma for the self-esteem of people with mental illnesses. *Psychiatric Services*, 52, 12, 1621-1626.
- Links, P. S. (1983). Community surveys of the prevalence of childhood psychiatric disorders: A review. *Child Development*, 54, 531-548.
- Littlewood, R. (1990). From categories to contexts: a decade of the "new cross-cultural psychiatry". *British Journal of Psychiatry*, 156, 308-327.
- Liu, S. I., Lu, R. B., & Lee, M. B. (2008). Non-psychiatric physicians' knowledge, attitudes and behavior toward depression. *Journal of Formosan Medical Association*, 107, 12, 921-931.
- Liu, S. I., Mann, A., Cheng, A., Tjung, J. J., & Hwang, L. C. (2004). Identification of common mental disorders by general medical doctors in Taiwan. *General Hospital Psychiatry*, 26, 282-288.

- Liu, X. (2009). Ordinal regression analysis: fitting the proportional odds model using Stata, SAS and SPSS. *Journal of Modern Applied Statistical Methods*, 8, 2, 632-645.
- Llovera, I., Ward, M. F., Ryan, J. G., LaTouche, T., & Sama, A. (2003). A survey of the emergency department population and their interest in preventative health education. *Academic Emergency Medicine*, 10, 2, 155-160.
- Lopez, A. D., Mathers, C. D., Ezzati, M., Jamison, D. T., & Murray, C. J. L. (2006). Measuring the global burden of disease and risk factors, 1990-2001. In A. D. Lopez, C. D. Mathers, M. Ezzati, D. T. Jamison, & C. J. L. Murray. *Global burden of disease and risk factors* (pp. 1-13). New York: Oxford University Press.
- Lopez, A. D., & Murray, C. J. L. (1998). The global burden of disease, 1990-2020. *Nature medicine*, 4, 11, 1241-1243.
- Loveday, R. (2001). *Prevention in traditional Africa. HIV/AIDS care and counselling: A multidisciplinary approach*. Cape Town: Person Education.
- Lund, C., & Flisher, A. J. (2006). Norms for mental health services in South Africa. *Social Psychiatry and Psychiatric Epidemiology*, 41, 587-594.
- Lund, C., Kleintjies, S., Campbell-Hall, V., Mjadu, S., Petersen, I., Bhana, A., ... Flisher, A. J. (2008). Mental health policy development and implementation in South Africa: a situation analysis. Phase 1 country report. Mental Health and Poverty Project. Retrieved from http://www.who.int/mental_health/policy/development/SA%20Country%20Report%20-%20Final%20Draft%20Jan%202008.pdf
- Lund, C., Kleintjies, S., Kakuma, R., Flisher, A. J., & the MHaPP Research Programme Consortium. (2010). Public sector mental health systems in South Africa: inter-provincial comparisons and policy implications. *Social Psychiatry and Psychiatric Epidemiology*, 45, 393-404.
- Lund, C., Petersen, I., Kleintjies, S., & Bhana, A. (2012). Mental health services in South Africa: taking stock. *African Journal of Psychiatry*, 15, 402-405.
- Lunsford, T. R., & Lunsford, B. R. (1995). The research sample, Part I: Sampling. *Journal of Prosthetics and Orthotics*, 7, 3, 105-112.
- Lynch, E. & Medin, D. (2006). Explanatory models of illness: a study of within-culture variation. *Cognitive Psychology*, 53, 285-209.
- Machado, J. D., Caye, A., Frick, P. J., & Rohde, L. A. (2013). DSM-5. Major changes for child and adolescent disorders. In J. M. Rey (ed.). *IACAPAP e-Textbook of Child*

- and Adolescent Mental Health* (pp. 1-22). Geneva: International Association for Child and Adolescent Psychiatry and Allied Professions.
- Mandal, J., & Parija, S.C. (2014). Informed consent and research. *Tropical Parasitology*, 4, 2, 78-79.
- Mann, C. J. (2003). Observational research methods. Research design II: cohort, cross sectional, and case-control studies. *Emergency Medicine Journal*, 20, 54-60.
- Marie, D., & Miles, B. (2008). Social distance and perceived dangerousness across four diagnostic categories of mental disorder. *Australian and New Zealand Journal of Psychiatry*, 42, 126-133.
- Mash, R. J. (2000). Are you thinking too much? Recognition of mental disorders in South African general practice. *South African Family Practice*, 22, 2, 22-27.
- Masuda, A., Suzumura, K., Beauchamp, K. L., Howells, G. N., & Clay, C. (2005). United States and Japanese college students's attitudes toward seeking professional psychological help. *International Journal of Psychology*, 40, 303-313.
- Mathers, C. D., Lopez, A. D., & Murray, C. J. L. (2006). The burden of disease and mortality by condition: data, methods, and results for 2001. In A. D. Lopez, C. D. Mathers, M. Ezzati, D. T. Jamison, & C. J. L. Murray. *Global Burden of Disease and Risk Factors* (pp. 45-240). New York: Oxford University Press.
- Matoane, M. (2012). Locating context in counselling: the development of indigenous psychology in South Africa. *Psychotherapy and Politics International*, 10, 2, 105-115.
- Mazama, A. (2001). The Afrocentric paradigm: contours and definitions. *Journal of Black Studies*, 31, 4, 387-405.
- Mbanga, N. I., Niehaus, D. J. H., Mzamo, N. C., Wessels, C. J., Allen, A., Emsley, R. A., & Stein, D. J. (2002). Attitudes towards and beliefs about schizophrenia in Xhosa families with affected probands. *Curationis*, 25, 69-74.
- Mbiti, J. S. (1969). *African religions and philosophy*. Nairobi: East African Educational Publishers.
- Mbiti, J. S. (2015). *Introduction to African religion* (2nd ed.). Illinois: Waveland Press.
- McCabe, R. & Priebe, S. (2004). Explanatory models of illness in schizophrenia: Comparison of four ethnic groups. *British Journal of Psychiatry*, 185, 25-30.
- Mccann, T. V., Lu, S., & Berryman, C. (2009). Mental health literacy of Australian Bachelor of Nursing students: a longitudinal study. *Journal of Psychiatric and Mental Health Nursing*, 16, 61-67.

- McLennan, W. (1997). *Mental health and wellbeing: profile of adults, Australia 1997*. Canberra: Australian Bureau of Statistics and Australian Government Publishing Service.
- McSweeney, J. C., Allan, J. D., & Mayo, K. (1997). Exploring the use of explanatory models in nursing research practice. *Journal of Nursing Scholarship*, 29, 3, 243-248.
- Meetoo, D, & Meetoo, L. (2005). Explanatory models of diabetes among Asian and Caucasian participants. *British Journal of Nursing*, 14, 3, 154-159.
- Meissner, O., & Buso, D. L. (2007). Traditional male circumcision in the Eastern Cape- scourge or blessing? *South African Medical Journal*, 97, 5, 371-373.
- Menkiti, I. A. (1984). Person and community in African traditional thought. In R A Wright (Ed.), *African Philosophy: an Introduction* (3rd ed.) (pp. 171-181). New York: University Press AM.
- Mickus, M., Colenda, C. C., & Hogan, A. J. (2000). Knowledge of mental health benefits and preferences for type of mental health providers among the general public. *Psychiatric Services*, 51, 2, 199-202.
- Mikhail, B. I., & Petro-Nustas, W. I. (2001). Transcultural adaptation of Campion's health belief model scales. *Journal of Nursing Scholarship*, 33, 2, 159-165.
- Mkhize, L. P., & Uys, I. R. (2004). Pathways to mental health care in KwaZulu-Natal. *Curationis*, 27, 64-71.
- Mkize, N. (2004). Psychology: an African perspective. In D Hook, N Mkhize, P Kiguwa, A Collins, E Burman, & I Parker. *Critical Psychology* (pp. 24-52). Cape Town: UCT Press.
- Mkhize, N. (2006). Communal personhood and the principle of autonomy: the ethical challenges. *Continuing Medical Education*. 24, 1, 26-29.
- Mkhize, N. (2008). Ubuntu and harmony. In R Nicolson(ed.). *Persons in Community: African Ethics in a Global Culture* (pp. 35-44). Scottsville: University of KwaZulu Natal Press.
- Mkhize, N. (2013). Psychology: An African perspective. In K Ratele, N Duncan, D Hook, N Mkhize, P Kiguwa, & A Collings. *Self, community & psychology* (pp. 4-1-4-29). Claremont: Juta and Company Ltd.
- Mkhize, N., & Kometsi, M. J. (2008). Community access to mental health services: Lessons and recommendations. *South African Health Systems Journal*, 11, 103-113.

- Mohamed-Kaloo, Z., & Laher, S. (2014). Perceptions of mental illness among Muslim general practitioners in South Africa. *South African Medical Journal*, 104, 5, 350-352.
- Mokgobi, M. G. (2014). Understanding traditional African healing. *African Journal of Physical, Health Education, Recreation and Dance*, 2, 24-34.
- Moleko, A. G. (2012). Cultural and cross-cultural psychology. In M Visser, & A G Moleko, *Community psychology in South Africa* (2nd ed.) (pp. 163-176). Pretoria: Van Schaik Publishers.
- Moodi, M., Razaiean, M., Mostafavi, F., & Sharifirad, G. (2012). Determinants of mammography screening behavior in Iranian women: a population-based study. *Journal of Research in Medical Sciences*, 17, 750-759.
- Morrow, V. & Richards, M. (1996). The ethics of social research with children: An overview. *Children & Society*, 10, 90-105.
- Mpem, T. (2015). Public perception and attitude towards mental illness in Otukpo town of Benue State. *The International Journal of humanities & Social Studies*, 3, 4, 228-232.
- Mufamadi, J. (2001). A group of traditional healers' perceptions of and approaches to the treatment of mental illness. *Indigenous Knowledge Conference*, 88-103. Retrieved from <http://datalib.usask.ca/iportal/2007.10.17/IKC-2001/IKC-2001-Mufamadi.pdf>
- Muijs, D. (2011). *Doing quantitative research in education with SPSS* (2nd ed.). Los Angeles: SAGE Publications.
- Murray, C, J, L., & Lopez, A, D. (1996). *The global burden of disease: a comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020*. Boston: Harvard University Press.
- Murray, C. J. L., Lopez, A. D., & Jamison, D. T. (1994). The global burden of disease in 1990: summary results, sensitivity analysis and future directions. *Bulletin of the World Health Organization*, 72, 3, 495-509.
- Myers, L J. (1987). The deep structure of culture: relevance of traditional African culture in contemporary life. *Journal of Black Studies*, 18, 1, 72-85.
- Myers, L. J. (1993). *Understanding an Afrocentric worldview: Introduction to an optimal psychology* (2nd ed.). Dubuque, IA: Kendall/Hunt.
- Mzimkulu, K. G., & Simbayi, L. C. (2006). Perspectives and practices of Xhosa-speaking African traditional healers when managing psychosis. *International Journal of Disability, Development and Education*, 53, 4, 417-431.

