



**Difficulties in knowledge and perceptions of mental illness amongst the student population: perspectives gained from a Participatory Action Research project by psychology master's students from the University of KwaZulu-Natal**

**By**

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## **DECLARATION**

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: ..... Date: ...28/01/2021.....

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## **ACRONYMS**

**FGD:** Focus Group Discussion

**SPSS:** Statistical Package for the Social Sciences

**SRT:** Social Representation Theory

**UKZN:** University of KwaZulu Natal

**WHO:** World Health Organisation

## **ABSTRACT**

Mental illness is currently one of the most concerning and prevalent global health challenges. The researcher undertook this investigation in an attempt to obtain a clearer understanding of the difficulties in knowledge and perceptions of mental illness amongst the student population at the University of KwaZulu-Natal's (UKZN) Howard College campus. The Participatory Action Research (PAR) method was implemented to identify the most appropriate method for mental health awareness and to encourage help-seeking behaviour.

This mixed method study explores difficulties in perceptions and understandings of University students regarding mental illness; the first phase utilised a sample of 5 participants who formed a focus group. The findings revealed that students' traditional and cultural beliefs were given the same priority as Western thoughts on mental illness, and treatments were often combined. Difficulties in knowledge and perceptions were found to be attributable to the cultural divide between Western and traditional notions. Participants indicated that their knowledge and perceptions of mental illness was influenced by societal and cultural beliefs.

With PAR methodology being employed to develop a mental illness awareness poster and with the impact of exposure to the poster being in a sample of 17 university students (who shared their perceptions and understandings of mental illness pre-and post-exposure to the poster). Study findings suggest that exposure to poster may have been associated with increased knowledge and more informed understandings of mental illness among students surveyed.

**Keywords: Knowledge Mental illness Perceptions Participatory Action Research Student population**

## CHAPTER ONE: INTRODUCTION

### 1. Introduction to the study

Globally, the prevalence of individuals experiencing mental illness continues to mount. World Health Organization [WHO] (2016) reports indicate that roughly one in ten individuals has a mental illness issue, globally. Approximately thirteen percent of the global disease burden may be attributed to mental illness, a figure that is predicted to ascend in the future (Teachman et al., 2018). The South African Stress and Health (SASH) study indicated that the rate of stress in South Africa is high as approximately 30.3% of the general community experience a mental disorder during their lifetimes (Herman et al., 2009). Amuyunzu-Nyamongo (2013) postulates that mental illness is viewed as a quiet pestilence affecting most portions of the world, yet it is highly stigmatised.

The conceptualisation of mental disorders includes various considerations such as cultural socialisation, historical context, levels of scientific knowledge and the level of education about certain conditions, amongst other factors (Njenga, 2007). The prevailing understanding of mental illness is profoundly premised upon an overwhelmingly Westernised worldview of mental health. The understanding of mental illness among citizens of non-western nations is largely problematic because it differs from the Westernised perspective (Watters, 2010). For instance, South Africa is known to have a rich socio-political history, with culturally diverse groups. The different tribes view mental illness differently. According to Seligman and Csikszentmihalyi (2014), the movement towards conceptualising mental illness in a more culturally inclusive perspective has been underway globally. The implication thereof is that the foundations of a more socially and culturally well-versed comprehension regarding mental health have been laid.

According to Wade and Halligan (2017), the Westernised method of dealing with mental illness in the nineteenth century was the bio-medical ideal of medication. The Bio-medical model advocates that mental illnesses or disorders are generally neuro-physiological, as iterated by Deacon (2013). Pharmacological intervention is emphasised when treating the assumed natural anomalies of the brain. Schomerus et al. (2012) iterate that the Bio-medical model underpins nineteenth and mid-twentieth century formation of mental sickness, which have ruled practice and policy strategy and practices in the worldwide health services framework for decade. Western psychiatric and psychological practice utilises the bio-psychosocial model, which considers biological, psycho-social and socialisation aspects

(Schomerus et al., 2012). The conceptualisation of mental illness using the Bio-psychosocial model shows that mental disorders are influenced by predisposition due to genetic and/or environmental stressors. Álvarez, Pagani and Meucci (2012) postulate that this then causes forms of dysfunction that present in various forms of mental disorders.

Contrary to the above, Leavey, Loewenthal and King (2016) found that Africans tend to conceptualise illness as being socially constructed. Moreover, Semrau et al (2015) state that Africans' understanding of mental disorders is deeply rooted in views reinforced through the presence of spirits that were inherited from ancestors that are believed to affect an one's wellbeing and health (Semrau et al., 2015). Akomolafe (2012) posits that the cause of mental illness in many traditional societies is understood to be the reason for hardships and ill-health linked to activities of supernatural agents. Moreover, perspectives gained from Africa, indicated that mental illness has been treated as a subject that was taboo, which may stem from the societal stigma linked to mental illness, which Amuyunzu-Nyamongo (2013) referred to as a silent pandemic.

The aforementioned literature proves that the conceptualisation of mental illness is seen differently by culturally diverse groups. Various studies have been conducted on the understandings and conceptualisations of mental illness (Burns, 2011); (Engelbrecht & Kasiram, 2012); (Furnham & Hamid, 2014). Perspectives on mental illness are informed through epistemological imbalances, which various authors such as Akomolafe (2012) and Burns (2011) purport as concluding that Western conceptions are favoured as compared to non-Western or indigenous perspectives. In the South African healthcare system, Westernised and indigenous conceptualisations play a crucial role.

Lasalvia (2015) posits that understanding of mental illness is influenced by thoughts, knowledge and perceptions towards individuals who are identified as being mentally ill. Furthermore, Ukpong and Abasiubong (2010) indicate that individuals with mental illness are also confronted with prejudice, stigmatisation and isolation. Mentally ill individuals are perceived as alienated or as deviating from the prevailing societal norms, as shown by various studies by (Barke, Nyarjo and Klecha, 2011) and Lauritzen et al., (2015). Globally, there is evidence that poor knowledge, lack of insight and misconceptions towards mental illness contribute to the hostility of affected persons (Barke et al., 2011; Bener & Ghuloum, 2011; Chikaodiri, 2009; Ukpong & Abasiubong, 2010).

University students at multicultural universities like the University of KwaZulu-Natal may offer perspective that is unique on the difficulties of the dominant knowledge and held perceptions regarding mental illness. Generally, tertiary education institutions are deemed to prioritise freedom and expression, production of knowledge, where critical thinking is encouraged, conducting this research based on the understanding and perceptions of mental illness in the context of students in institutions of higher learning relevant as it may produce valuable data. A review of literature indicates that most studies on the knowledge and perceptions amongst the university population towards mental illness have not been of qualitative in nature, for example studies by Ali et al. (2017), Hyde (2011) and Furnham and Hamid (2014).

### **1.1 Research problem**

In recent years, mental health issues amongst university students have been identified as an increasing concern (Brown, 2018; Evans et al., 2018; Xiao et al., 2017). A survey conducted by the World Health Organization on students across 21 countries found that the criteria for a mental disorder was at least met by one-fifth (20.3%) of the population in the previous year (Aurbach et al., 2016). The movement to de-colonise the field of Psychology for the purpose of including indigenous knowledge systems is of particular interest to how mental illness would be conceptualised and understood (Cruz & Sonn, 2015). Researchers argue that knowledge and perceptions of mental illness are shaped by Western hegemonic perspectives, aetiologies and diagnostic systems (Akomolafe, 2012; Aphane, 2015; Burns, 2011). According to Akomolafe (2012), “these perspectives are at odds with prevailing constructed beliefs and practices of culturally diverse groups that characterise South Africa’s population”. This means that in comparison to their Western counterparts, African countries may hold contrasting views when conceptualising mental illness, especially in South Africa where there is evidence from Burns (2011) and Engelbrecht and Kasiram (2012) that individuals are informed by cultural and societal norms.

The conceptualisation of mental illness amongst the youth is of particular significance. This is a critical period, as McGorry, Purcell, Goldstone and Amminger (2011) found that many mental disorders manifest during adolescence and early adulthood. By 2010, 10-20% of young individuals experienced mental health complications, globally (Herrman, 2011; United Nations General Assembly, 2010). Whiteford et al. (2013) assert that, globally, young people are excessively affected by mental syndromes and associated at-risk

behaviours. Mental health difficulties account for many ailments amongst young adults in all cultures. There is evidence indicating how understanding and perceptions of mental illness is formed based on culture and socialisation by Ali et al. (2017), Hyde (2011) and Furnham and Hamid (2014).

The aim of this study is to increase knowledge and understanding mental illness and to remove barriers to help seeking behaviour. This study seeks to close the gap in the extant literature by exploring the difficulties/challenges in knowledge and perceptions of mental illness. A Participatory Action Research (PAR) method was used to understand what could be done about such difficulties. O'Brien (1998) states that the advantage of adopting a PAR method is that, unlike other research methods, it is more of a holistic approach to problem-solving, rather than a single method for collecting and analyzing data. Saunders, Lewis and Thomas (2003) describe the goal of PAR as bringing about positive social change through the research process. In keeping with this, the participants had to identify core issues related to perceptions of mental illness, and engage with such issues in order to derive some resolution. These efforts were then assessed (O'Brien, 2001). According to Carr and Kemmis (1986:186), action research adopts a more activist role with the aims to "transform the present to produce a different future", which was in line with the researcher's goal. The four key values of PAR were described by Bostock and Freeman (2003) as empowerment, support and relationships, learning and social change.

## **1.2 Study aim**

The aim was to explore the difficulties/challenges in knowledge and perceptions of mental illness amongst a selected student population using Participatory Action Research with Psychology master's students from the University of KwaZulu-Natal.

## **1.3 Study objectives**

**1.3.1** To identify difficulties in obtaining knowledge about mental illness and how it affects help-seeking behaviour amongst a selected student population.

**1.3.2** To engage in an action-based research intervention related to addressing the identified difficulties of knowledge and perceptions of mental illness.

## ***1.4 Research questions***

**1.4.1** What are the difficulties in knowledge and perceptions of mental illness that exist and how are they affecting help-seeking behaviour amongst the student population?

**1.4.3** Which interventions related to addressing difficulties of knowledge and perceptions on mental illness are recommended by students from the selected university?

## **1.5 Key concepts**

This study utilised different key concepts imperative to the clarity of the study. These are listed below;

### **1.5.1 Knowledge**

Oxford Dictionaries (2017) defines Knowledge as facts, information and skills acquired through experience or education. In the context of health, knowledge includes “information acquired about the prevalence; aetiology; risk factors; prevention; transmission; pathophysiology; symptomatology; progression; recommended action in the presence of specific health problems; treatment; precautions; sequel, existence and availability of healthcare services; and patients’ rights” (Trevethan, 2017, p.2).

### **1.5.3 Participatory Action Research**

Participatory Action Research is an approach to research in communities that emphasizes participation and action, as per the definition offered by Saunders, Lewis and Thomas (2003).

### **1.5.4 Perceptions**

Perceptions are defined by Höijer (2011) describes perceptions as how one regards, understands or interprets something, and which may include common ways in which one may conceive, ponder and evaluate a social phenomenon.

### **1.5.4 Mental illness**

According to the Diagnostic and Statistical Manual of Mental Disorders – 5 (DSM-5. 2013) mental illness is a recognised disorder which is characterised by a clinically significant

disturbance in an individual's cognition, emotion regulation, or behaviour. Such a disturbance reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. Accompanying this definition there are a myriad of requirements that must be met to make a diagnosis and subsequent recommendations for treatment (Pescosolido & Martin, 2015). The cultural and social environment of an individual is also considered when diagnosing and assessing for mental illness as conceptualisations of mental illness are constructed differently depending on cultural, social, religious and context-specific variants (APA, 2013).

### **1.5.5 Student population**

Student population in a tertiary institution refers to pupils post-secondary school, attending organised tertiary learning and training activities for professional development in fields such as arts, humanities, technology, science and other more specialized fields (Assié-Lumumba, 2005).

### **1.6 Significance of the study**

Mental health issues amongst the university population has been identified as a critical issue for higher education; it is rapidly increasing and viewed as an epidemic (Gallagher, 2012; Bedell, 2016; Offord, 2016, Sanghani, 2016). It has a significant impact on the lives of the youth, as it affects their academic achievement, self-esteem and interpersonal relations (Zins, Bloodworth, Weissberg, & Walberg, 2004). According to Sheals, Tombor, McNeil and Shahab (2016), international studies indicate that individuals have difficulties identifying and comprehending concepts related to mental illness. As a result, Jorm (2012) indicated that poor mental health knowledge is also a contributing factor to preventing individuals with symptomology for mental disorder to help-seeking behaviours. Understanding of mental illness influences decision making, interaction and communication. It is assumed that certain universal facts regarding mental illness may be embraced by all, and the benefits that come with this process include what Jorm (2000) describes as individuals being able to identify potential mental health difficulties, promotion of help-seeking behaviours from professionals, adherence to effective treatment and giving support to individuals diagnosed and living with mental illness.

This study aims to understand the difficulties in knowledge and perceptions of mental illness amongst the student population. The use of PAR aims to encourage behaviour and attitude

change towards mental illness, and to de-stigmatise mental illness within societies. This is done through mental health literacy, which aims “to replace myths about mental illness with correct information,” (Corrigan et al., 2002, p.189). Moreover, this particular study aspires to enlighten readers on culturally and socially formed perspective of knowledge systems related to mental illness at a culturally diverse tertiary education institution. Findings from this study may furthermore function to enlighten help-seeking behaviours, also to possibly address interventions in the near future on mental disorders in tertiary institutions.

## **1.7 Structure of the dissertation**

This dissertation consists of seven chapters, these chapters address the overall aim of the study, the aspects are summarised below;

### *Chapter One: Introduction*

Chapter one serves as a road map as it gives direction and informs the reader on what to expect in the document. This chapter presents the study by providing relevant background information, outlines the research problem, the purpose and research objectives. It also summarises the significance of the study.

### *Chapter Two: Literature review*

This chapter reviews the relevant literature to the study. The presentation of the literature is under sub-headings which include; the global perspective of the prevalence of mental illness, mental health literacy in developing countries, understanding and beliefs about mental illness and also understanding and beliefs in treatment of mental illness in countries that are still developing. The last section of this chapter presents literature on stigma related to mental illness and studies on mental illness amongst the student population.

### *Chapter Three: Theoretical framework*

The theoretical frameworks that underpin this study is detailed in this chapter.

### *Chapter Four: Research methodology*

This chapter provides the methodological outline of the study. It begins with explaining the research methodology and the phases that the research study embarks on till the end. Then the study design and approaches, followed by the research paradigm, and a short description of

the role of the researcher in the study. This section also covers the selection of participant, data collection instruments, methods used for data collection and data analysis. This chapter concludes with presentation of ethical considerations.

#### *Chapter 5*

The focus on this chapter was on the participants' biographical data and the data analysis.

#### *Chapter 6*

This chapter focuses on the discussions of the analysed data from both the qualitative and quantitative aspect. It also gives narratives to support the main themes gathered.

#### *Chapter 7*

This chapter reviews the research questions along with key objectives in light of the literature, and conclusions are drawn, leading to future recommendations.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.0 Introduction**

Deliberations on knowledge and perceptions of mental illness/health have hardly attracted robust considerations, especially amongst the student population. Much like other areas of mental health studies, the knowledge of mental health on the one hand and the perceptions of mental health on the other have only attracted sparse attention within the context of South African higher education. Thus, pertinent to this chapter is the need to summarize and synthesize scholarly discussions on the theme of knowledge and perceptions of mental illness, and other related issues that dovetail into the research questions. Before exploring the relevant themes, it is important to explain the concept of a literature review. Collins and Hussey (2013) postulate that a literature review accustoms the researcher with significant information needed for the uncovering of novel knowledge through the unearthing of existing research chasms.

The literature review in this study is arranged in a way that comprises varied empirical arguments from peer-reviewed journals and other related research outputs. The first segment of this chapter begins with the prevalence of mental illness, both globally and locally. It also focuses on factors that influence mental health. The second section of the chapter delves on issues related to mental health literacy; knowledge and beliefs of mental health in Africa; and the treatment of mental illness from an African perspective. The third section reflects on stigmatization of mental illness. Lastly, the fourth section deliberates on studies that are pertinent to knowledge and perceptions of psychological illness amongst the student populace.

### **2.1 The prevalence of mental illness: a global perspective**

A directory of 301 illnesses revealed that globally, mental health complications are one of the foremost sources of the general disease burden (De Hert et al., 2011). Globally, mental health complications constitute 21.2% of years survived with debility (Vos et al., 2013). Consistent with the 2013 Global Burden of Disease investigation, the WHO (2014) reported that globally, the principal mental health difficulty is depression, followed by anxiety, schizophrenia and bipolar syndrome. According to Briggs (2013), in 2013, depression was the second foremost reason of years survived with disability globally, after lower back pain,

whilst in 26 countries, depression was the key driver of disability. Ferrari et al. (2010) assert that “depressive syndromes add to the strain of suicide and heart disease on death and disability, which together have an uninterrupted and ancillary impression on the extent and superiority of life”. The World Health Organization (WHO) appraises that between 35% and 50% of individuals with stark mental health complications in established countries, and 76 – 85% in un-industrialized nations, obtain no treatment (Demyttenaere et al., 2004).

The Global Burden of Disease Study (2010) assessed that 400 million individuals were agonised by depression, whilst a further 270 million suffered from anxiety ailments, 59 million from bipolar conditions and 24 million suffered from schizophrenia. The study also indicated that 140 million individuals were plagued by liquor and drug conditions (Whiteford et al., 2010; WHO, 2014). In 2016, Vos et al. (2017) report that there were 1.1 billion individuals living with mental health and substance exploitation ailments and in all but four nations internationally, major depressive syndromes featured among the top ten causes of sickness. Most individuals living with mental health complaints are found in low- and middle-income countries (LMICs), which include South Africa (Wang et al., 2007). The extraordinary occurrence of mental disorders in LMICs can be attributed to struggle and disturbance; starvation and scarcity; poor admission to well-being and social maintenance; and social dissimilarity (Kohrt et al., 2012). Regardless of the high pervasiveness of mental disorders in LMICs, these nations devote under 3% of their health resources to mental healthcare although mental disorders account for 25.5% of the years lived with debility (WHO, 2011; 2014). The Department of Health (2013) in South Africa states that neuropsychiatric illnesses are tiered third in their involvement in the burden of diseases, after HIV/AIDS and other communicable infections. In a 12-month examination of mental health conditions in South Africa, Herman et al. (2009) found that the most predominant mental disorder was anxiety (15.8%), followed by substance consumption conditions (13.3%) and mood maladies (9.8%).

The pervasiveness of post-traumatic stress disorder (PTSD) in patients appearing in public health clinics in South Africa was as great as 19.9% in the timeframe 2003–2004. Throughout the equivalent period, females were expected to be identified with major depressive syndrome, 1.75 times more than their male counterparts (Grobler et al., 2013). Men are at an amplified threat of mounting substance-use syndromes (Department of Health,

2013). There has been an intensification in the sum of circumstances connected with mental health disorders conveyed in the media in South Africa. Further, the encumbrance of mental disorders is highlighted through its co-morbidity with other sicknesses, including HIV (Seedat, 2013).

The most dominant mental disorders amongst university students are depression, anxiety and stress, with Field et al. (2012) iterating that depression is the most frequently identified mental ailment among university students in many countries that include Spain, England, Australia and the United States of America. The pervasiveness of depression amongst first-year female undergraduate students in Canada and the United States of America was twofold, that of their masculine complements: 14% and 7% correspondingly (Field et al., 2012). Nevertheless, Vaez and Laflamme (2008) indicated that female university students utilised health amenities when compared to their male counterparts. Further, in terms of those who had required maintenance, the number of females (64.8%) was meaningfully greater than that of males (35.2%) (Vaez & Laflamme, 2008). Male students often repudiated, or unsuccessfully expressed whether they had used mental health facilities throughout their university program.

The outcomes of Vaez and Laflamme (2008) were consistent with Burris et al. (2009) that female students had apparent inferior mental health eminence in compared to the male students, and were more susceptible to depression throughout university. Miller and Chung (2009) found that 43.2% of university students had such stark depression, indicating that working within the academic background was a trial. Consistent with Field et al. (2012), as many as 86% of universities investigated in the interior of the United States of America acknowledged cumulative degrees of depression within academic institutions. Depressive indications led to inferior academic performance among the affected scholars and increased their susceptibility to supplementary mental health difficulties: counting anxiety, invasive thoughts, regulating intrusive thoughts and sleep instabilities (Field et al., 2012).