- Nambi, S. K., Prasad, J., Singh, D., Abraham, V., Kuruville, A., & Jacob, K. S. (2002). Explanatory models and common mental disorders among patients with unexplained somatic symptoms attending a primary care facility in Tamil Nadu. *The National Medical Journal of India*, 15, 331-335.
- Nayak, B. S. (2013). Challenges of cultural relativism and the future of feminist universalism. *Journal of Politics and Law*, 6, 2, 83-89.
- Nelms, L. W., & Gorski, J. (2006). The role of the African traditional healer in women's health. *Journal of Transcultural Nursing*, 17, 2, 184-189.
- Neuman, L. W. (2000). *Social research methods: qualitative and quantitative approaches* (4th ed.). Boston, MA: Allyn and Bacon.
- Nevid, J. S. (2009). *An introduction to psychology* (4th ed.). Australia: Wadsworth Cengage Learning.
- Ng, W. J., & Lindsay, R. C. L. (1994). Cross-race facial recognition. Failure of the contact hypothesis. *Journal of Cross-Cultural Psychology*, 25, 2, 217-223.
- Njoki, N. W. (2005). African indigenous knowledge: claiming, writing, storing, and sharing the discourse. *Journal of Thought*, 40, 2, 27-46.
- Nnebue, C. C. (2013). Informed consent in research. *Afrimedical Journal*, 1,1, 5-10.
- Nobels, W. W. (1990). African philosophy: foundations of Black psychology. In R. E. Jones (ed.), *Black psychology* (pp. 47-63). Berkeley, CA: Cobb & Henry.
- Nolen-Hoeksema, S. (2008). *Abnormal psychology* (4th ed.). Boston: McGraw-Hill.
- Nolen-Hoeksema, S. (2011). *Abnormal psychology* (5th ed.). New York: McGraw-Hill.
- Nordenfelt, L. (2006). The concepts of health and illness revisited. *Medicine, Health Care and Philosophy*, 10, 5-10.
- Norman, R., Bradshaw, D., Schneider, M., Pieterse, D., & Groenewald, P. (2006). *Revised burden of disease estimates for the comparative risk factor assessment, South Africa 2000. Methodological Note*. Cape Town: South African Medical Research Council. Retrieved from <http://www.mrc.ac.za/bod/RevisedBurdenofDiseaseEstimates1.pdf>
- Norquist, G. S., & Regier, D. A. (1996). The epidemiology of psychiatric disorders and the de facto mental health care system. *Annual Review of Medicine*, 47, 473-479.
- Nwoye, A. (2006). Remapping the fabric of the African self: a synoptic theory. *Dialectical Anthropology*, 30, 119-149.
- Nwoye, A. (2015). African psychology and the Africentric paradigm to clinical diagnosis and treatment. *South African Journal of Psychology*, 45, 3, 305-317.

- Obasi, E. M. (2002). *Construction and validation of the worldview analysis scale* (Unpublished masters thesis) Graduate School of The Ohio State University: Columbus. Retrieved from https://etd.ohiolink.edu/rws_etd/document/get/osu1140709350/inline
- O'Connell, M. C. (1982). Spirit possession and role stress among the Xesibe of eastern Transkei. *Ethnology*, 21, 1, 21-37.
- Okello, E. S., & Neema, S. (2007). Explanatory models and help-seeking behaviour: pathways to psychiatric care among patients admitted for depression in Mulago hospital, Kampala, Uganda. *Qualitative Health Research*, 17, 1, 14-25.
- Olumbe, D. (2008). African worldview: an introduction. Retrieved from https://watumishivaneno.files.wordpress.com/2014/08/african_worldview_introduction.pdf
- Omolewa, M. (2007). Traditional African modes of education: their relevance in the modern world. *International Review of Education*, 53, 593-612.
- Ong, A. D., & Weiss, D. J. (2000). The impact of anonymity on responses to sensitive questions. *Journal of Applied Social Psychology*, 30, 8, 1691-1708.
- Orb, A., Eisenhauer, L., & Wynaden, D. (2000). Ethics in qualitative research. *Journal of Nursing Scholarship*, 33, 1, 93-96.
- Orji, R., Vassileva, J., & Mandryk, R. (2012). Towards an effective health interventions design: an extension of the health belief model. *Online Journal of Public Health Informatics*, 4, 3, e9. doi: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3615835/>
- Parry, C. D. H. (1996). A review of psychiatric epidemiology in Africa: strategies for increasing validity when using instruments transculturally. *Transcultural Psychiatric Research Review*, 33, 173-188.
- Passer, M. W., & Smith, R. E. (2008). *Psychology: The science of mind and behaviour* (4th ed.). New York: McGraw-Hill.
- Passer, M., Smith, R. E, Holt, N., Bremner, A., Sutherland, E., & Vliek, M. L. W. (2009). *Psychology: The science of mind and behaviour*. London: McGraw-Hill.
- Patel, P. (2009). Introduction to quantitative methods. Empirical Law Seminar. Harvard Law School, Harvard University, US. Retrieved from http://hls.harvard.edu/content/uploads/2011/12/quantitative_methods.pdf
- Patel, V. (1995). Explanatory models of mental illness in Sub-Saharan Africa. *Social Science and Medicine*, 40, 9, 1291-1298.

- Patel, V. (2011). Traditional healers for mental health care in Africa. *Global Health Action*, 4, 7956. doi: 10.3402/gha.v4i0.7956.
- Patel, V., Gwanzura, F., Simunyu, E., Lloyd, K. & Mann, A. (1995). The phenomenology and explanatory models of common mental disorders: A study in primary care in Harare, Zimbabwe. *Psychological Medicine*, 25, 1191-1199.
- Pelto, P., & Pelto, G. H. (1997). Studying knowledge, culture, and behaviour in applied medical anthropology. *Medical Anthropology Quarterly*, 11, 2, 147-163.
- Petersen, I. (2000). Comprehensive integrated primary mental health care for South Africa. Pipe dream or possibility? *Social Science & Medicine*, 51, 321-334.
- Petersen, I., Bhana, A., Campbell-Hall, V., Mjadu, S., Lund, C., Kleintjies, S., ... Mental Health and Poverty Research Programme Consortium. (2009). Planning for district mental health services in South Africa: a situational analysis of a rural district site. *Health Policy and Planning*, 24, 140-150.
- Petersen, I., Bhana, A., & Swartz, L. (2012). Mental health promotion and the prevention of mental disorders in South Africa. *African Journal of Psychiatry*, 15, 411-416.
- Petersen, I., & Lund, C. (2011). Mental health service in South Africa from 2000 to 2010: one step forward, one step back. *South African Medical Journal*, 101, 10, 751-757.
- Pettigrew, T. F. (1998). Intergroup contact theory. *Annual Review of Psychology*, 49, 65-85.
- Pettigrew, T. F. & Tropp, L. R. (2006). A meta-analytic test of intergroup contact theory. *Journal of Personality and Social Psychology*, 90, 5, 751-783.
- Peu, M. D., Troskie, R., & Hattingh, S. P. (2001). The attitude of community health nurses towards integration of traditional healers in primary health care in North-West Province. *Curationis*, 24, 3, 49-55.
- Phares, E. J., & Trull, T. J. (1997). *Clinical Psychology. Concepts, methods, and profession*. (5th ed.). Pacific Grove: Brooks/Cole Publishing Company.
- Phelan, J. C., & Link, B. G. (2004). Fear of people with mental illness: the roles of personal and impersonal contact and exposure to threat or harm. *Journal of Health and Social Behaviour*, 45, 1, 68-80.
- Piko, B. F., & Bak, J. (2006). Children's perceptions of health and illness: images and lay concepts in preadolescence. *Health Education Research*, 21, 5, 643-653.
- Pilkington, C., & Pretorius, L. (2015). A conceptual model of the research methodology domain with a focus on computing fields of study. *Proceedings*

of the 7th International Joint Conference on Knowledge Discovery, Knowledge Engineering and Knowledge Management, 2, 96-107.

- Pillay, A. L., & Kometsi, M. J. (2007). Training psychology students and interns in non-urban areas. In N Duncan, B Bowman, A Naidoo, J Pillay & V Roos. *Community psychology: analysis, context and action* (pp. 367-379). Cape Town; UCT Press.
- Pillay, A. L., Kometsi, M. J., & Siyothula, E. B. (2009). A profile of patients seen by fly-in clinical psychologists at a non-urban facility and implications for training and future services. *South African Journal of Psychology*, 39, (3), 289-299.
- Pillay, A. L. & Lockhat, M. R. (1997). Developing community mental health services for children in South Africa. *Social Science and Medicine*, 45, 10, 1493-1501.
- Poreddi, V., Blrudu, R., Thimmaiah, R., & Math, S. B. (2015). Mental health literacy among caregivers of persons with mental illness: a descriptive survey. *Journal of Neuroscience in Rural Practice*, 6, 3, 355-360.
- Poss, J. E. (2001). Developing a new model for cross-cultural research: synthesizing the health belief model and the theory of reasoned action. *Advances in Nursing Science*, 23, 4, 1-15.
- Prentice-Dunn, S. P., & Rogers, R. W. (1986). Protection motivation theory and preventive health: beyond the health belief model. *Health Education Research*, 1, 3, 153-161.
- Pretorius, E. (2001). Traditional healers. In *South African Health Review*, pp. 249-256. Pretoria, South Africa: Health Systems Trust.
- Pretorius, H. W. (1995). Mental disorders and disability across cultures: a view from South Africa. *The Lancet*, 345, 534.
- Prinsloo, E. D. (2001). A comparison between medicine from an African (Ubuntu) and Western philosophy. *Curations*, 24, 1, 58-65.
- Pruss-Ustun, A., Mathers, C., Corvalan, C., & Woodward, A. (2003). Introduction and methods: assessing the environmental burden of disease at national and local levels. *World Health Organization: Geneva. Environmental Burden of Disease Series, No 1*.
- Puckree, T., Mkhize, M., Mgobhozi, Z., & Lin, J. (2002). African traditional healers: what health care professionals need to know. *International Journal of Rehabilitation Research*, 25, 247-251.
- Punch, K. F. (2003). *Survey research: the basics*. London: Sage Publications.
- Quest, T., & Marco, C. A. (2003). Ethics seminars: vulnerable populations in emergency medicine research. *Academic Emergency Medicine*, 10, 1294-1298.