Anxiety syndromes are extensively widespread and they constitute one of the most communal categories of mental health difficulties among students (Aldiabat et al., 2014). Further, 75% of 40 million Americans identified with anxiety indicated that they experienced their primary incident of anxiety at the age of 22 years. The pervasiveness of depression,

together with anxiety was 15.6% among scholars and 13% among graduate students (Eisenberg et al., 2007). Panic conditions and comprehensive anxiety disorders were not as predominant amongst scholars and alumnus students, with 4.2% and 3.8%, respectively. According to Eisenberg et al. (2007), the proportion of anxiety complaints amongst female students was twice that of their male counterparts. Ibrahim et al. (2013) focused on the occurrence and forecasters of anxiety and depression amidst female medical undergraduates in King Abdulaziz University, Saudi Arabia. The results indicated that the pervasiveness of anxiety was 34.9%. The anxiety emanated from abridged practical courses, academic disappointments and emotive aspects through the six months prior to the study. The main deduction made by Ibrahim et al. (2013) from these revisions was that anxiety can cause morbid ideation, substance misuse, physical disorders, hazardous sexual behaviour, and has an undesirable influence on the reasoning and erudition aptitudes amongst university students.

Although stress is neither categorised nor acknowledged as a mental ailment, Seedat et al. (2009) state that it is measured as one of the greatest risk features that leads to or is associated with mental illness. Stress is identified as one of the most dominant threat features for mental sickness amidst university students since they must deal with an immense assortment of dissimilar educational, communal and individual trials (Bray et al., 2004; Oman et al., 2008; Waghachavare et al., 2013). For example, 36% of university students in the United States of America were overwhelmed, while 36% of all scholars were intellectually fatigued. In Saudi Arabia, Sani et al. (2012) investigated the pervasiveness of stress amidst medical students in Jizan University and discovered that the frequency of stress amongst medical students was 71.9%, with females being more stressed (77%) than their male counterparts (64%).

The foremost features linked with professed stress amongst students were extensive hours of schoolwork, examinations, and very constricted time agendas. Further, psychosomatic and domestic concerns, the non-existence of entertainment in the university grounds, and the schooling structure itself were identified as other factors contributing to stress (Pascoe et al., 2019). Research has shown that ongoing stressors have undesirable stimuli on both bodily and cerebral health, which consumes a person's drive and may lead to reduced functional efficiency (Oman et al., 2008). According to Waghachavare et al. (2013),

assimilating stress-controlling mechanisms into university prospectuses will be supportive in mitigating the occurrence of this difficulty and other mental health complaints connected to stress.

## **2.2 Mental health literacy**

Wickstead and Furnham (2017) assert that the conceptualisation of mental illness requires that the attainment of mental health literacy is prioritized, as studies that have compared mental health literacy and health literacy indicated that people are more knowledgeable about physical health than mental health. As a concept, “mental health literacy” got introduced by Jorm et al. (Jorm et al., 1997, p.182) referring to the “knowledge and beliefs about mental illnesses which aids in their recognition, management and/or prevention”. The introduction of this concept contributed positively to policy, and it informed many interventions (Jorm, 2015). Mental health literacy encompasses the capability to identify specific disorders, as well as knowledge on seeking mental health facts and information regarding causes and risk factors on mental health. Moreover, one’s knowledge of self-treatments and views aimed at promoting appropriate help-seeking behaviours in those affected embraces Jorm et al.’s (1997) concept of mental health literacy (Jorm et al., 1997).

In the current study, the key concepts relating to mental health literacy are inclusive of the following: “(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 behaviours; and (f) knowledge of how to seek mental health information” (Jorm, 2000, p.396). Low mental health literacy can influence a decreased perception of need, as well as subsequent utilisation rates, according to Gagnon, Gelinis and Friesen (2015). Failing or delaying to seek appropriate treatment may result in adverse effects and may increase one’s chances of developing more severe mental health consequences. To the contrary, early management leads to a reduction in disabling symptoms (Eisenberg, Hunt, & Speer, 2012; Jorm, 2000).

Proof of insufficient mental health literacy became evident, especially amongst the student population. For example, Farrer, Leach, Griffiths, Christensen and Jorm (2008)

indicated that 27% of college-aged students suffer from a diagnosable mental disorder. Sixty-four percent of students dropped out of college due to a mental disorder (NAMI, 2012). Research suggests that college students are unable to effectively recognise their own symptoms or mental illness (Vanheusden et al., 2008). Furnham, Cook, Martin and Batey (2011) assessed students' mental health literacy and only eight of the ninety-seven mental disorders listed were recognised by most respondents. In another study Farrer et al. (2008) found that less than 50% of the youth was able recognise depression, and an estimated 25% could precisely identify psychosis.

The increasing onset of mental illness, along with decreased mental health literacy amongst the student population suggests poor seeking behaviour among this group. Poor mental health literacy that causes decreased help-seeking behaviour amongst college students has the potential to negatively influence academic success and educational attainment, as shown by Kessler, Foster, Saunders and Stang (1995) and Eisenberg, Hunt and Speer(2012); productivity and employment (Wang, et al., 2007; Eisenberg, Hunt & Speer, 2012); social relations (Wang, et al., 2007; Eisenberg, Hunt, Speer &, 2012); and the use of substances, as per Weitzman (2004). A study focusing on help-seeking behaviour amongst the youth found perceived stigma, difficulties in identifying symptoms (poor mental health literacy) and individuals preferring to be self-reliant as the most crucial barriers to help-seeking (Gulliver, Griffiths, & Christensen, 2010). These findings suggest that the promotion of mental health literacy among students is important.

### **2.2.1 Mental health literacy in countries that are developing**

Estimates by Jorm (2012) suggest that the incidence of mental illnesses in developing countries are equally high as the rates in countries that are developed. The prevalence rate of common mental illnesses across five countries that are still developing, namely Lesotho, Zimbabwe, Pakistan, Chile and Brazil found a median range of 20% - 30% (Acharya, 2001). Extant literature by Jorm (2012) indicates that in developing countries, mental health literacy is sparse, especially in comparison to already developed countries. Mental health literacy that is poor is more concerning in both countries with low and middle-income due to distorted views on mental well-being, such as difficulty in accessing mental health services (Ganasen et al., 2008). In addition, poor mental health literacy shapes the beliefs and attitudes that

society hold in relation to mental health, attitudes and beliefs. These often lead to stigma and discrimination regarding mental illness. Poor mental health literacy results in delays in the early detection and treatment of mental ill-health, adding to the burden of disease and the ever-growing “treatment-gap” between the need for, and access to, mental health services (Kelly, Jorm, & Wright, 2007).

In South Africa, Jorm (2012) avers that the low level of mental health literacy has been proven to result in negative connotations in terms of behavior towards treatment and help-seeking efforts for mental illness. Furthermore, the public’s perceptions of mental illness are associated with the country’s unique socio-political and cultural landscape (Ventevogel, Jordaan, Reis and de Jong, 2013). This could best explain why South Africa has high levels of traditional treatment, given that traditional healers are integrated within the country’s healthcare system (Aphane, 2015). Jack et al. (2013) argue that for treatment to be more efficient, and to increase access to care, mental healthcare treatment needs to be integrated into existing traditional health systems.

The need to recognise mental health is one of the strands of mental health literacy that informs the knowledge and behaviour of the community towards the mentally ill person (Corrigan, River, & Penn, 2014). In South Africa, a study was conducted with the aim of establishing the status of mental health knowledge and interventions implemented to counteract stigma or prejudice (Kulumal et al., 2010). The findings indicated that knowledge about mental health was generally. Furthermore, conclusions indicated that anti-stigma campaigns and interventions to increase knowledge were required. Ganasen et al. (2008) stated that irrespective of ethnicity or socio-economic status, improved treatment of the mentally ill could be predicted by good mental health knowledge. South Africa’s mental health literacy can be best explained by what Jorm (2012) alludes to as more pressing concerns like economic constraints and other societal issues. According to Sue, Sue and Sue (2003), developing countries may focus on more essential standard needs for human survival such as nourishment and housing, whilst not prioritizing mental healthcare needs. This is an indication that knowledge is inadequate and information about psychiatric disorders are incorrect and that mental health literacy in South Africa is not prioritized.

### **2.2.2 Understanding and views about mental illness in countries that are developing**

According to Rogers and Pilgrim (2014), research indicates that the comprehension of mental illness in developing countries is not individualized nor universal. However, mental illness is socially constructed and defined. Arrendondo & Toporek (2004) state that the nature of mental illness, its determinants, and causes are all conceptualized differently in various societies and among populations. The beliefs and knowledge related to mental illness are described by Jorm (2012) as being deeply rooted in such aspects as existing social conceptions, culture and personal beliefs.

Research conducted in the sub-Saharan region indicated that respondents were not able to recognise psychiatric illnesses and believed that supernatural factors were the causes of mental illness (Atilola, 2014). In developing countries, Jorm et al. (1997) cite studies that indicate that major depression and schizophrenia are the easiest to identify as constituting mental illness. In both developing and developed countries schizophrenia is mostly confused with other mental disorders (Jorm, 2012). In addition, according to Furnham and Hamid (2014), mental disorders such as anxiety or personality disorders were misunderstood, as compared to major depression and schizophrenia.

Knowledge and beliefs about mental illness through the lens of African societies is no doubt predicated on the unusual attitude towards the mentally ill individual, which is evidently obvious in their rejection by members of the community (Bourget & Chenier, 2007). Mental illness is believed to be the proprietorship of evil spirits, sorcery or curses (Chikomo, 2011). Ajala and Okeke (2015) conducted a study in Nigeria, investigating knowledge, attitudes and views on the cause, expression and remedies of mental illness. Drug abuse, the will of God, and demonic possession were identified as the causal factors of mental disorders (Ajala & Okeke, 2015). These findings pointed to a lack of community knowledge regarding mental illness. Therefore, it is logical to argue that cultural beliefs and attitudes are fundamental causes or attributions of mental illness, particularly those held by most African populations. In a similar study by Oluwanuga and Kola (2006) exploring the nexus between clinically stable out-patients and functional psychotic disorders, findings indicated that many participants explained that mental disorders were predominantly caused by supernatural influences (Oluwanuga & Kola, 2006).

A large concentration of studies conducted on knowledge and beliefs of mental disorders as investigated in Africa, were mainly focused on the West African context. Most of them exuded poor knowledge of causative factors of mental illness. Further, most of them indicated that the mentally ill are hazardous and unfit for normal social cohesion (Khan& Salaiman, 2009). A South African study cited by Mubbashar and Farooq (2010) found that family members of mentally ill persons frequently experience high levels of anger and stigma. While it is generally problematic to generalise the knowledge and beliefs about mental illness, even within the same scope such as geographical continent, a study conducted in Ghana explained that in rural areas, there seems to be a greater dependence on cultural explanations of mental illness (Abiodun, 2013). Another study cited by Aphane (2015) and Ganasen et al.(2008) concluded that beliefs in ancestors and their influence on the spiritual provocations of psychological disorders are rife in developing countries that are non-western.

Across the African continent, people's knowledge and beliefs on mental illness are still largely attributed to supernatural reasons and remedies (Adewuya & Manjuola, 2005). Consequently, these belief systems often result in awkward or self-destructive responses to mental illness (Aghukwa, 2010), which include suicide and delays in seeking treatment (Mubbashar & Farooq, 2010). Moreover, there is an indication that with such poor knowledge and beliefs, the effectiveness of mental healthcare services is affected negatively, hence advancing the contention by policy-makers that mental illness is likely incorrigible or unresponsive to medical solutions (Khan & Sulaiman, 2009). Although there are efforts made to increase acceptance of the mentally ill, Lasalvia (2015) avers that developing countries evidence a lack of awareness about mental illness. According to Olwit (2015), mentally ill individuals are still not socially accepted, and they are still perceived as being different from others.

### **2.3 Understanding and beliefs about treatment on mental illness**

This section of the literature review seeks to unpack the different types of treatment for mental health in developing countries. There is a suggestion that there is a strong connection between culture and causes of mental illness, which also influences treatment methods (Aphane, 2015). Abbo, Ekblad, Waako, Okello and Musisi (2009) Studies conducted in many Africa countries which found that traditional healing practices were preferred to psychiatric treatments. Alphane (2015) postulates that indications are that "individuals are motivated to

seek help for mental illness based on their knowledge, belief systems and prevailing social paradigms”.

A study conducted in Ethiopia explained that those who believe in unnatural causes of mental illness opt for traditional practices a form of treatment (Highet, Hickie, & Davernport, 2002). In Malawi, a study on beliefs on mental disorders explained that mentally ill individuals who held beliefs in mystical reasons had less compliance with medical treatment as they consulted to traditional doctors (Crabb et al., 2012). Similarly, in Ethiopia, use of witchcraft, herbs and holy water as treatment alternatives were preferred to medical treatment, a narrative which Ajala and Okeke (2015) state indicates that in Africa, traditional alternatives are preferred to the application of medical treatment of mental health.

Sehoana’s (2013) study indicated that practitioners in government hospitals use the psychotherapeutic abilities they have obtained through preparation in order to underwrite the management of mental disorders in short-term cases. Assimilating dissimilar modalities came to the fore with the acknowledgement that diverse aspects affect human behaviour (Palmer & Woolfe, 2000; Lombo, 2010). A holistic approach is stimulated among Pedi practitioners in South Africa since most of the patients are from rural settings whereby aiding the client with a group of specialists may similarly contribute to decreasing travelling expenses when amenities are far from patients live (Akinboade, 2008; Sodi, 1987). Treatment procedures pursued in the Pedi community reveal that sufferers first seek native healers. At a later stage, they pursue mental healthcare amenities available at hospitals. Sorsdahl et al. (2009; 2011) indicated that 41%–61% of patients with mental disorders have accessed a traditional healer. However, Mpfu et al. (2011) emphasized that the treatments and rituals vary amongst ethnic groups. These treatments usually seek to maintain a state of equilibrium and preserve the fortification from what is perceived to be the source of sickness (Mkize & Uys, 2004; Shai, 2012).

Furthermore, Mkize and Uys (2004) posit that the services of customary healers are inexpensive when compared with those offered by Western mental healthcare suppliers. The absence of transportation and insufficient information on types of assistance available play a part in the use of indigenous therapists who are eagerly accessible for unremitting care (Peu, Troskie, & Hatting, 2001). Apart from indigenous cultures, Christianity is also a faith that is

usually practiced in the Pedi community. According to Sehoana (2013), patients would repeatedly seek management through prayer and the amenities of the church (Elphick & Davenport, 1997; Truter, 2007).

The use of traditional medicine has deep-seated relevance. It remains one of the widely used treatments in Africa for the treatment of mental illness, especially in sub-Saharan Africa (Mjosund & Eriksson, 2005). This revelation, not excluding South Africa, also has its relevance for the treatment of mental illness (Patel, 2011). In South Africa, traditional healers must be registered for the practice and treatment of mental disorders (Akighir, 2013). However, very little evidence is available to measure their effectiveness and contribution to the treatment of mental disorders in the country (Macfarlane & Alpers, 2009).

Atilola (2014) postulates that in sub-Saharan Africa, there is a severe lack of resources to provide mental health services also, there is poor access to care, with a need for campaigns and initiatives for mental health literacy and knowledge about the various treatment choices that exist. Barriers to accessing care and management of mental illness in Africa is inclusive of the stigma associated with mental illness and the misconceptions that informs both the individual and collective understandings of mental illness (Adewuya & Makanjuola, 2009; Bruwer et al., 2011). Interestingly, there was a study which results indicated that plenty of health professionals had perceptions that are negative towards the mentally ill, something which potentially affected the quality of treatment and health promotion interventions (Sheals et al., 2016).

It appears that in developing countries, there is a complicated interaction between cultural beliefs and the socially constructed nature of mental illness. Literature indicates that the stigmatisation of mental illness contributes negatively to both provision of treatment that is effective and sufficient care.

#### **2.4 Stigma related to mental illness**

The uptake of mental health services is generally lower in developing countries than in countries that are already developed (Schomerus & Angermeyer, 2008; Wang et al., 2007). The help-seeking behaviours linked with the uptake of these services are often as a result of the stigma associated with mental ill-health (Corrigan & Rüsch, 2002; Schomerus & Angermeyer, 2008). Goffman (1963, p.3) defines stigma as an “attribute that is deeply

discrediting”. Rössler (2016) states that stigma can be described at three conceptual levels, namely cognitive, emotional, and behavioural. Stigma is often used to describe the negative and hurtful attitudes held by members of society towards persons with mental illness (Arboleda-Flórez & Stuart, 2012).

Stigma often happens (i) when people identify a particular characteristic as needing a special label or category, and the (ii) attitudes and beliefs held by people, link individuals who have been labelled with undesirable characteristics or stereotypes, (iii) which leads to distinctions being made between labelled individuals, creating divisions between “us” and “them”, (iv) leaving labelled individuals subjected to negative reactions by people, (v) which perpetuates discrimination, disadvantages and results in loss of status, often culminating in unequal opportunities (Link & Phelan, 2001; Link, Yang, Phelan, & Collins, 2004; Phelan, 2005; Stuart, 2006).

Globally, stigma and discrimination related to mental illness have been identified as the highest barriers to effective psychiatric patient care (Saxena, Funk, & Chrisholm, 2014). Dijkster and Koomen (2007) iterate that stigmatisation is usually paired with psychological or physical impairment which may impact an individual or collection. According to Thornicroft (2013), stigma may be understood as combination of negative knowledge, behaviour and perceptions, directed towards someone or something that seems unusual to prevailing societal norms. The discrimination frequency in mental healthcare settings against mental healthcare users ranges from 16% to 44% (Henderson et al., 2014). Egbe et al. (2014) mention that stigma is also found to be a major barrier when accessing psychiatric healthcare and when managing the illness.

There are various types of stigma, ranging from internalised or self-stigma to communal or public stigma and recognized or structural stigma (Cheon & Chiao, 2012). According to Seeman et al. (2016), Self-stigma manifests in individual perceptions of ostracism and indignity, leading to truncated self-confidence, weakened social alteration, joblessness, estrangement, pulling away from others and suicide. Structural stigma is replicated in strategies and practices of health suppliers that act as a hindrance to mentally ill individuals, occasioning in incomplete admittance to superior healthcare as compared to other illnesses (Pederson & Paves, 2014). This produces barricades to pursuing assistance, patient security and observance to management by people with mental health illnesses, owing to their fear of being branded (Seeman et al., 2016). Oxele et al. (2017) refer to public stigma as the

judgement of mentally ill individuals by the overall population, which results in the internalisation of perceived undesirable approaches and beliefs. Regardless of the type, Clement et al. (2015) found that stigma related to psychological illness worsens poor self-esteem, exclusion from society, and increases social anxiety.

Stigma and judgement do not only disturb individuals with mental illnesses, but affect their households and caregivers. People in developing countries experience greater intensities of humiliation and embarrassment than those in developed countries. This is due to traditional inspirations and the absence of admission to mental health awareness edification, according to Pederson and Paves (2014). Lack of knowledge about mental illness perpetuates the stigma suffered by the mentally ill. Furthermore, Kupungwe et al. (2010) assert that those individuals diagnosed with psychiatric conditions experience difficulty integrating into society.

Sadler, Kaye and Vaughn (2015) postulate that stereotypical opinions filter through diverse cultural and social settings. Western countries portray undesirable beliefs about individuals with mental illness such as being violent and dangerous, which Kapungwe et al. (2010) contend also perpetuates negative stereotypes. Similarly, some collective cultures portray the mentally ill as a threat to others and themselves, and this further continues discrimination and stigmatisation against individuals with mental illness (Chikaodiri, 2009).

Egbe et al. (2014) maintain that stigma towards mental illness on the African continent is high. Studies conducted within Africa, cited by Chikaodiri (2009) indicate that people who are diagnosed with mental illnesses are perceived as being non-rational and are normally considered to be 'filthy, violent and dangerous'. Furthermore, other studies found that some communities revealed that mental illness was believed to result from ancestral glitches or wicked spirits (Richman & Hatzenbuehler, 2014). Such perceptions exacerbate the social isolation of the individual with mental illness and their families, with commensurate negative impacts on their life (Gureje et al., 2005).

The reduction of stigma has been identified as crucial in improving mentally ill infected and affected lives (Egbe et al., 2014). Globally, mental healthcare awareness programmes are implemented. However, Ukpong and Abasiubong (2010) assert that mentally ill individuals face an increased chance of being ostracised, given negative labels, being ill-treated and not being understood by society. Furthermore, studies conducted within the

African continent indicate that most people's beliefs and attitudes towards the mentally ill are negative. This is exacerbated by poor understanding on mental illness (Barker et al., 2011).