- Ramgoon, S., Dalasile, N. Q., Paruk, Z., & Patel, C. J. (2011). An exploratory study of trainee and registered psychologists' perceptions about indigenous healing systems. *South African Journal of Psychology*, 41, 1, 90-100.
- Ramose, M. B. (2005). *African philosophy through Ubuntu*. Harare, Zimbabwe: Mond Books Publishers.
- Regier, D. A., Boyd, J. H., Burke, J. D. jr; Rae, D. S., Myers, J. K., Kramer, M., Robins, L. N., George, L. K., Karno, M., & Locke, B. Z. (1988). One-month prevalence of mental disorders in the United States. *Archives of General Psychiatry*, 45(11) 977-986.
- Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and service. *Archives of General Psychiatry*, 50 (2) 85-94.
- Rich, M., Patashnich, J., & Chalfen, R. (2002). Visual illness narratives of asthma: explanatory models and health-related behaviour. *American Journal of Health Behaviour*, 26, 6, 442-453.
- Rimer, B. I. L. (2008). Models of individual health behaviour. In K Glanz, B K Rimer, & K Viswanath (Eds.). *Health behaviour and health education: Theory, research, and practice* (4th ed.) (pp. 41-44). San Francisco, CA: Jossey-Bass.
- Ritsher, J. B., Otilingam, P, G., & Grajales, M. (2003). Internalized stigma of mental illness: psychometric properties of a new measure. *Psychiatry Research*, 121, 31-49.
- Rodriguez-Testal, J. F., Senin-Calderon, C., & Perona-Garcelan, S. (2014). From DSM-IV-TR to DSM-5: Analysis of some changes. *International Journal of Clinical & Health Psychology*, 14, 221-231.
- Rosenstock, I. M. (1974). The health belief model and preventative health behaviour. *Health Education Monographs*, 2, 354-386.
- Rosenstock, I. M. (2005). Why people use health services. *The Milbank Quarterly*, 83, 4, 1-32.
- Rosenstock, I. M., Strecher, V, J., & Becker, M. H. (1994). The health belief model and HIV risk behaviour change. In R. J. DiClemente & J. L. Peterson (Eds.). *Preventing AIDS: Theories and methods of behavioural interventions*. *AIDS prevention and mental health* (pp. 5-24). New York: Plenum Press.
- Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1998). Social learning theory and the health belief model. *Health Education Quarterly*, 15, 2, 175-183.

- Rosnow, R., & Rosenthal, R. (1996). *Beginning behavioural research. A conceptual primer*. New Jersey: Prentice-Hall International.
- Ross, E., & Devereil, A. (2010). *Health, illness and disability: psychosocial approaches*. Pretoria: Van Schaik Publishers.
- Rubin, G. J., Amlot, R., Page, L., & Wessely, S. (2009). Public perceptions, anxiety, and behaviour change in relation to the swine flu outbreak: cross-sectional telephone survey. *BMJ*, 339, b2651. Retrieved from <http://www.bmj.com/content/bmj/339/bmj.b2651.full.pdf>
- Rutter, M., & Sandbeg, S. (1985). Epidemiology of child psychiatric disorder: methodological issues and some substantive findings. *Child Psychiatry and Human Development*, 15, 4, 209-233.
- Sadock, B. J., & Sadock, V. A. (2003). *Synopsis of psychiatry. Behavioural sciences/clinical psychiatry* (9th ed.). Philadelphia: Lippincott Williams & Wilkins.
- Salkind, N. J. (2010). Cross-sectional design. In *Encyclopedia of Research Design*. doi: <http://dx.doi.org/10.4135/9781412961288.n96>
- Sam, D. L., & Moreira, V. (2012). Revisiting the mutual embeddedness of culture and mental illness. *Online Readings in Psychology and Culture*, 10,2, 1-20.
- Samouilhan, T., & Seabi, J. (2010). University students' beliefs about the causes and treatment of mental illness. *South African Journal of Psychology*, 40 (1), 74-89.
- Saraceno, B., & Saxena, S. (2002). Mental health resources in the world: results from Project Atlas of the WHO. *World Psychiatry*, 1, 1, 40-44.
- Schmidt, G. (2005). *The role of ancestors and living-dead in the life of Kenyan Christians*. Maryknoll Institute of African Studies of Saint Mary's University of Minnesota/ USA and Tangaza College: Nairobi/ Kenya.
- Schofield, B. (2014). Informed consent in research. *The European Health Psychologist*, 16, 3, 101-106.
- Schomerus, G., Lucht, M., Holzinger, A., Matschinger, H., Carta, M. G., & Angermeyer, M. C. (2010). The stigma of alcohol dependence compared with other mental disorders: a review of population studies. *Alcohol and Alcoholism*, 46, 2, 105-112.
- Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2006). Public beliefs about the causes of mental disorders revisited. *Psychiatry Research*, 144, 233-236.
- Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2009). Attitudes that determine willingness to seek psychiatric help for depression: a representative population survey applying the Theory of Planned Behaviour. *Psychological Medicine*, 39, 1855-1865.

- Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social Science & Medicine*, 56, 299-312.
- Schulze, B., Richter-Werling, M., Matschinger, H., & Angermeyer, M. C. (2003). Crazy? So What! Effects of a school project on students' attitudes towards people with schizophrenia. *Acta Psychiatrica Scandinavica*, 107, 142-150.
- Scott, L., & Chur-Hansen. (2008). The mental health literacy of rural adolescents: Emo subculture and SMS texting. *Australian Psychiatry*, 16 (5), 359-362
- Seape, S., & Drennan, G. (2007). Southern African categories of distress. In S E Baumann (Ed.), *Primary health care psychiatry: A practical guide for southern Africa* (pp. 54-66). Cape Town: Juta & Co, Ltd.
- Sedgwick, P. (2014). Cross-sectional studies: advantages and disadvantages. *BMJ*, 348:g2276. doi: [10.1136/bmj.g2276](https://doi.org/10.1136/bmj.g2276)
- Seedat, S., Stein, D. J., Herman, A., Kessler, R., Sonnega, J., Heeringa, S., ... Williams, D. (2008). Twelve-month treatment of psychiatric disorders in the South African Stress and Health Study (World Mental Health Survey Initiative). *Social Psychiatry and Psychiatric Epidemiology*, 43, 889-897.
- Semenya, B., & Mokwena, M. (2012). African cosmology, psychology and community. In M Visser, & A G Moleko, *Community psychology in South Africa* (2nd ed.) (pp. 71-84). Pretoria: Van Schaik Publishers.
- Shelton, J, N., Trail, T. E., West, T. V., & Bergsieker, H, B. (2010). From strangers to friends: the interpersonal process model of intimacy in developing interracial friendships. *Journal of Social and Personal Relationships*, 27, 1, 71-90.
- Shizha, E., & Charema, J. (2011). Health and wellness in Southern Africa: incorporating indigenous and western healing practices. *International Journal of Psychology and Counselling*, 3, 9, 167-175.
- Shook, N. J. & Fazio, R. H. (2008). Interracial roommate relationships. An experimental field test of the Contact Hypothesis. *Psychological Science*, 19, 7, 717-723.
- Simon, M. K., & Goes, J. (2013). *Scope, limitations, and delimitations*. Retrieved from <http://dissertationrecipes.com/wp-content/uploads/2011/04/limitationscopedelimitation1.pdf>
- Singh, D., & Mkhize, D. L. (2006). Psychiatric epidemiology: an introduction. *South African Journal of Psychiatry*, 12, 4, 91-93.

- Sirey, J. A., Bruce, M. L., Alexopoulos, G. S., Perlick, D. A., Friedman, S. J., & Meyers, B. S. (2001). Perceived stigma and patient-rated severity of illness as predictors of antidepressant drug adherence. *Psychiatric Services, 52*, 12, 1615-1620.
- Sisonke District Municipality. (2014). *5 Year Integrated Development Plan: 2012 – 2017*. doi:
<http://www.harrygwalandm.gov.za/index.php/documents/idp?download=164:2013-2014-final-sisonke-district-municipality-idp>
- Slade, T., Johnston, A., Browne, M. A. O., & Andrews, G. (2009). 2007 National Survey of Mental Health and Wellbeing: methods and key findings. *The Royal Australian and New Zealand College of Psychiatrists, 43*, 594-605.
- Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. (2009). *The mental health of Australian 2: report on the 2007 National Survey of Mental Health and Wellbeing*. Canberra: Department of Health and Ageing.
- Slowther, A., Boynton, P., & Shaw, S. (2006). Research governance: ethical issues. *Journal of the Royal Society of Medicine, 99*, 65-72.
- Sobiecki, J. F. (2008). A review of plants used in divination in southern Africa and their psychoactive effects. *Southern African Humanities, 20*, 333-351.
- Sobiecki, J. F. (2012). Psychoactive *ubulawu* spiritual medicines and healing dynamics in the initiation process of southern Bantu diviners. *Journal of Psychoactive Drugs, 44*, 3, 216-223.
- Sodi, T. (1998). *A phenomenological study of healing in a North Sotho community* (Unpublished doctoral thesis). University of Cape Town, Cape Town.
- Sodi, T., & Bojuwoye, O. (2011). Cultural embeddedness of health, illness and healing: prospects for integrating indigenous and Western healing practices. *Journal of Psychology in Africa, 21*, 3, 349-356.
- Solomon, A., & Wane, N. N. (2005). Indigenous healers and healing in a modern world. *Multicultural Aspects of Counselling Series, 22*, 52-60.
- Sorsdahl, K. R., Flisher, A. J., Wilson, Z., & Stein, D. J. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumalanga, South Africa. *African Journal of Psychiatry, 13*, 284-290.
- Sorsdahl, K. R., Mall, S., Stein, D. J., & Joska, J. A. (2010). Perspectives towards mental illness in people living with HIV/AIDS in South Africa. *AIDS Care, 22*, 11, 1418-1427.
- Sorsdahl, K. R. & Stein, D. J. (2010). Knowledge of and stigma associated with mental disorders in a South African community sample. *The Journal of Nervous and Mental Disease, 198*, 10, 742-747.

- Sorsdahl, K. R., Stein, D., & Lund, C. (2012). Mental health services in South Africa: scaling up and future directions. *African Journal of Psychiatry*, 15, 168-171.
- South Africa. Department of Co-operative Governance and Traditional Affairs. (2013). Notice in terms of Section 16 (1)(b) of the local government: Municipal Structures Act, 1998 (ACT NO 117 of 1998): Sisonke Municipality (Provincial Gazette Vol. 7 No. 1023, 19 September 2013). Pretoria: Government Printer.
- Spiro, M. E. (2001). Cultural determinism, cultural relativism, and the comparative study of psychopathology. *Ethos*, 29, 2, 218-234.
- Stangor, C. (2004). *Research methods for the behavioural sciences*. (2nd ed.). New York, NY: Houghton Mifflin Company.
- Starkweather, J. & Moske, A. K. (2011). *Multinomial logistic regression*. Retrieved from https://it.unt.edu/sites/default/files/mlr_jds_aug2011.pdf
- Statistics South Africa. (2011a). Mid-year population estimates. Retrieved from www.statssa.gov.za/publications/P0302/P03022011.pdf
- Statistics South Africa (2011b). The South Africa I Know, The Home I Understand. doi: http://www.statssa.gov.za/?page_id=993&id=greater-kokstad-municipality
- Stein, D. J., Seedat, S., Herman, A., Moomal, H., Heeringa, S. G., Kessler, R. C., & Williams, D. R. (2008). Lifetime prevalence of psychiatric disorders in South Africa. *The British Journal of Psychiatry*, 192, 112-117.
- Stephen, W. G., & Finlay, K. (1999). The role of empathy in improving intergroup relations. *Journal of Social Issues*, 55, 729-743.
- Stiggelbout, A. M., Molewijk, A. C., Otten, W., Timmermans, D. R. M., van Bockel, J. H., & Kievit, J. (2004). Ideals of patient autonomy in clinical decision making: a study on the development of a scale to assess patients' and physicians' views. *Journal of Medical Ethics*, 30, 268-274.
- Stopher, P. (2012). *Collecting, managing, and assessing data using sample surveys*. New York: Cambridge University Press.
- Straker, G. (1994). Integrating African and Western healing practices in South Africa. *American Journal of Psychotherapy*, 48, 3, 455-467.
- Struwig, F. W., & Stead, G. B. (2001). *Planning, designing and reporting research*. Cape Town: Pearson Education South Africa.
- Stuart, H., & Arboleda-Florez, J. (2001). Community attitudes toward people with schizophrenia. *Canadian Journal of Psychiatry*, 46, 245-252.

- Sturgeon, S. (2007). Health promotion challenges: promoting mental health as an essential aspect of health promotion. *Health Promotion International*, 21, 1, 36-41.
- Sue, D. W., & Sue, D. (2003). *Counselling the culturally diverse: theory and practice* (4th ed.). New York: John Wiley & Sons, Inc.
- Sue, D., Sue, D. W., Sue, D., & Sue, S. (2010). *Foundations of abnormal behaviour* (10th ed.). Australia: Wadsworth Cengage Learning.
- Suhr, D. (2011). *Answering your research questions with inferential statistics*. Bolder, CO. University of Northern Colorado. Retrieved from http://www.wuss.org/proceedings10/analy/2970_4_ANL-Suhr2.pdf
- Sukamolson, S. (2005). *Fundamentals of qualitative research*. Retrieved from <http://www.culi.chula.ac.th/Research/e-Journal/bod/Suphat%20Sukamolson.pdf>
- Summerfield, D. (2014). A short conversation with Arthur Kleinman about his support for the global mental health movement. *Disability and the Global South*, 2, 406-411.
- Swartz, L. (1998). *Culture and mental health: a southern African view*. Cape Town: Oxford University Press- Southern Africa.
- Swartz, L. (2007). Culture and Language. In S E Baumann (Ed.), *Primary health care psychiatry: A practical guide for southern Africa* (pp. 46-53). Cape Town: Juta & Co, Ltd.
- Swartz, L., & MacGregor, H. (2002). Integrating services, marginalizing patients: psychiatric patients and primary health care in South Africa. *Transcultural Psychiatry*, 39, 29, 155-172.
- Tarkang, E. E., & Zotor, F. B. (2015). Application of the health belief model (HBM) in HIV prevention: a literature review. *Central African Journal of Public Health*, 1, 1, 1-8.
- Teesson, M., Slade, T., & Mills, K. (2009). Comorbidity in Australia: findings of the 2007 National Survey of Mental Health and Wellbeing. *The Royal Australian and New Zealand College of Psychiatrists*, 43, 606-614.
- Terre Blanche, M., & Kelly, K. (1999). Interpretive methods. In M. Terre Blanche, K Durrheim, & D Painter (Eds.). *Research in practice: Applied methods for the social sciences* (pp. 123-146). Cape Town: University of Cape Town Press.
- Thabede, D. (2008). The African worldview as the basis of practice in the helping professions. *Social Work/Maatskaplike Werke*, 44, 3, 233-245.

- Thakker, J., & Ward, T. (1998). Culture and classification: the cross-cultural application of the DSM-IV. *Clinical Psychology Review*, 18,5, 501-529.
- The Local Government Handbook (2015). *A complete guide to municipalities in South Africa*. doi: <http://www.localgovernment.co.za/districts/view/18/Harry-Gwala-District-Municipality>
- Thom, R. (2007). Psychiatry at primary healthcare level. In S E Baumann (Ed.), *Primary health care psychiatry: A practical guide for Southern Africa* (pp. 2-9). Juta & Co, Ltd: Cape Town.
- Tjale, A. A. (2004). Historical perspective. In A A Tjale., & L de Villiers (Eds.). *Cultural issues in health and health care* (pp. 1-11). Cape Town: Juta & Co, Ltd.
- Tomlinson, M., Grimsrud, A. T., Stein, D. J., Williams, D. R., & Myer, L. (2009). The epidemiology of major depression in South Africa: Results from the South African Stress and Health study. *South African Medical Journal*, 99, 5, 368-373.
- Tredoux, C. (1999). Sound conclusions: judging research designs. In M. Terre Blanche & K. Durrheim (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 309 - 330). University of Cape Town Press: Cape Town.
- Trump, L., & Hugo, C. (2006). The barriers preventing effective treatment of South African patients with mental health problems. *South African Psychiatry Review*, 9, 249-260.
- Truter, I. (2007). African traditional healers: cultural and religious beliefs intertwined in a holistic way. *South African Pharmaceutical Journal*, 74, 8, 56,-60.
- Tsai, J. L. & Chentsova-Dutton, Y. (2009). Understanding depression across cultures. In I H Gotlib & C L Hammen (Eds.) *Handbook of depression* (2nd ed.)(pp. 467-491). New York: The Guilford Press.
- Turkum, A, S. (2004). Developing a scale of attitudes toward seeking psychological help: validity and reliability analysis. *International Journal for the Advancement of Counselling*, 26, 3, 321-329.
- Udefi, A. (2012). Philosophy, mythology and African cosmological system. *Global Journal of Human Social Science Geography & Environmental Geosciences*, 12, 10, 59-64.
- ul Haq, N., Hassali, M. A., Shafie, A. A., Forooqui, M., & Aljadhey, H. (2012). A cross-sectional assessment of knowledge, attitude and practice towards hepatitis B among healthy population of Quetta, Pakistan. *BMC Public Health*, 12, 692-700.

- Umberson, D., Chen, M., House, J. S., Hopkins, K., & Slaten, E. (1996). The effect of social relationships on psychological well-being: are men and women really different? *American Sociological Review*, 61, 837-857.
- Ursin, L. O. (2009). Personal autonomy and informed consent. *Medical health Care and Philosophy*, 12, 17-24.
- Ustun, T. B. (1999). The global burden of mental disorders. (Commentaries). *American Journal of Public Health*, 89, 9, 1315-1318.
- Ustun, T. B., Ayuso-Mateos, J. L., Chatterji, S., Mathers, C., & Murray, C. J. L. (2004). Global burden of depressive disorders in the year 2000. *British Journal of Psychiatry*, 184, 386-392.
- Ustun, T. B. & Sartorius, N. (1995). *Mental illness in general health care: an international study*. New York: Wiley & Sons.
- Vandiver, V. L. (2009). *Integrating health promotion and mental health: an introduction to policies, principles, and practice*. New York: Oxford University Press.
- van Reinsburg, P., & Berk, M. (2001). Special investigations. In B Robertson, C Allwood, & C Gagiano. *Textbook of psychiatry for southern Africa* (pp. 65-76). Cape Town: Oxford University Press, Southern Africa.
- van Rensberg, A.B.R.J. (2009). A changed climate for mental health care delivery in South Africa. *African Journal of Psychiatry*, 12, 157-165.
- van 't Veer, J. T. B., Kraan, H. F., Drosseart, S. H. C., & Modde, J. M. (2006). Determinants that shape public attitudes towards the mentally ill: A Dutch public study. *Social Psychiatry and Psychiatric Epidemiology*, 41, 310-317.
- van Vuuren, D., & Maree, A. (1999). Survey methods in market and media research. In M Terre Blanche, K Durrheim, & D Painter (Eds.). *Research in practice: applied methods for the social sciences* (pp. 269 – 286). Cape Town: University of Cape Town Press.
- van Wyk, B. (2011). Research design and methods: part 1. Retrieved from [file:///Users/user/Downloads/research_and_design_i%20\(1\).pdf](file:///Users/user/Downloads/research_and_design_i%20(1).pdf)
- Verhoef, H., & Michel, C. (1997), Studying morality within the African context: a model of moral analysis and construction. *Journal of Moral Education*, 26, 4, 389-407.
- Viriri, A., & Mungwini, P. (2010). African cosmology and the duality of Western hegemony: the search for an African identity. *The Journal of Pan African Studies*, 3, 6, 27-42.

- Vogel, D. L., Wade, N. G., Wester, S. R., Larson, L., & Hackler, A. H. (2007). Seeking help from a mental health professional: the influence of one's social network. *Journal of Clinical Psychology, 63*, 3, 233-245.
- Vos, T., Flaxman, A. D., Naghavi, M., Lozano, R., Michaud, C., Ezzati, M., ... Murray, C. L. (2012). Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *The Lancet, 380*, 2163-2196.
- Wallace, B. C., & Constantine, M. G. (2005). Africentric cultural values, psychological help-seeking attitudes, and self-concealment in African American college students. *Journal of Black Psychology, 31*, 4, 369-385.
- Washington, K. (2010). Zulu traditional healing, Afrikan worldview and the practice of ubuntu: deep thought for Afrikan/Black psychology. *The Journal of Pan African Studies, 3*, 8, 24-39.
- Wassenaar, D. R. (2006). Ethical issues in social science research. In M. Terre Blanche, K. Durrheim, & D Painter (Eds.), *Research in practice: applied methods for the social sciences* (pp. XX-XX). Cape Town: University of Cape Town Press.
- Wasunna, C., Tegli, J., & Ndebele, P. (2014). Informed consent in an African context. In M. Kruger, P. Ndebele, & L. Horn (Eds.), *Research ethics in Africa: A resource for research ethics committees*. Stellenbosch: Sun Press (pp. 57-62).
- Watson, J. (2001). How to determine sample size: Tipsheet #60. University Park, PA: Penn State Cooperative Extension. Retrieved from <http://www.extension.psu/evaluation/pdf/TS60.pdf>
- Weisberg, H. F., Krosnick, J. A., & Bowen, B. D. (1996). *An introduction to survey research, polling, and data analysis* (3rd ed.). London: SAGE publications.
- Weiss, M. G. & Somma, D. (2007). Explanatory models in psychiatry. In D Bhugra, & K. S. Bhui (eds.), *Textbook of cultural psychiatry* (pp. 124-140). Cambridge: Cambridge University Press.
- Weissman, M. M. (1987). Advances in psychiatric epidemiology: rates and risks for major depression. *American Journal of Public Health, 77*, 4, 445-451.
- White, R. (2013). The globalisation of mental illness. *The Psychologist, 26*, 3, 182-185.
- Wichman, A. (1998). Protecting vulnerable research subjects: practical realities of institutional review board review and approval. *Journal of Health Care Law & Policy, 1*, 1, 88-104.