## **2.5 Studies on mental health amongst the student population**

Fleming et al. (2012) describe a quantitative study at a university in Dublin (Ireland) where an appraisal of the association regarding the negative perceptions of mental illness and that of sexual category, self-empathy and fulfilment with life was conducted. This study explored the opinions of psychology students and contrasted this with the perceptions of law students regarding mental illness. The study revealed that knowing somebody with a mental illness in the midst of pursuing one's studies in a course that places significance on mental health, brought about optimistic views on those with mental illness (Fleming et al., 2012). The conclusion of the study reinforced other studies, which demonstrated that advanced education levels prompt progressively positive perceptions about mentally ill individuals, in addition to increasingly precise information about mental illnesses (Jorm, 2012; Fleming et al., 2012).

The utilisation of psychological interventions amongst student populace at the University of Cape Town (UCT) by Flisher, De Beer and Bokhorst (2002) discovered that ladies belonging to the 20- 24-year age group were prone to seek treatment for mental health problems when compared to their males counterparts for seeking mental health treatment. Furthermore, the investigation demonstrated that emotional wellness facilities at UCT were under-used, as only 4% of the student population consulted with the service. The researchers' conclusion was that the mental healthcare services were restricted due to stigmatisation and discrimination that may accompany students who seek these services. Poor utilisation of healthcare services was exacerbated by uncertainty regarding the level of privacy practised whilst visiting the psychological well-being facility (Flisher, De Beer, & Bokhorst, 2002).

Nursing students were found to possess more compassionate perceptions regarding the mentally ill when contrasted with business students, according to Vijiyalakshmi et al. (2013). In this study, findings indicated that the students who studied nursing were of the view the mentally ill are capable of acquiring jobs and perform generally sound in the community, succeeding management. Nursing undergraduates indicated to possess fewer

critical arrogances towards the psychologically indisposed and accepted that the general population are commonly partial when dealing with the mentally ill (Vijayalakshmi et al., 2013). The researchers' conclusion was that nursing undergraduate's perspectives and other healthcare specialists are encouraging compared to business students and the overall population because of the disposition of their field of study in a health and health-related field.

Zolar, Strbad and Svab (2007) sought to determine whether psychiatric training influenced stigma against individuals with mental illness among a student populace. The results indicated that students whom had finished their psychiatric training as an aspect of their coursework possessed more positive perspectives about the mentally ill than undergraduate student who had no exposure to psychiatric training. Nonetheless, notable themes that emerged from the study uncovered that distress and estrangement aimed at the psychologically ill were noticeable, whilst psychologically ill people were seen as being inept. This pattern was reflected in both first and third world countries, and South African is no exception (Dietrich et al., 2006; Zolar et al., 2007).

A qualitative study by UCT academics sought to uncover university students' perceptions of mental illness (Hyde, 2011). The sample comprised 13 respondents from four individual school divisions. The themes that emerged from the investigation uncovered interrelated aspects, which might have contributed to the formation of undesirable opinions. When defining mental illness, Hyde (2011) states that respondents neglected to see psychological illness as taking place alongside a range and deliberated the term mental illness to identify with being insane. Insights on the reasons for mental illness, for example biological, traditional and social, were discovered. With regard to other accessible written works highlighting the traditional and socially assembled explanation of mental illness (Aphane, 2015), topics on religion, mysticism, and black magic emerged (Hyde, 2011). Moreover, in this study, the author highlighted that research on this topic in South Africa was scarce and a recommendation was investigate further in this particular field.

This literature suggests that negative perceptions of those with mental illness are lessened with individuals who poses higher learning and or who are exposed to individuals with mental illness. However, it is evident that amongst the student population, negative

attitudes towards those with mental illness is rife. Moreover, the literature indicated that perceptions on mental illness and help-seeking behaviours comes from knowledge base that exists amongst students on aspects of the causality of mental illness, and their cultural attributions.

## **2.6 Conclusion**

Perceptions on mental illness are shaped by one's culture and belief system, which determine the treatment pathway for that particular individual. Through the literature reviewed evidence indicate that mental illness is a pandemic that affects all, either directly or indirectly, and that there are various factors that contribute to psychological disorders. It was clear that mental health literacy was insufficient in both developed and developing countries. The complicated relationship between one's cultural beliefs and perceptions of mental illness was also found to be socially and culturally constructed in countries still developing, they were also found to affect help-seeking behaviours negatively.

Difficulties in understanding mental illness were viewed to be generally negative because of negative attitudes, stigmatisation and the discrimination that exists. However, extant literature revealed that student populations displayed a better understanding of mental illness compared to other groups. All these themes were discussed to appreciate and lengthen the students' difficulties in knowledge and perceptions of mental illness. The next chapter introduces the theoretical framework underpinning this study.

## **CHAPTER THREE: THEORETICAL FRAMEWORK**

### **3.0 Introduction**

This chapter is a presentation of the theoretical framework, which underpins the study. The theoretical framework is deemed necessary as it gives meaning to a research study (Imenda, 2014). Grant and Osanloo (2014) describe the theoretical framework as the 'blueprint' or guide for research. Moreover, Adom, Hussein and Agyem (2018) caution that a research study that does not have a theoretical framework is problematic for readers when determining the academic position and the core factors leading to the researcher's hypothesis. Akintoye (2015) asserts that research findings become more generalisable and meaningful when a theoretical framework is utilised. According to Grant and Osanloo (2014), there is an expectation that all aspects of the research are linked to the chosen theoretical framework. In this study, two relevant theories that underpin the knowledge base of the phenomenon under investigation were used.

Giddens (1991) purports that the biology of human advancement is the logical investigation of the dynamic, shared settlement for the duration of the existence between a functioning, developing person and the changing properties of the prompt settings wherein the developing individual lives. Giddens (1991) further iterates that this human advancement process is influenced by the relations between these settings and the bigger locales in which the settings are inserted. To dissect this person-environment interaction, this study is informed by two theories that are relevant to the study: Bronfenbrenner's Ecological Systems Theory and the Theory of Social Representations. Bronfenbrenner (1989) built up his Ecological Systems Theory by seeking to characterise and comprehend human improvement within the setting of the arrangement of connections that structure the individual's condition.

### **3.1 Bronfenbrenner's Ecological Systems Theory**

According to Bronfenbrenner's underlying hypothesis (2002), the environment comprises four layers of frameworks, which connect in complex manners and can both affect and be influenced by the individual's advancement. He later included a fifth measurement that involves the component of time. This hypothesis can be stretched out to display the advancement of an association and is especially suitable for depicting the unpredictable frameworks of an educational locale or even of an individual place of learning (Bronfenbrenner, 2002). Each of the four framework layers is portrayed below.

### **3.1.1 Micro-system**

Bronfenbrenner (1989) underlines that the conceivable significance for improvement of the characteristics of individuals in the immediate environment has added to the first meaning of the micro-system. The microsystem is characterised by Bronfenbrenner (1995) as the example of exercises, jobs and relational connections experienced by a developing individual in a specific setting with physical and material highlights and containing different people with particular qualities of disposition, character and frameworks of conviction. This layer shapes many structures with which an individual has direct contact, with the impacts between the creating individual and these structures being bi-directional.

The individual impacts on and is also affected by the micro-system. In this case, Berk (2000) states that it would be the nearest condition for students and incorporates the structures with which the student keeps up direct contacts. Paquette and Ryan (2001) interpret Bronfenbrenner's thoughts and maintain that at this level, the relations between people occur in two different ways – from the student and towards the student. For instance, a student's parents and supervisors have an impact on their convictions and conduct. However, the student can also have an impact on the parents and supervisor's convictions and conduct. Bronfenbrenner (1989) calls this bi-directional impact and he brings up how such connections exist. Puroila and Karila (2001) postulate that from the outset, the student's connection to others is dyadic and later, the student can deal with a few simultaneous interactive connections.

### **3.1.2 Meso-system**

The meso-system contains the linkages between microsystems (Bronfenbrenner, 2002). Similarly, as the direction of impact between the university and each structure inside the micro-system is bi-directional, and the meso-system includes bi-directional impacts between these different structures. Paquette and Ryan (2001) characterise the meso-system by saying that this layer produces the associations between the student's micro-systems. For example, associations between the student's supervisor and guardians or the student's church and the neighbourhood. A case of the meso-system of an individual university can be found in the connections and elements between two of its microsystems, students and parents.

Parental assumptions about the scholarly and extra-curricular achievements of their children who are studying can regularly make a powerful and impactful environment and atmosphere for the university. Absurdly, Penn (2005) states that high desires and low resilience for

disappointment can create a dynamic between parents and students that is portrayed by pressure and dread. This dynamic affects the university experience in different immediate and aberrant ways. For instance, the student's conduct in the lecture hall coming about because of such expectations. Pressures to ensure the child's prosperity is placed on university staff by the parent; or an endeavour by school faculty to shield students from such parental weights by confining the amount of information that is imparted with respect to student accomplishment (Penn, 2005).

### **3.1.3 Exo-system**

The exo-system relates to the bigger social framework and includes occasions, possibilities, choices and approaches over which the developing individual has no impact (Harkonen, 2003). The exo-system in this manner applies a uni-directional impact that is straightforward, or by implication, impacts the developing individual. According to Harkonen (2003), the exo-system of an individual university may be involved with such structures as educational guidelines, financial matters, government order, and local disasters. The inquiry is whether the definition can imply that while the individual is not a member of any condition, the relations between the situations would in any case structure his/her exo-system (Bronfenbrenner, 2002).

### **3.1.4 Macro-system**

The macro-system can be thought of as the "social blueprint" of a given culture, subculture or expansive social setting, and Bronfenbrenner and Morris (2006) describe it as comprising the overall example of qualities, conviction frameworks, ways of life, openings, customs and assets installed therein. This framework is commonly considered to apply a uni-directional impact upon not just the individual, but the small-scale, meso- and exo-systems too. The macro-system of an individual university is typified not just in the social, political, social and monetary atmosphere of the nearby network, but by that of the country in general. According to Bronfenbrenner (2002), the social and theoretical models that are normal for the macro-system are moved, starting with one generation, then onto the next by the methods for various cultural institutions such as family, school, assembly, work environments and organizations that moderate the procedures of socialisation.