- Wiles, R., Crow, G., Heath, S., & Charles, V. (2006). *Anonymity and confidentiality*. Paper presented at the ESRC Research Methods Festival, University of Oxford, United Kingdom.
- Wiles, R., Crow, G., Heath, S., & Charles, V. (2008). The management of confidentiality and anonymity in social research. *International Journal of Social Research Methodology*, 5, 417-428.
- Williams, C. (2007). Research methods. *Journal of Business & Economic Research*, 5, 3, 65-72.
- Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., & Moomal, H. (2008). Twelve-month mental disorders in South Africa: prevalence, service use and demographic correlates in the population-based South African Stress and Health Study. *Psychological Medicine*, 38, 211-220.
- Winders, S. (2013). Culture and mental health: a symbiotic relationship. *Student Psychology Journal*, 4, 1-14.
- Wittchen, H. U., Essau, C. A., von Zerssen, D., Krieg, J. C. & Zaudig, M. (1992). Lifetime and six-month prevalence of mental disorders in the Munich follow-up study. *European Archives of Psychiatry and Clinical Neuroscience*, 241, 247-258.
- Wolff, G., Pathare, S., Craig, T., & Leff, J. (1996). Community knowledge of mental illness and reaction to mentally ill people. *British Journal of Psychiatry*, 168, 191-198.
- World Health Organization. (2001). Strengthening mental health promotion. World Health Organization (Fact Sheet, No 220), Geneva. doi: <http://www.who.int/mediacentre/factsheets/fs220/en/>
- World Health Organization. (2002). Mental health global action program. World Health Organization, Geneva. doi: www.who.int/mental_health/actionprogramme/en/
- World Health Organization. (2003). Investing in mental health. Department of Mental Health and Substance Dependence, Noncommunicable Diseases and Mental Health. World Health Organization: Geneva. Retrieved from www.who.int/mental_health/media/investing_mnh.pdf
- World Health Organization. (2004). Guidelines of safety monitoring of herbal medicines in pharmacovigilance systems. World Health Organization: Geneva. Retrieved from <http://apps.who.int/medicinedocs/documents/s7148e/s7148e.pdf>

- World Health Organization (2005). *Mental health atlas 2005*. Department of Mental Health and Substance Abuse: Geneva. doi:
www.who.int/mental_health/evidence/mhatlas05/en/index.html
- World Health Organization (2016). *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings. Version 2.0*. Italy: WHO Library Cataloguing-in-Publication Data.
- World Medical Association. (2001). World Medical Association Declaration of Helsinki. Ethical principles for medical research involving human subjects. *Bulletin of the World Health Organization*, 79, 4, 373-374. Retrieved from
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2566407/pdf/11357217.pdf>
- Yen, J., & Wilbraham, L. (2003). Discourses of culture and illness in South African mental health care and indigenous healing, part II: African mentality. *Transcultural Psychiatry*, 40, 4, 562-584.
- Yongsi, H. B. N. (2015). Knowledge and attitudes towards mental health and mental illness among general public in Yaounde. *SAS Journal of Medicine*, 1, 1, 26-32.
- Zheng, M. (2015). Conceptualization of cross-sectional mixed methods in health science: a methodological review. *International Journal of quantitative and Qualitative Research Methods*, 3, 2, 68-87.

Appendices

Appendix A: Vignettes used in the current study

Depression vignette: Bheki is 30 years-old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. Bheki doesn't feel like eating and has lost weight. He can't keep his mind on his work and keeps delaying making any decisions. Even day-to-day tasks seem too much for him. This has come to the attention of Bheki's boss, who is concerned about the poor quality of his work. Bheki feels he will never be happy again and believes his family would be better without him. Bheki has been so desperate, he is thinking of ways to end his life.

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

Alcohol dependence vignette: Bheki is 30 years old. During the last month he has started to drink more than his usual amount of alcohol. In fact, Bheki has noticed that he needs to drink twice as much as he used to, to get the same effect. Several times, he has tried to cut down, or stop drinking, but he can't. Each time he has tried to cut down, he becomes very agitated, sweaty and he couldn't sleep, so he took another drink. Bheki's family has complained that he is often hungover, and has become unreliable- making plans one day, and cancelling them the next day.

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INFORMED CONSENT

Hello

Mr. MJ Kometsi, a doctoral student at the University of KwaZulu-Natal, 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 45 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 (HSS/0527/013D). In the event of any problems or concerns/questions regarding this study, you may contact the researcher, Mr Kometsi (033 260 5374), his supervisor Prof. Nhlanhla Mkhize (031 260 2006), or Miss 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 result in a Doctoral Thesis and published in accredited journals.
4. Your participation in this study is voluntary. You are not forced to participate in this study
5. 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?

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

.....

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 district do you stay in?

- 1. Greater Kokstad
- 2. Kwa Sani

Race / Ethnicity

- 1. African
- 2. Indian
- 3. Coloured
- 4. White
- 5. Other *specify*.....

What is your highest level of education?

- 1. Never went to school
- 2. Primary
- 3. Secondary
- 4. Tertiary

Religious Affiliation

- | | | | |
|---------------------|--------------------------|------------------|--------------------------|
| 1. Atheist | <input type="checkbox"/> | 6. Buddhist | <input type="checkbox"/> |
| 2. Christian | <input type="checkbox"/> | 7. Hindu | <input type="checkbox"/> |
| 3. Jehova's Witness | <input type="checkbox"/> | 8. Jewish | <input type="checkbox"/> |
| 4. Muslim | <input type="checkbox"/> | 9. Non-religious | <input type="checkbox"/> |
| 5. African religion | <input type="checkbox"/> | | |
| 10. Other | <input type="checkbox"/> | | |
- specify.....

Home Language:

- | | | | |
|--------------|--------------------------|--------------|--------------------------|
| 1. Afrikaans | <input type="checkbox"/> | 7. English | <input type="checkbox"/> |
| 2. isiZulu | <input type="checkbox"/> | 8. Ndebele | <input type="checkbox"/> |
| 3. Sepedi | <input type="checkbox"/> | 9. Sesotho | <input type="checkbox"/> |
| 4. Swati | <input type="checkbox"/> | 10. Tsonga | <input type="checkbox"/> |
| 5. Tswana | <input type="checkbox"/> | 11. isiXhosa | <input type="checkbox"/> |
| 6. Venda | <input type="checkbox"/> | 12. Other | <input type="checkbox"/> |
- specify.....

Below is a scenario describing health problems of an individual and his life issues. He is not a real person, but there are people like him. If you happen to know someone who resembles him 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

Bheki is 30 years-old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. Bheki doesn't feel like eating and has lost weight. He can't keep his mind on his work and keeps delaying making any decisions. Even day-to-day tasks seem too much for him. This has come to the attention of Bheki's boss, who is concerned about the poor quality of his work. Bheki feels he will never be happy again and believes his family would be better without him. Bheki has been so desperate, he is thinking of ways to end his life.

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

.....

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

.....

Q3. What would you call Bheki's problem?

.....

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

.....

Q5. If you wanted to help Bheki, what would you do?

.....

Q6. If you had a problem right now like Bheki, would you go for help?

- a. Yes
- b. No
- c. I don't know

If you responded “Yes” to Question 6 above: Answer Questions 7 – 9. Or else, proceed to Question 10

Q7. Whom would you ask for help?

Q8. How confident would you be in your ability to ask this person/place for help?

- a. Very confident
- b. Confident
- c. Not confident at all

Q9. What might stop you from seeking help from this person/place?

.....

Q10. If you had a problem right now like Bheki’s, would you feel comfortable to talk to your family member about it?

- a. Yes
- b. No
- c. I don’t know

Q11. If you had a problem right now like Bheki’s, would you feel comfortable to talk to a friend about it?

- a. Yes
- b. No
- c. I don’t know

Q12. In your opinion, how likely it is that Bheki’s situation might have been caused by:

	Very likely	Somewhat likely	Less likely	Don’t know
a. Own bad character				
b. Chemical imbalance in the brain				
c. The way he was raised				
d. Stressful circumstances in his 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 he committed				

Q13. There are a number of different people, some professional, some not, who could possibly help Bheki. Are each of the following people likely to be helpful, harmful, or neither for Bheki?

	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 his problem on his own			
o. Other (<i>please specify</i>)			

Q14. Do you think the following different MEDICINES are likely to be helpful, harmful, or neither to Bheki?

	Helpful	Harmful	Neither
a. Vitamins, minerals and tonics			
b. Traditional medicine			
c. Pain relievers such as aspirin, panado, grandpa, compral			
d. Antidepressant			
e. Antibiotics			
f. Sleeping pills			
g. Anti-psychotics			
h. Tranquilizers such as valium			
i. Other (<i>please specify</i>)			

Q15. Do you think the following TREATMENTS are likely to be helpful, harmful, or neither to Bheki?

	Helpful	Harmful	Neither
a. Becoming more active such as playing more sports, walking			
b. Reading about people with similar problems; how they coped			
c. Getting out and about more			
d. Attending courses on relaxation, stress management, meditation			
e. Stop drinking alcohol			
f. Consulting a Psychologist			
g. Being admitted to a psychiatric ward of a hospital			
h. Having an occasional alcohol drink to relax			
i. Going on a special diet or avoiding certain foods			
j. Being locked away			

Q16. Do you think the following will be helpful, harmful, or neither for Bheki?

	Helpful	Harmful	Neither
a. Consulting a website that gives information about his problem			
b. Consulting an expert using e-mail or the web about his problem			
c. Consulting a book that gives information about his problem			
d. Receiving information about his problem from a health care worker in his community			
e. Listening to a radio or TV programme on health-related issues			
f. Consulting a nurse in his local clinic			
g. Consulting a trusted, expert traditional healer in his village			
h. Consulting his local pastor/priest/priestess			

Q17. The next few questions ask what you think are Bheki's chances of recovery. What would be the likely result if Bheki 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. Full recovery, but problems would probably re-occur
- c. Partial recovery
- d. Partial recovery, but problems would probably re-occur
- e. No improvement
- f. Don't know

Q18. What would be the likely result if Bheki did NOT have any professional help? Would you say.... (please choose one)

- a. Full recovery with no further problems
- b. Full recovery, but problems would probably re-occur
- c. Partial recovery
- d. Partial recovery, but problems would probably re-occur
- e. No improvement
- f. Don't know

Q19. Suppose Bheki received the sort of help that you think is most appropriate for his problems, for each of the following, how do you think Bheki would be IN THE LONG TERM, compared to other people in the community?

	More likely	Just as likely	Less likely	Depends	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					

Q20. Now, for the next few questions, we would like you to tell us what DO YOU THINK OR BELIEVE about these statements?