Berk (2000) posits that the macro-system is the outmost layer for the student. It has no particular structure, yet it holds the social qualities, conventions and laws. Saarinen et al. (1994) state that the effect of the macro-system will frequently be seen simply in the wake of

making examinations between children and young people, experiencing childhood in various social orders. Similarly, the surroundings of a student, their environment at home and their upbringing will directly affect their perceptions of mental illness.

### **3.1.5 Chrono-system**

The chrono-system is not one of the four framework layers. It relates to a time-based measurement that impacts the activity of all degrees of the natural frameworks. The chrono-system can allude to both short-and long- haul time measurements of the person through the span of a life expectancy, just as the sociologically recorded time measurement of the macro-system in which the individual lives (Bronfenbrenner, 2002). The chrono-system of an individual school in this way might be spoken to by both the everyday and year-to-year formative changes that happen in its student body, teaching staff, curricular decisions and so on, just as the general number of years in activity (i.e. a more up-to-date school faces difficulties and openings that vary from those of a school that has been in activity for a length of time) (Saarinen et al. 1994).

Hence, Bronfenbrenner and Morris (2006) postulate that the difficulties experienced in understanding mental illness amongst students can be addressed immediately and the correct views on mental illness can endure throughout the student body.

### **3.2 Social Representations Theory**

Social Representations Theory was first detailed by Serge Moscovici (2000). It has impacted on the work of analysts from diverging fields. Moscovici (2000), cited in Højjer (2011, p.3) describes “social representation as a collective phenomenon, which is socially co-constructed by individuals within a particular social grouping”. Social Representation Theory (SRT) is used to describe “a set of concepts, statements and explanations that originate from daily life in the course of inter-individual communications... they might even be said to be contemporary versions of common sense” (Moscovici 1981, p.181). Within the South African context, numerous study outcomes highlight the role socialisation plays in the construction of mental illness (Allen, Balfour, Bell, & Marmot, 2014; Jorm, 2012).

Social Representations Theory offers another procedure for reviewing how the media and individuals develop cultural and policy-driven concerns that transpire in the current era, or some particular timespan (Berglez, Olausson, & Højjer, 2009). As a theory of communication, it joins culture and individuals, media and community. The theory is

applicable to media and communication research. It brings to the fore a few communicative instruments, clarifying how thoughts are imparted and changed into what is seen as good judgment.

This study utilised the SRT to understand the way in which knowledge develops in different contexts, the purpose it serves for different groups because the way those different forms of knowledge interact with one another has real transformative power and potential (Krause, 2003; Jovchelovitch & Priego-Hernandez, 2013). This theory was considered fit for this study as it would address “the problem of how socially and culturally shared knowledge influences individual ways of perception, experience and action” (Flick, 2002, p.23). In this study, which was based on the overall student population, the sample comprised a distinct social group that had its own comprehension of mental illness based on social constructs. The student population comprised diverse individuals holding different social representations. Moscovici (2000) avers that one may perceive mental illness as social representations formed through an interaction of one’s beliefs, social practices and shared knowledge that exists within a specific population or society. Such a view emphasises the social nature and origins of individual beliefs and behaviours and recognises the cultural and historical grounding of contemporary beliefs and practices. Foster (2011) postulates that this would mean that individuals and social groups hold existing representations of mental illness, even if these may not be particularly extensive or fully developed. These representations are deemed by Bauer and Gaskell (1999; 2008) as impacting the way that individuals within these social groups communicate, make decisions and interact with members of their own and other groups. The theory offers another procedure for reviewing how the media and individuals develop cultural and policy-driven concerns that transpire in the current era, or some particular timespan (Berglez, Olausson, & Höijer 2009). As a theory of communication, it joins culture and individuals, media and community.

### **3.3 Historical origins of the concept**

The term *social representation* was originally invented by Serge Moscovici in 1961. According to Moscovici (2000), the idea of "social representation" was considered to be "thoughts in movement", formed through communication. The term ‘social representation’ has developed into a theory that Moscovici (1981) addresses it as a structure of knowledge, views, practices, ideas and perceptions among the people within a society or community or that is socially constructed.

People add to the development of social representations in the exchange between social structure and the person (Moscovici, 2000). In contemporary social orders, the individual has some self-sufficiency and acclimatising social portrayals may transform them. People are "set free" from customary restricting social edifices, for example; family, social classification and faith, which previously guided reasoning and conduct (Beck & Beck-Gernsheim, 2001; Giddens, 1994). There is a more prominent level of decision-making concerning elective methods of living and techniques of how to arrive at that point. According to Moscovici (1984), people are challenged with an incredible assortment of particular knowledge with respect to the gatherings to which they belong, thus every person should select an appropriate representation through the authentic open market of portrayals.

Social Representations Theory maintains a strategic distance from social determinism and opens up to procedures of change, yet simultaneously, the individual is installed in and shaped by social structures (Moscovici, 1961). Moscovici (1961) highlights how portrayals emerge through social cooperation and communication amongst people and gatherings. Furthermore, Joffe (2002) posit that "Social" additionally denotes that the substance of portrayals is social as they reflect in various ways, chronicled, social and financial settings, and conditions and practices.

### **3.4 The social representations of mental illness**

Dixit (2005) describes his notion of mental illness as being closely related to the social values pertinent in any social context. Hence, in order to understand the common meaning of mental illness, Dixit (2005) asserts that the relationship between individual knowledge and implicit social knowledge needs to be explored, which can be achieved by studying the social representation of mental illness. Mental illness as a social representation is thereby understood by Clemence, Doise and Lorenzi-Ciodi (2014) as the shared notions of a social object known in that community which it exists, and it is used for behaving and communicating. According to Foster (2001), some types of knowledge on mental illness are viewed as inferior or even harmful to both the holder and wider society. Many of these forms of knowledge are those that exist at a more community-based level: for example, non-Western understandings of mental health experiences (Littlewood & Lipsedge, 1989; Wagner, Duveen, Verman, & Themel, 2000), or the understandings held by people as 'mentally ill' by the medical profession (Foster, 2001). The most important aspects of the social representation of mental illness was the extreme social connotation attached to the

meaning and explanations of mental illness. Moliner and Rateua (2012) iterate that the meaning of mental illness in terms of manifestations, symptoms, causes, and consequences was understood within the context of social functioning and normal behaviour. The social standards of behaviour and average ways of behaving becomes blurred in the common sense representation of mental illness.

The general representations of mentally ill individuals is that they are isolated from society, not actively involved in societal “normal activities”, perceived as potentially dangerous and different from “normal human beings” (Batel, Castro, Devine-Wright & Howarth, 2016, p.415). In addition, Batel, et al. (2016) stated that mental illness was closely linked to social deviance and criminal behaviour, which indicates that social reality is a construct that represents the collection of individuals or people hold.

### **3.5 Communicative mechanisms**

Social Representations Theory determines how aggregate comprehensions are shaped and changed through correspondence, with emphasis on the socio-psychological procedures or instruments included (Höijer, 2008). According to Deaux and Philogéne (2001), all human associations surmise aggregate cognitions that are social portrayals; although people and gatherings produce social representations through social cooperation and correspondence.

Moscovici (1984) identified two elements of representations, which are anchoring and objectification. These elements conventionalise items, people and occasions by giving them a particular structure; restrict them to a given classification; and steadily set them up as unmistakable and shared comprehensions. They are similarly prescriptive since social edifices and conventions are imposed upon individuals. Despite the fact that individuals join these edifices and conventions in their individual minds, they still reconsider aggregate perceptions. It is significant to note that individuals and groups can modify and change commonly held perceptions. Deaux and Philogéne (2001) iterate that the thought regarding a fundamental connection between the group and the person; between the contemporary and the historical; and between the known and the obscure pervade the theory of social representations.

### **3.5.1 Anchoring**

By interaction, social representations are fortified repeatedly in other social representations. This is a sort of social osmosis by which new social representations are joined into the notable ones at the same time as the last ones are changed by the novel ones. In stages, the new thoughts become notable thoughts and part of the aggregate casings of references of a general public (Moscovici, 2000). According to Bauer and Gaskell (1999), anchoring implies that new thoughts or phenomenon are identified with a notable phenomenon.

### **3.5.2 Objectification**

Objectification makes the obscure known by changing it into something solid that individuals may see and connect with in their faculties (Bauer & Gaskell, 1999). Billig (1993) describes objectification as a sort of appearance of abstract thoughts, which transpires, especially in the media, by speaking to the thoughts as solid phenomena prevailing in the physical domain. Objectifying is, as indicated by Moscovici (2000), a substantially more dynamic procedure than anchoring, which happens naturally each time we are challenged with new phenomena. “Objectifying, that is transforming a new thought into solid reality, necessitates more exertion” (Zurbriggen, 2013, p.1). Moscovici's (1988;2007) own exploration on the extent of psychoanalytic speculation in French society is fundamentally an investigation of how the theoretical and social perceptions of analysis – the oblivious, conscience, buildings, anxieties and so forth – is generalised into solid components in public discerning.

### **3.6 Relevance of the theories to the study**

In understanding the difficulties in knowledge and perceptions of mental sickness amongst a populace of students, which is considerate of both a person's and societal agency, the Social Representations Theory and Bronfenbrenner's Ecological Systems Theory are preferably suitable to the study (Gilbert et al., 2013). When researching theoretical viewpoints underpinning studies of this nature, none could be found in the KwaZulu-Natal Province that used socially constructed understandings of mental illness. This study will therefore add value to similar research in the field, while gaining knowledge and perspectives of Psychology master's students on mental illness.

### **3.7 Conclusion**

Bronfenbrenner's (1989) Ecological Systems Theory, later called the Bio-ecological Systems Theory, is the hypothesis of human advancement. It is utilised in articulating the procedure of

human socialization, and it has been a vital aspect for receiving instruction. Bronfenbrenner has moulded the Conduct Model into the Human Advancement Model. In the hypothesis, distinction is made between the micro-, meso-, exo-, macro-and chrono-systems. The emphasis on representations of cultural phenomena and correspondence makes the theory of Social Representations exceptionally important for social studies. The theory is comprehended in its more profound sense, both as a procedure, a perspective on phenomena, as well as a framework depicting and clarifying them. Social Representations Theory focuses on social and cultural considerations of society: on how new social insights or representations of the truth are pressed onward and longstanding ones changed through communication. Dixit's (2005) findings revealed that social representations of mental illness were structured in terms of social understanding of the causes and consequences of mental illness.