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	I don't know
a. People with a problem like Bheki's could come out of it if they wanted to						
b. A problem like Bheki's is a sign of personal weakness						
c. Bheki's problem is not a real medical illness						
d. People with a problem like Bheki's are dangerous						
e. It is best to avoid people with a problem like Bheki's so that you don't develop this problem						
f. People with a problem like Bheki's are unpredictable						
g. If I had a problem like Bheki's I would not tell anyone						
h. I would not employ someone I knew he had a problem like Bheki's						
i. I would not vote for a politician if I knew he had suffered a problem like Bheki's						

Q21. Do you think that Bheki would be discriminated against by others in the community, if they knew about his problems?

- a. Yes
- b. No
- c. I don't know

Q22. Now, for the next few questions, we would like you to tell us what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with these statements

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	I don't know
a. Most people believe that people with a problem like Bheki's could come out of it if they wanted to						
b. Most people believe that a problem like Bheki's is a sign of personal weakness						
c. Most people believe that Bheki's problem is not a real medical illness						
d. Most people believe that people with a problem like Bheki's are dangerous						
e. Most people believe that it is best to avoid people with a problem like Bheki's so that you don't develop this problem						
f. Most people believe that people with a problem like Bheki's are unpredictable						
g. If they had a problem like Bheki's most people would not tell anyone						
h. Most people would not employ someone they knew had a problem like Bheki's						
i. Most people would not vote for a politician they knew had suffered a problem like Bheki's						

Q23. The next few questions ask about how willing you would be to have contact with someone like Bheki

	Definitely willing	Probably willing	Probably unwilling	Definitely unwilling	Don't know
a. How willing would you be to move next door to Bheki?					
b. How willing would you be to spend an evening socializing with Bheki?					
c. How willing would you be to make friends with Bheki?					
d. How willing would you be to have a relationship with Bheki?					
e. How willing would you be to have Bheki start working closely with you on a job?					
f. How willing would you be to have Bheki looking after your children?					
g. How willing would you be to have Bheki marry in your family?					
h. How willing would you be to live in the same room with Bheki?					
i. How willing would you be to eat food cooked by Bheki?					
j. How willing would you be to have people like Bheki living in your neighbourhood?					

Q24. There are many people in the community who suffer from problems like Bheki's. The next few questions are about possible causes of this sort of problem developing in ANYBODY. How likely do you think each of the following is to be a reason for such problems?

	Very likely	Likely	Not likely	Don't know
a. Could a virus or other infection, be a reason for this sort of problems?				
b. How likely is an allergy or reaction to be a cause?				
c. Could day-to-day problems such as stress, family arguments, difficulties at work or financial difficulties be a cause?				
d. Could the recent death of a close friend or relative be a reason?				
e. Could jealousy by co-workers, family or community members be the cause?				
f. Could some recent traumatic event such as being hijacked be a cause for this sort of problems?				
g. Could witchcraft (e.g. umeqo) or evil spirits be the cause?				
h. Could problems from childhood such as being badly treated or abused, losing one or both parents when young or coming from a broken home be a reason?				
i. Could a religious transgression or sin be the cause?				
j. How likely is that these sorts of problems are inherited or genetic?				
k. How likely is that these sorts of problems are caused by a chemical imbalance in the brain?				
l. How likely it is that this problem has been caused by ancestral anger or failure to perform cultural rituals?				
m. Is being a nervous person likely to be a reason?				
n. Could having weakness of character be a cause?				

Q25. People with a problem like Bheki's are:

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	I don't know
a. Dangerous						
b. Unpredictable						
c. Lacking self-control						
d. Aggressive						
e. Frightening						

Q26. Has anyone in your family or close circle of friends ever had problems similar to Bheki's?

- a. Yes
- b. No
- c. I don't know

Q27. If you answered 'Yes' to the question above, did just one person have the problem or more than one?

- a. One
- b. More than one
- c. Don't know

Q28. If you know a person who had problems similar to Bheki's, did you do anything to help the person?

- a. Yes
- b. No
- c. I don't know

Q29. If you answered 'Yes' to Q28 above, what did you do?

.....

Q30. Have they received any professional Western help or treatment for these problems?

- a. Yes
- b. No
- c. I don't know

Q31. Have you ever had problems similar to Bheki's?

- a. Yes
- b. No
- c. I don't know

Q32. If you answered 'Yes' to the question above, have you received any professional Western help or treatment for these problems?

- a. Yes
- b. No
- c. I don't know

Q33. Have you ever had a job that involved providing treatment or service to a person like Bheki's?

- a. Yes
- b. No
- c. I don't know

Q34. If you were to come into contact with people having a problem like Bheki's, would your contact with them be friendly and cooperative?

- a. Yes
- b. No
- c. I don't know

Q35. 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?

- d. Yes
- e. No
- f. I don't know

Q36. 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)

Q37. Which organization or institution providing care to the mentally ill, if any, can you think of?

.....

Q38. What is the nearest place in your area that provides treatment for people with mental health problems?

.....

Q39. Is there anything else you would like to say or mention about Bheki's problem?

.....

.....

.....

.....

.....

.....

THANK YOU!

Appendix C: isiZulu version of the vignettes

Depression vignette: UBheki uneminyaka engu30. Sekuphele amasonto ambalwa ezizwa ephatheke kabi ngendlela engajwayelekile. Nakuba ehlezi ezizwa ekhathele, njalo ebusuku akakwazi ukulala. UBheki akakuhaleli ukudla, futhi usenciphe kakhulu. Akakwazi ukucabanga ngomsebenzi, futhi ulokhu ehlehlisa ukuthatha izinqumo. Nezinto okumele engabe uyazenza usuku nosuku seziyamusinda. Lokhu sekuze kwanakwa nangumphathi wakhe, akaphathekile kahle ngokuthi umsebenzi kaBheki awusekho esimweni esamukelekile. UBheki uzizwa engathi angeke aphinde ajabule, futhi ubona engathi umndeni wakhe ungazizwa kangcono uma yena engasekho. Sekuze kwafika lapho uBheki esecabanga izindlela zokunqamula impilo yakhe

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

Alcohol dependency vignette: UBheki uneminyaka engu30. Kule nyanga edlule useqale ukuphuza ngaphezu kwalokhu ajwayele ukukuphuza. Impela uBheki useqale ukubona ukuthi usedinga ukuphuza ngokuphindwe kabili ukuze kube nomthelela ofanayo. Seziningana izikhathi asezame ngazo ukwehlisa noma ukuyeka ukuphuza, kodwa uyahluleka. Njalo uma ezama ukwehlisa, uzizwa ekhathazekile, ajuluke, angakwazi nokulala, bese ethatha esinye isiphuzo. Umndeni kaBheki usukhalazile ngokuthi usejwayele ukubanjwa ibhabhalazi, nokuthi akasathembekile – enze izinhlelo ngosuku oluthile, aphinde azinqume ngosuku olulandelayo.

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IMVUME ENOLWAZI

Sawubona,

Umfundi weziqu zobudokotela (doctoral student), uMJ Kometsi, 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 zinkinga zempilo, ukuthi bayaphi abantu uma bedinga usizo, nokuthi lezi zinkinga zilashwa kanjani. Awuphoqelekile kodwa ukuphendula imibuzo ongathandi ukuyiphendula.

Cishe kuzothatha imizuzu ephakathi kuka 15 no-20 ukuphendula imibuzo yale nhlobo. Noma ungavuma ukuphendula yonke imibuzo, uzobe usanalo ilungelo lokushiya ucwaningo nganoma isiphi isikhathi uma uthanda, akukho okubi okungakuvelela uma ulushiya lolu cwano, ngisho emva kokuba usuqalile.

Akukho futhi okubi esibona ukuthi kungakuvelela uma ubamba iqhaza kulolu cwano. IKomidi lase Nyuvesi yakwa Zulu-Natali elibhekene nokuthi ucwaningo lwenziwa ngendlela enobulungiswa (UKZN Research Ethics Committee) selizihlolile futhi lazamukela izimiso zalolu cwano eziqinisekisa ukuphatha abantu ngendlela efanelekile (HSS/0527/013D). Uma kwenzeka uba nenkinga noma imibuzo mayelana nocwano, ungathintana nomncwaningi u- Mr Kometsi ku-033 260 5374, umphathi wakhe uSolwazi N. Mkhize (031-260 2006) 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 cwano:

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 cwano.
2. Unelungelo lokungawuphenduli umbuzo ongathandi ukuwuphendula.
3. Imiphumela yalolu cwano izoba ingxenye yoMqulu weZobudokotela (Doctoral Thesis) futhi izoshicilelwa emibhalweni ezigabeni zezinhlobo zezincwadi ezifinyezele ezibizwa ngokuthi ama-jeneli (journals) amukelwe ngokusemthethweni.

4. Ukubamba kwakho iqhaza kulolu cwaningo kuzoba isinqumo sentando yakho.
5. 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 nhlobo.

Ngabe unayo imibuzo mayelana nalolu cwaningo?

Imvume yokuba ingxenye yocwaningo:

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

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

iSignesha yoMbambiqhaza

.....

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. Greater Kokstad
4. Kwa Sani

Ubuzwe

- | | |
|-------------------------------------|--------------------------------------|
| 1. African <input type="checkbox"/> | 3. Coloured <input type="checkbox"/> |
| 2. Indian <input type="checkbox"/> | 4. White <input type="checkbox"/> |
| 5. Okunye <input type="checkbox"/> | <i>chaza</i> |

Lapho owagcina khona kwezemfundo

- 5. Awukaze uye esikoleni
- 6. Primary
- 7. Secondary
- 8. Imfundo ephakeme

Inkolo yakho

- 1. Awukholelwa kuNkulunkulu
- 2. UngumKristu
- 3. Ofakazi bakaJehova
- 4. iSulumane
- 5. Ukholo lwesintu
- 10. Okunye
- 6. Buddhist
- 7. Hindu
- 8. umJuda
- 9. Awulandeli nkolo
- Sicela uchaze uma ukholelwa kokunye.....

Ulimi lwakho lwasekhaya:

- 1. Afrikaans
- 2. isiZulu
- 3. Sepedi
- 4. Swati
- 5. Tswana
- 6. Venda
- 7. English
- 8. Ndebele
- 9. Sesotho
- 10. Tsonga
- 11. isiXhosa
- 12. 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

UBheki uneminyaka engu30. Sekuphele amasonto ambalwa ezizwa ephatheke kabi ngendlela engajwayelekile. Nakuba ehlezi ezizwa ekhathele, njalo ebusuku akakwazi ukulala. UBheki akakuhaleli ukudla, futhi usinciphe kakhulu. Akakwazi ukucabanga ngomsebenzi, futhi ulokhu ehlehlisa ukuthatha izinqumo. Nezinto okumele engabe uyazenza usuku nosuku seziyamusinda. Lokhu sekuze kwanakwa nangumphathi wakhe, akaphathekile kahle ngokuthi umsebenzi kaBheki awusekho esimweni esamukelekile. UBheki uzizwa engathi angeke aphinde ajabule, futhi ubona engathi umndeni wakhe ungazizwa kangcono uma yena engasekho. Sekuze kwafika lapho uBheki esecabanga izindlela zokunqamula impilo yakhe

- Q1. Yini, uma kukhona, okungahambi kahle ngoBheki?
-
- Q2. Yini ocabanga ukuthi ibanga inkinga noma izinkinga zikaBheki?
-
- Q3. Ungayibiza ngani inkinga kaBheki?
-
- Q4. Uma ucabanga angasizwa kanjani uBheki?
-

Q5. Uma ubufuna ukusiza uBheki ubungamusiza kanjani?