Furthermore, mental illness derived its meaning from the expectations and norms of society. Social Representations Theory can contribute important commitments to social studies. By concentrating on how the media and the community anchor and objectify "new" logical, political and social issues, information can be obtained about crucial changes in the idea frameworks or aggregate importance creation of social orders. Continuous changes are physical procedures, as well as profoundly emotional and socio-cognitive processes (Beck & Beck-Gernsheim, 2001), the elements of which will be uncovered by the present study within the confines of Psychology master's students' perspectives of mental illness. An analysis of common understanding can provide an important basis to deal with mental distress. According to Dalal (2001), cited in Dixit (2005), the concern of health psychology should be the meaning and behaviour that structure illness experiences in a particular socio-cultural context. This can be done by studying the social representations of mental illness. The next chapter offers detailed data on the methodology used in this study.

## **CHAPTER FOUR: METHODOLOGY**

### **4.0 Introduction**

This study is a participatory action research (PAR), thus it commences with an introduction to PAR methodology followed by the research setting and the phases of the PAR project. The study utilised a mixed methods, thus qualitative and quantitative approaches were used to collect data required to achieve the objectives of the study. Further, the description of the research paradigm and the selection criteria for identifying participants for the qualitative component and respondents for the quantitative component is provided. An outline of the data collection tools, data collection method and data analysis. The chapter concludes with a details of how validity, trustworthiness and ethical considerations were ensured.

### **4.1 Participatory Action Research**

Given (2008) postulates that Participatory Action Research (PAR) varies from other approaches to public health research on the grounds that it depends on reflection, data collection and action that aims to improve health and reduce health inequities by including the general population, who thus takes actions to improve their very own health. A PAR methodology was adopted because it is uniquely suited for researching and supporting social change. It is suitable for the purpose of cross-examining social research with exploratory action to promote development. Given (2008) states that PAR involves formulating a plan and overlapping cycles of investigation, carrying out the intended intervention and evaluating the outcomes, whilst incorporating all stages of collecting, analysis of data, and generation of knowledge.

#### *Study setting*

The study was conducted at the University of KwaZulu-Natal (UKZN), Howard College campus. UKZN has five campuses located in Durban and Pietermaritzburg. There are three campuses in Durban, and one campus in Pinetown. Pinetown falls under Durban Metropolitan. The fifth campus is in Pietermaritzburg. Howard College falls under eThekweni Municipality. It's the only university in KwaZulu-Natal that offers Masters in Clinical Psychology.

### *Phases of the PAR project*

The researcher identified the topic and developed the research proposal in collaboration with the research supervisor. The phases of the study were as follows:

#### **Phase One: Permission to conduct research**

- Requested gatekeeper's permission from the Registrar to conduct research with students from the University of KwaZulu-Natal's Howard College campus (see Appendix A).
- Submitted ethical clearance form to the Humanities and Social Sciences Research Ethics Committee to gain approval to collect data (see Appendix B).

#### **Phase Two: Recruiting strategies**

The researcher designed a presentation outlining the objectives of the study, along with the selection criteria for potential participants (Psychology master's students). Presentation was presented to Psychology master's students at the Psychology Clinic boardroom (see Appendix C: Participant consent form).

#### **Phase Three: Focus groups**

After the participants were recruited, details of the proposed focus group discussions were shared. Questions were designed for the purpose of initiating conversations amongst participants (see Appendix D: Focus group discussion guide).

#### **Phase Four: Action plan**

The researcher facilitated the focus group discussions. However, participants were able to participate in discussions freely within planned interventions. The main concerns in the group were addressed through action. Consistent with the principles of PAR, members designed a research intervention in the form of a poster. They selected the content and decided on the themes, which had possible solutions to address the difficulties of obtaining knowledge on mental illness amongst the student population (see Appendix G: Poster Project).

#### **Phase Five: Recruitment strategy for the evaluation process**

The researcher posted the intervention in a public space (Shepstone Building), where poster was visible to the student population. Participants were asked to review the content in the intervention and evaluate their knowledge prior to, and after reading the content. Evaluation was conducted on the impact of the intervention on addressing the student population's

difficulties with obtaining knowledge on mental illness. Questions designed to assess the impact were generated by participants of the focus group (see Appendix F: Structured questionnaire).

### **Phase Six: Evaluation**

The impact of the intervention was evaluated through the quantitative method, where the respondents reported on whether the action plan changed their knowledge and perceptions on mental illness through a survey.

## **4.2 Research approach and design**

According to Creswell et al. (2011), Research design denotes a procedure that includes the general assumptions of the investigation, from the methods of analysis to the recording of results. The research design is carefully related to the goals of the investigation and whether the design is capable of constructing data that will deliver solutions to exploration questions. For this study, the objective research assumption was charted. By definition, “methods are the procedures used to collect and analyse information” (Crotty, 1998; Saunders, 2007, p.20). The three research distinct approaches are qualitative, quantitative and mixed methods (Creswell et al., 2011).

This study utilized mixed method approach, thus both qualitative and quantitative approaches were used. Mixed method research is known to serve as method and methodology for conducting research, which involves the collection of data, analysing and integrating quantitative and qualitative research in a single study (Creswell & Poth, 2018). However, the qualitative method was the dominant approach used in this study. Data were collected in different phases and served different purposes. The next section elaborates on the utilisation of the two approaches, quantitative and qualitative.

### **4.2.1 The qualitative component**

Qualitative approach places “an emphasis on the qualities of entities, and on processes and meanings that are not experimentally examined or measured (if measured at all) in terms of quantity, amount, intensity or frequency” (Denzin & Lincoln, 2008, p. 14). The qualitative approach was utilised for phase three of the research study, which included engaging in a focus group. It was well suited for this phase since the goal was to interpret and document an

entire phenomenon from an individual's viewpoint or frame of reference (Mason, 2006). Emphasis was on the depth than the breath of data (Ulin, Robinson & Tolley, 2004).

The qualitative approach was adopted in this study due to this section focusing on deeper understanding of the lived experiences of the students, especially the difficulties they encountered in obtaining knowledge on mental illness and how these difficulties affected their help seeking behaviour. Data were collected through a focus group. Although it used unstructured questions, the research questions were clearly defined and carefully designed to cover all aspects of the study before data collection.

#### **4.2.2 The quantitative component**

According to Maree (2016, p.215) quantitative research is “the process that is systematic and objective in its ways of using numerical data from only a selected subgroup of a universe (or population) to generalise the findings to the universe that is being studied”. In this study, the researcher and co-researchers designed a structured questionnaire that the respondents administered. This was best suited for phase six of the study, data included collection of data through a survey and that were analysed statistically. The results were based on a sample size that represented this section of the study population. The questionnaire had clearly defined research questions aimed at achieving the objectives of the study, which was the evaluation of the poster project intervention.

Rovai et al. (2014) state that quantitative research is characterised by the researcher pinning a theory, which is demonstrated within a specific hypothesis, which is tested, then conclusions are drawn based on the hypothesis. This is followed by a sequence of observations and data analysis (Rovai et al., 2014). The hypothesis tested in this phase was based on the students' knowledge on mental illness and through the data being analysed statistically. Conclusions were drawn.

#### **4.3 Research paradigm**

The researcher used the constructivist paradigm because it assumes that people construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences, according to Charmaz (2006). According to the constructivist paradigm, learning does not just happen from the traditional method of teachers standing in front of the class and lecturing (Charmaz, 2006). Instead, it occurs only when the learner discovers the

knowledge through the spirit of experimentation and doing (Dogru & Kalender, 2007). For instance, in this study, the researcher aimed to elicit and understand how the student population constructed their individual and shared meanings around the difficulties of knowledge and perceptions on mental illness (Charmaz, 2006).

### **4.3.1 Assumptions of Participatory Action Research**

The basic assumptions of PAR are based on the way society is structured, and how it functions, which entails how social change should occur, including the role of knowledge in achieving power, and the use of power and control (Selener, 1997). PAR is the “systematic collection and analysis of data for the purpose of taking action and making change by generating practical knowledge” (Gills & Jackson, 2002, p. 264).

Participatory action researchers view society and social change from a radical structural perspective (McNiff & Whitehead, 2006; Irfan, 2016), whereby the basic structure of society gets to be questioned, whilst concentration is placed on the overall structural conditions at both the macro and micro levels and allowing the researchers to generate and promote the process of social, political and economic exploitation of the poor majority by elite groups in society. Solutions are viewed as processes through which subjects become social actors, participating, by means of grassroots mobilisations in actions intended to transform society (Irfan, 2016).

## **4.4 Selection of participants**

### **4.4.1 Focus group**

According to Neuman (2014), a research population comprises the target population, which is defined as a specific pool of cases that the researcher wants to study. Neuman (2014) further postulates that the unit being sampled, the geographical location and the temporal boundaries of populations all form part of the research population. For the purpose of this research study, the research population consisted of Psychology master’s students registered at the University of KwaZulu-Natal. Rubin and Babbie (2009) assert that the smaller group that the study observes is called a sample, and the process of selecting this group is called sampling. The researcher purposively selected five participants, where each participant was selected for a specific purpose. A small group was purposively selected due to prioritising quality, than quantity. The small group was more manageable and controllable, than a larger group would be.

Given (2008) advises that selecting participants who share a similar perspective on the topic is the most common strategy for producing the kind of group composition that generates active exchanges, such as creating a homogenous group. Purposive sampling operates on the premise that when one is aware of what is to be studied and the purpose of the study too, hence purposive sampling is considered appropriate (Rubin & Babbie, 2009). Green (2007) posits that purposive sampling in qualitative research simply implies that participants are chosen on the basis that they will generate useful data for the study.

The researcher conducted two focus group interviews with participants at the UKZN Psychology Clinic boardroom on the 4<sup>th</sup> of October 2019 at 13:00 and on the 11<sup>th</sup> of October 2019 at 11:00 as this was convenient for the participants. The criteria for the selection of participants was as follows:

- Participant must be a Psychology master's student at the University of KwaZulu-Natal (Phase: Two).
- Willingness to take part in a focus group, share experiences and ideas.
- Willingness to participate in a Participatory Action Research project.
- General students studying at the University of KwaZulu-Natal (Phase: Five).
- Willingness to take part in the evaluation of the research project.

#### **4.4.2 Student sample**

In gathering qualitative data, convenient sampling (non-probability sampling) was utilised. According to Campbell (2016), convenient sampling entails a process whereby researcher chooses elements that are easily accessed until the sample stretches to the desired size. There was no lists available, respondents were selected due to their easy accessibility and proximity to the researcher and co-researchers. The researcher and co-researchers posted a poster intervention at the main entrance of a public space (Shepstone Building) at UKZN, Howard College campus. The respondents had to be willing to partake in the evaluation intervention (see consent form appendix E).