.....

Q6. Ukube wena njengamanje ubunenkinga efana nekaBheki, ungalubheka usizo?

- d. Yebo
- e. Cha
- f. Angazi

Uma uphendule wathi 'Yebo' kunombolo 6 wemibuzo, qhubeka uphendule unombolo 7-9 wemibuzo noma uqhubeke uye kunombolo 10.

Q7. Ungaya kuphi ukuyocela usizo?

Q8. Ungazithemba kangakanani ukuthi ungakwazi ukumcela lowo muntu usizo/ukubheka usizo kuleyo ndawo?

- d. Ngingazithemba kakhulu
- e. Ngingazithemba ngokwanele
- f. Ngingangazithemba nhlobo

Q9. Yini engakuvimba ekutheni ubheke usizo kulomuntu/kulendawo?

.....

Q10. Ukuba wena njengamanje ubunenkinga efana nekaBheki, ungazizwa ukhululekile ukukhuluma ngayo nelunga lomndeni wakho?

- d. Yebo
- e. Cha
- f. Angazi

Q11. Ukube wena njengamanje ubunenkinga efana nekaBheki, ungazizwa ukhululekile ukukhuluma ngayo nomngani wakho?

- d. Yebo
- e. Cha
- f. Angazi

Q12. Ngokubona kwakho, mangakanani amathuba okuthi isimo sika Bheki sibangwe yilokhu okulandelayo:

	Mangingi amathuba	Akhona wona amathuba	Mancane amathuba	Angazi
a. Ukuthi ungumuntu ongasimilo				
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				

Q13. Ziningi izinhlobo zabantu, abanye abangochwepheshe, abanye abangasibo, okungenzeka bakwazi ukumsiza uBheki. Bheka laba bantu ababaliwe abalandelayo. Ngokubona kwakho, makanganani amathuba omuntu ngamunye okuthi akwazi ukumsiza uBheki, 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			
o. Okunye (<i>sicela uchaze</i>)			

Q14. Uma ucabanga le MITHI elandelayo ehlukehukene inganosizo, ingamulimaza, noma ingangamenza nokukodwa kwalokhu uBheki?

	Anganosizo	Angamulimaza	Angangamenza nokukodwa kwalokhu
a. Vitamins, minerals and tonics Ama-vithamini, ama minerali (njengeziphuzo eziqethe okusansimbi) noma iziphuzo/imithi equkethe izakhamzimba (tonics)			
b. Imithi yesintu			
c. Amaphilisi ezinhlungu, njenge aspirin, 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)			
i. Okunye (<i>sicela uchaze</i>)			

Q15. Uma ucabanga, lezi zindlela ezilandelayo ZOKWELAPHA zingamusiza, zingamulimaza, noma zinganga menza nokukodwa kwalokhu uBheki?

	Kunganosizo	Kungamulimaza	Kungangamenza nokukodwa kwalokhu
a. Ukuzivocavoca, njengokubamba iqhaza kwezemidlalo, ukuzihambela (ukwelula izinyawo—take a walk)			
b. Ukufunda ngokuthi abanye abantu ababenenkinga efanayo basizakala kanjani			
c. Ukuphuma ashawe umoya			
d. Ukufunda ngezindlela zokuphumula, zokuqonda ingcindezi, ukuzindla (meditation)			
e. Ukuyeka ukuphuza utshwala			
f. Ukwelashwa komqondo			
g. Ukungena esibhedlela sengqondo			
h. Ukuthintathinta (ukushayashaya) nje utshwala ukuze akwazi ukuphumula			
i. Ukushintsha indlela adla ngayo noma ukuyeka ukudla okuthile			
j. Ukuvalelwa			

Q16. Uma ucabanga lokhu okulandelayo kungamusiza, kungamulimaza, noma kungangamenza nokukodwa kwalokhu uBheki?

	Kungamusiza	Kungamulimaza	Kungangamenza nokukodwa kwalokhu
a. Ukubheka kwi internet izindawo ezinika ulwazi mayelana nenkinga abhekene nayo			
b. Ukuthintana nochwepheshe nge e-mail noma nge internet mayelana nenkinga abhekene nayo			
c. Ukufunda incwadi enika ulwazi mayelana nenkinga abhekene nayo			
d. Ukuthola ulwazi mayelana nenkinga abhekene nayo emntwini osebenza ngezempilo emphakathini wakhe			
e. Ukulalela umsakazo noma umabonakude (TV) mayelana nokuthintana nezempilo			
f. Ukuthintana no nesi ekliniki langakubo			
g. Ukuthintana ne nyanga ethembekile emphakathini wakhe			
h. Ukuthintana nomfundisi, noma umamfundisi (umfundisikazi) wakhe			

Q17. Imibuzo elandelayo ikubuza ukuthi wena ucabanga ukuthi mangakanani amathuba okuthi angalapheka uBheki. Uma uBheki engathola usizo lwochwepheshe ocabanga ukuthi kungayilo olungafaneleka, ikuphi okunokwenzeka kulokhu okulandelayo? Ungathi.... (sicela ukhethe okukodwa)

- g. Angalapheka ngokuphelele, angabe esaba nalezi zinkinga futhi
- h. Angalapheka ngokuphelele, kodwa izinkinga zakhe zingabuye zibuye futhi
- i. Angalapheka lapha nalapha, kodwa hhayi ngokuphelele
- j. Angalapheka lapha nalapha, kodwa hhayi ngokuphelele, futhi izinkinga zakhe zingabuye zibuye futhi
- k. Angangalapheka
- l. Angazi

Q18. Yini enganokwenzeka uma uBheki ANGANGALUBHEKA NHLOBO usizo lochwepheshe? Ungathi...
(sicela ukhethe okukodwa)

- a. Angalapheka ngokuphelele, angabe esaba nalezi zinkinga futhi
- b. Angalapheka ngokuphelele, kodwa izinkinga zakhe zingabuye zibuye futhi
- c. Angalapheka lapha nalapha, kodwa hhayi ngokuphelele
- d. Angalapheka lapha nalapha, kodwa hhayi ngokuphelele, futhi izinkinga zakhe zingabuye zibuye futhi
- e. Angangalapheka
- f. Angazi

Q19. Asike sithi uBheki uyaluthola lolu sizo wena ocabanga ukuthi ilona olufanelekile ekulapheni izinkinga zakhe, kulokhu okulandelayo, ucabanga ukuthi uBheki 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					

Q20. 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. Abantu abanezinkinga ezifana nezikaBheki bangayeka ukuxakwa izona nganoma isiphi isikhathi abasithandayo						
b. Inkinga efana nekaBheki iluphawu lokuba ntekenteke komuntu						
c. Inkinga efana nekaBheki akusona isifo sangempela						
d. Abantu abanenkinga efana nekaBheki bayingozi						
e. Kungcono ukubagwema abantu abanenkinga efana nekaBheki ukuze ungazitholi usunalenkinga nawe						
f. Abantu abanenkinga efana nekaBheki abahlelekile (not organised)						
g. Uma bengine nkinga efana nekaBheki bengingeke ngitshele muntu						
h. Bengingeke ngiqashe umuntu onenkinga efana nekaBheki						
i. Bengingeke ngimuvotela uSopolitiki engimaziyo ukuthi unenkinga efana nekaBheki						

Q21. Uma ucabanga abantu bomphakathi bangamucwasa na uBheki uma bangase bazi ngezinkinga zakhe?

- d. Yebo
- e. Cha
- f. Angazi

Q22. Manje, kule mibuzo elandelayo, sicela usitshela ukuthi wena ucabanga ukuthi **ININGI LABANTU** likholwani. Sicela uveze ukuthi uvumelana noma uphikisana kangakanani nalezi zitatimende.

	Ngivumelana kakhulu	Ngivumelana nakho	Angivumelani kodwa futhi angiphikisani nakho	Ngiyaphikisana nakho	Ngiphikisana kakhulu	Angazi
a. Abantu abaningi bakholelwa ekutheni abantu abanezinkinga ezifana nezikaBheki bangayeka ukuxakwa izona nganoma isiphi isikhathi abasithandayo						
b. Abantu abaningi bakholwa ekutheni inkinga efana nekaBheki iluphawu lokuba ntekenteke komuntu						
c. Abantu abaningi bakholwa ekutheni inkinga efana nekaBheki akusona isifo sangempela						
d. Abantu abaningi bakholwa ekutheni abantu abanenkinga efana nekaBheki bayingozi						
e. Abantu abaningi bakholwa ekutheni kungcono ukubagwema abantu abanenkinga efana nekaBheki ukuze bona bangazitholi sebenayo nabo						
f. Abantu abaningi bakholwa ekutheni abantu abanenkinga efana nekaBheki abahlelekile (not organised)						
g. Abantu abaningi bangangatshela muntu u bona benenkinga efana nekaBheki						
h. Abantu abaningi bangangamuqasha umuntu onenkinga efana nekaBheki						
i. Abantu abaningi bangangamuvotela uSopolitiki abamaziyo ukuthi wake waba nenkinga efana nekaBheki						

Q23. Imibuzo elandelayo ibuza ukuthi ungazimisela kangakanani ukuzibandakanya nomuntu onjengoBheki

	Ngingazimisela ngempela	Mhlawum bhe Ngingazimisela	Mhlawum bhe ngingangazimisela	Ngingangazimisela ngempela	Angazi
a. Ungazimisela kangakanani ukuba umakhelwane kaBheki?					
b. Ungazimisela kangakanani ukuchitha isikhathi uzipholele noBheki?					
c. Ungazimisela kangakanani ukuba umngani kaBheki?					
d. Ungazimisela kangakanani uku thandana noBheki (uma ungowesilisa, ukuthandaba nowesifazane onezinkinga ezifana nezika Bheki)					
e. Ungazimisela kangakanani ukusebenzisana noBheki?					
f. Ungazimisela kangakanani ukuthi uZBheki anakekele izingane zakho?					
g. Ungazimisela kangakanani ukwamukela ukuthi uBheki ashadele kini?					
h. Ungazimisela kangakanani ukuhlala egumbini/ekamelweni elilodwa noBheki?					
i. Ungazimisela kangakanani ukuthi udle ukudla okuphekwe uBheki?					
j. Ungazimisela kangakanani ukwamukela ukuthi abantu abafana noBheki bahlale emphakathini wakho?					

Q24. Baningi abantu emphakathini abahlushwa izinkinga ezifana nezikaBheki. Imibuzo elandelayo imayelana nezinto ezingabanga lezi zinkinga KUNOMA UBANI. Ngokucabanga kwakho, mangakanani amathuba okuthi isimo ngasodwa kulezi ezilandelayo sibange izinkinga ezifana nalezi?

	Maningi amathuba	Akhona amathuba	Awekho amathuba	Angazi
a. Kungenzeka yini ukuthi igciwane noma ukutheleleka kube imbangela yezinkinga ezifana nalezi?				
b. Kungenzeka yini ukuthi i-allergy noma i-reaction kungaba imbangela? (I – allergy isho amasosha omzimba azwela ngendlela edlulele ezimweni ezithile okudala izimpawu zomkhuhlane, njengokuzwela kakhulu uthuli noma ugwayi okudala ukuthimula, ukuzwela ilanga okungadala izinkinga zesikhumba, njalonjalo). Isihlungu enye yama allergies esikhumba ajwayelekile).				
c. Kungenzeka yini ukuthi izinkinga zosuku nosuku, njenge ngcindezi (stress), ukuphikisana emndenini, izinkinga emsebenzini, noma izinkinga zemali zibe imbangela?				
d. Kungenzeka yini ukuthi ukushona komngani osondelene naye noma kwesihlobo kube imbangela?				
e. Kungenzeka ukuthi umona ovela kumuntu asebenza naye, noma ilunga lomndeni noma ilunga lomphakathi imbangela?				
f. Kungenzeka yini ukuthi isimo esihlasimulisayo, njengengozi yemoto embi kakhulu, noma ukubanjwa inkunzi kube imbangela yezinkinga ezifana nalezi?				
g. Kungenzeka ukuthi ukuthakathwa (e.g. umeqo) noma imimoya emibi imbangela?				
h. Kungenzeka yini ukuthi izinkinga ezisukela ebunganeni, njengokuphathwa kabi noma ukuhlukumezeka, ukulahlekelwa umzali oyedwa noma bobaili usamncane, noma ukuqhamuka ekhaya eliphukile (eliyinhlanhlaka), kube imbangela?				
i. Kungenzeka ukuthi ukona ngokwenkolo imbangela?				
j. Mangakanani amathuba okuthi izinkinga ezifana nalezi ziwufuzo?				
k. Mangakanani amathuba okuthi inkinga efana nale ibangwa ukungahambi kahle kwamakhemikhali (izithako ezincinyana) engqondo?				
l. Mangakanani amathuba okuthi inkinga efana nale ibangwa ukuthukuthela kwamadlozi (izinyanya) noma ukungaphumeleli ukwenza imisebenzi yesintu? (ulaka lwabaphansi noma ukufulathelwa amadlozi?)				
m. Ngabe ukuba umuntu onovalo kungaba imbangela?				
n. Ngabe ukungabi nasimilo kungaba imbangela?				

Q25. Abantu abanenkinga afana nekaBheki:

	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						

Q26. Ukhona umuntu emndenini wakho noma kubangani bakho osondelene nabo oseke waba nezinkinga ezifana nezikaBheki?

- d. Yebo
- e. Cha
- f. Angazi

Q27. Uma uphendule ngo 'Yebo' kumbuzo ongenhla, ngabe ngumuntu oyedwa kuphela oseke waba naleyo nkinga noma bangaphezulu koyedwa?

- d. Oyedwa
- e. Bangaphezulu koyedwa
- f. Angazi

Q28. Uma kukhona umuntu omaziyo owake waba nezinkinga ezifana nezikaBheki, ngabe kukhona owake wakwenza ukusizeni lomuntu?

- d. Yebo
- e. Cha
- f. Angazi

Q29. Uma uthe 'Yebo' kumbuzo 28 ngasenhla, wenzani?

.....
.....

Q30. Ngabe lo muntu useke waluthola usizo lochwepheshe noma ukulapheka kwalezi zinkinga?

- d. Yebo
- e. Cha
- f. Angazi

Q31. Ngabe wena wake waba nezinkinga ezifana nezikaBheki?

- d. Yebo
- e. Cha
- f. Angazi

Q32. Uma uthe 'Yebo' kulo mbuzo ongenhla, ngabe usuke waluthola usizo lochwepheshe (abasebenza ngokwesilungu/ngokwaseNtshonalanga) noma ukulapheka kwalezi zinkinga?

- a. Yebo
- b. Cha
- c. Angazi

Q33. Ngabe usuke waba nomsebenzi ophathelene nokulapha noma ukunika abantu abafana noBheki usizo oluthile?

- a. Yebo
- b. Cha
- c. Angazi

Q34. Uma ungase uzithole usuxhumene nomuntu onezinkinga ezifana nezikaBheki, ngabe ukuxhumana kwakho naye kungaba nobungane kanye nokubambisana?

- a. Yebo
- b. Cha
- c. Angazi

Q35. Imibuzo elandelayo imayelana nesimo somqondo, abezindaba, kanye nezihlangano zezimo zomqondo. Ngabe usuke wabona, wafunda, noma wezwa izindaba ezimayelana nezimo zomqondo ezinyangeni ezingu6 ezedlule?

- a. Yebo
- b. Cha
- c. Angazi

Q36. Uma uthe 'Yebo' kumbuzo 35 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)

Q37. Ngabe ikhona inhlangano noma isikhungo sezinkinga zengqondo ongazicabanga ngalo mzuzu?

.....

Q38. Iyiphi indawo eseduze kunazo zonke endaweni ohlala kuyo elapha abantu abanezinkinga zengqondo?

.....

Q39. Ngabe kukhona okunye ongathanda ukukusho mayelana nenkinga ka Bheki?

.....

.....

.....

.....

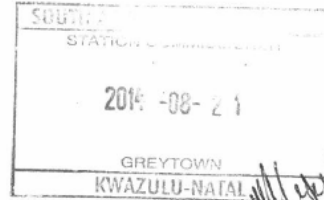
SIYABONGA

Appendix E: An ethical clearance certificate with stamps from the municipal manager and SAPS of Greytown



4 July 2013

Mr Molelekoa J. Kometsi 212561295
School of Applied Human Sciences
Howard College Campus



Protocol reference number: HSS/0527/013D
Project title: Mental health literacy: notions and attitudes toward mental disorders and beliefs about treatment among African residents of Sisonke District in KwaZulu-Natal

Dear Mr Kometsi

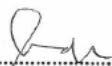
Expedited Approval

I wish to inform you that your application has 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 school/department for a period of 5 years.

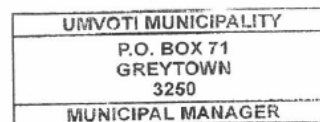
I take this opportunity of wishing you everything of the best with your study.

Yours faithfully


.....
Dr S Singh (Deputy Chair)

/px

cc Supervisor: Professor NJ Mkhize
cc Co-Supervisor: Professor AL Pillay
cc Academic Leader Research: Professor D McCracken
cc Post Graduate Administrator: Ms A Luthuli




Humanities & Social Sciences Research Ethics Committee
Professor Urmilla Bob (Chair) and Dr Shenuka Singh (Deputy Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban, 4000, South Africa
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Website: www.ukzn.ac.za

Operating Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS



Appendix F: An ethical clearance certificate with stamps from the municipal manager and SAPS of Greater Kokstad Municipality

 **UNIVERSITY OF KWAZULU-NATAL**
INYUVESI YAKWAZULU-NATALI

4 July 2013

Mr Molelekoa J. Kometsi 212561295
School of Applied Human Sciences
Howard College Campus

Protocol reference number: HSS/0527/013D
Project title: Mental health literacy: notions and attitudes toward mental disorders and beliefs about treatment among African residents of Sisonke District in KwaZulu-Natal


Dear Mr Kometsi

I wish to inform you that your application has been granted Full Approval. **Expedited 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 school/department for a period of 5 years.

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

Yours faithfully


Dr S Singh (Deputy Chair)
/px


cc Supervisor: Professor NJ Mkhize
cc Co-Supervisor: Professor AL Pillay
cc Academic Leader Research: Professor D McCracken
cc Post Graduate Administrator: Ms A Luthuli

(039) 797 11 30 (SAPS - KOKSTAD)

Humanities & Social Sciences Research Ethics Committee
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Website: www.ukzn.ac.za

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville



INSPIRING GREATNESS

Appendix G: An ethical clearance certificate with stamps from the municipal manager and SAPS of Kwa Sani Municipality

 **UNIVERSITY OF
KWAZULU-NATAL**
INYUVESI
YAKWAZULU-NATALI

4 July 2013

Mr Molelekoa J. Kometsi 212561295
School of Applied Human Sciences
Howard College Campus

Protocol reference number: HSS/0527/013D
Project title: Mental health literacy: notions and attitudes toward mental disorders and beliefs about treatment among African residents of Sisonke District in KwaZulu-Natal

Dear Mr Kometsi

I wish to inform you that your application has been granted Full Approval. **Expedited 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 school/department for a period of 5 years.

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

Yours faithfully


.....
Dr S Singh (Deputy Chair)
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cc Supervisor: Professor NJ Mkhize
cc Co-Supervisor: Professor AL Pillay
cc Academic Leader Research: Professor D McCracken
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Humanities & Social Sciences Research Ethics Committee
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Website: www.ukzn.ac.za

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

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Appendix H: An example of 5 sets of random numbers generated by *Randomizer* computer programme

Random Integer Set Generator

You requested 5 sets with 30 unique random integers in each, taken from the [1,200] range. The integers in each set were sorted in ascending order.

Here are your sets:

- Set 1: 1, 4, 11, 12, 15, 22, 35, 38, 39, 42, 51, 63, 74, 75, 79, 80, 84, 98, 108, 109, 120, 121, 126, 127, 154, 156, 157, 180, 182, 196
- Set 2: 2, 7, 14, 20, 30, 31, 43, 50, 52, 55, 66, 78, 86, 88, 89, 113, 116, 120, 121, 122, 124, 127, 144, 151, 155, 161, 169, 172, 175, 184
- Set 3: 8, 10, 17, 21, 27, 31, 38, 43, 55, 57, 61, 69, 89, 92, 96, 98, 108, 112, 124, 133, 143, 144, 148, 153, 159, 161, 172, 173, 180, 198
- Set 4: 4, 5, 7, 13, 15, 25, 28, 40, 50, 60, 79, 91, 94, 98, 99, 101, 104, 110, 113, 121, 124, 129, 134, 144, 156, 168, 171, 172, 182, 199
- Set 5: 1, 6, 17, 18, 28, 51, 56, 67, 83, 88, 94, 105, 117, 124, 125, 126, 130, 131, 139, 142, 151, 156, 157, 160, 187, 190, 192, 196, 198, 200