#### **4.5 Data collection method**

Data collection places emphasis on how the data crucial for the research was generated (Flick, 1998). Ulin, Robinson, and Tolley (2005), state that observation, in-depth interview, and focus group discussion are the primary methods that form the foundation of qualitative

data. This study used the focus groups for the quantitative component and used the survey method for the qualitative component.

### *Focus group*

For the purpose of this study, the researcher utilised focus group discussions (FGDs). The same participants who participated in the first FGD participated in the second FGD (see consent form in appendix C). The focus group comprised of five (5) participants. Focus groups are known as a form of qualitative interviewing that uses a researcher-led group discussion to generate data (Given, 2008). These are used based on the assumption that the social construction of reality in research occurs through interactions between the investigator and respondents (Lincoln & Guba, 2000). Given (2008) states that focus groups create the opportunity for participants to engage in meaningful conversations about the topics that researchers wish to understand.

Participants were relatively free to discuss the topic as they saw it fit (informal discussion). Further, open-ended questions were used to give more flexibility to the researcher and participants in a more structured fashion where the researcher took a more active role in the issues being discussed (De Vos et al., 2011). Since this study needed evaluation, focus groups were used during the preliminary phase to cater for such aspects as needs assessment, program development, and in follow-up or summative evaluation, to learn about the participants' experiences with a program, as suggested by Give, (2008). Permission to use an audio recorder was sought from the participants. The strategy for intervention was developed by the participants from their own experiences that were probably effective in their own life. The participants felt that a poster was more effective than the YouTube intervention that was initially suggested, as it facilitated interaction between the participants and respondents on the research study.

### *Survey*

According to qualitative researchers, multiple realities exist. Similarly, there are multiple interpretations available from different individuals that are equally valid (Geertz, 1973). For the evaluation process, which featured after the intervention was developed, a quantitative approach was used as a method to collect data because human phenomena and variables in human behaviour can be studied objectively, as described by Parahoo (2006). Measurable questions in the form of a questionnaire were determined by the focus group in order to

evaluate the impact of the project amongst the student sample. Questionnaires were utilised as they enable data to be gathered in large quantity in a short period of time, given that they are also cost effective (Flick, 2011). The researcher and co-researchers used self-administered questionnaire where the respondents were approached at the entrance of the Shepstone Building and asked to complete the questionnaire.

A descriptive design involving brief structured interviews was utilised (see appendix F), along with details collected on the impact of the project on the current attitude, knowledge and informed behaviour on mental illness after reading the poster. The method of data collection for this section was a written questionnaire. A total 17 respondents completed the questionnaire. Quantitative data was analysed using a statistical computer programme (SPSS) (LoBiondo & Haber, 2006).

#### **4.5.1 Data collection tools**

The qualitative component of the study used two data collection tools. These were (1) the researcher as key instrument, and (2) Focus group interview guide.

##### *The researcher as key instrument*

According to Terre Blanche and Kelly (1999, p. 126). “Everybody has the skills to do interpretive research, but to do it well one needs to turn these [basic skills] into specialised research skills”. The researcher is a crucial instrument when collecting qualitative data (Pezalla, Pettigrew, & Miller-Day, 2015). As a novice researcher, in order to collect worthwhile data, considerable time was spent on extensive reading on articles and books based on research methods. The researcher learnt that “qualitative interviewing is more than a set of skills, it is also a philosophy, an approach to learning” (Rubin & Rubin, 2011, p.2). This was important for the purpose of obtaining worthwhile data. Thus, the researcher had to enhance their interviewing skills, and encouraged participants to share their worldviews in their own choice of words.

##### *Focus group discussion guide*

The interview in qualitative research is viewed as “conversation with a purpose” (Burgess, 1984, p. 102). It is also seen as a dialogue, and not a question and answer session (Barker, 1999). The purpose of utilising the focus group interview was to cover both the factual and meaning level (Van Teirjligen, 2014). This interview guide aimed to describe the meanings of central themes in the world of the subjects being investigated. A focus group discussion

guide was generated to guide the interview process which aimed to cover all aspects of the research study prior to the actual interview. It also served as a reminder and helped to standardise questions across participants (see Appendix D: Focus group discussion guide).

## **4.6 Data analysis**

### **4.6.1 Qualitative data analysis**

In qualitative research, data analysis is considered as an on-going process that occurs informally even before to the formal stage of data analysis. This study's analysis commenced with active listening and transcription of the FGD voice recording. Verbatim transcriptions are recognised as objective and most loyal (Kvale, 1996). However, some statements were rephrased and condensed in order to capture the only aspects which were of interest to the study (Lubombo, 2014).

According to Neuman (2014), qualitative researchers analyse data by organising it into categories based on themes, concepts or similar features. In this study, thematic analysis was used since it organises and describes patterns across the dataset with rich detail and progresses a step further by interpreting the many aspects of the research topic. According to Rubin and Babbie (2009), the process of thematic analysis entails an active process wherein the researcher engages in a rigorous process of data familiarisation, data coding and theme development. Thus, the researcher organised the data into conceptual categories that created themes and concepts, which were used to analyse the collected data. The researcher was guided by the five step approach to data analysis - where the proposed intervention strategy stemmed from the participants - as proposed by Terre Blanche et al. (2006). The five steps are described below:

#### *Step 1: Familiarisation and immersion*

This is whereby the researcher familiarises and immerses him/herself in the data by re-reading the text a few times over and over and thus making notes and summaries. At this stage, the researcher is working with the texts, rather than lived experiences (Terre Blanche et al., 2006). The aim is to master the data and remember what is contained in it.

#### *Step 2: Inducing themes*

Step 2 refers to the process of identifying specific themes that are apparent in the underlying data. According to Terre Blanche et al. (2006), it starts with listing themes, drawing mind

maps and branching notes of all themes that come to mind as the researcher studies the text. It shows connections between themes, sub-themes, sub-categories and clusters of information (Terre Blanche et al., 2006).

### *Step 3: Coding*

The coding process refers to “breaking down a body of data (text domain) into labelled, meaningful pieces, with the view to later cluster the ‘bits’ of coded material together under the code heading, and further analysing them both as a cluster and in relation to other clusters” (Terre Blanche et al., 2006, p.143). This process is done with the intent to gain a deeper understanding and not forgetting data that did not form part of the identified themes.

### *Step 4: Elaboration*

According to Terre Blanche et al. (2006), elaboration is a process where the researcher obtains finer meanings, finding the connection between meanings and identifying commonalities and differences. Further, the researcher pays attention to both generalities and uniqueness, which were not captured in the original coding system (Terre Blanche et al., 2006). The researcher was required to revise the initial coding process to develop a more comprehensive analysis of the data.

### *Step 5: Interpretation and checking*

This refers to the written report of the phenomenon being investigated. Terre Blanche et al. (2006) state that the researcher is expected to write a report, presenting the analysed themes as sub-headings. This stage is only reached when all questions that have been asked at the beginning of the research have been answered and the interpretation matches the data that has been collected (Terre Blanche et al., 2006).

### ***Feedback session***

Participatory action research (PAR) varies amongst other public health research approaches due to it being based on reflection, collecting data and engaging in action that is aimed at improving health and eradicate health inequities through the involvement of the persons who, in turn, partake in actions to improve their own health (Baum, MacDougall & Smith, 2006). Data collected from the focus group was categorised based on main themes, concepts and subthemes. The second session of the focus group entailed giving feedback to participants on the analysed data from the first focus group session. Participants were given feedback on the

core themes that were identified to be difficulties in the knowledge and perceptions of mental illness amongst the student population as guideline for the next stage of the research project which was concluded to be a poster intervention.

#### **4.6.2 Quantitative data analysis**

The analysis of quantitative data was conducted using numbers so the reply to each question of phase 5 was coded using numbers on an ordinal scale of 1 to 5. Parahoo (2006) mentions that numbers on an ordinal scale are in ascending order, with no equal steps implied between the numbers. The responses to each question of the questionnaire was coded using numbers in the normal logic. The services of a statistician were engaged to input the data directly on a computer package, Statistical Package for the Social Sciences (SPSS), and to analyse the data as advised by Walters and Freeman (2010). Findings were reported from the brief structured interviews and represented as descriptive statistics.

#### **4.7 Validity and reliability**

The data collection tool was both valid and reliable. Validity and reliability is a crucial concern in PAR. Schneider (2012) asserts that PAR positions itself in sharp dissimilarity to customary social research methods, whether calculable or qualitative, wherein the professional investigator collects data from research respondents and turns that information into understanding. The participation of inexperienced investigators in PAR consequently elevates inquiries about whether the information created by commonplace individuals can be considered as valid. The dominant problem surrounds the study concerning whose knowledge or experience is valid enough to guide the study. In this case, the researcher along with research supervisor devised the research protocol.

A customary quantitative methodology for investigation, which dominates in the field of mental health studies, recommends measures that must be trailed to yield information that will be considered as dependable and valid, free of adulteration and partiality (Palinkas, 2014). Participatory researchers, alternatively, accept as true that all investigators, quantitative or otherwise, come to their exploration with ethics and viewpoints and that these unavoidably outline the research (Gray, 2000). They are certain that encompassing people with undeviating knowledge of the problem being deliberated on proposes a method to progress the excellence and significance of exploration, and that specific understanding and familiarity is a valid and significant cradle of information (Gray, 2000). Various researchers endorse the use of the expressions “value-based” and “knowledge-based” more willingly than

“evidence-based” strategy and preparation (Beresford, 2006; Davidson et al., 2009; Fulford & Wallcraft, 2009).

Qualitative researchers have retorted to challenges about validity from customary quantitative academics with principles for evaluating superiority and validity in qualitative investigation (Lincoln, 1995; Richardson, 2000). PAR researchers have answered with standards for evaluating excellence and validity in participatory research. Bradbury and Reason (2001) recommend a sequence of six queries, which this study satisfies, to direct the valuation of PAR projects as follows:

- “Is there relational contribution?
- Is it practically beneficial?
- Is it conceptually, academically and procedurally coherent?
- Does it prolong people’s ways of knowing?
- Is it substantial?
- Does it lead to new or transformed social practices?”( p.444),

#### **4.8 Trustworthiness of the study**

To ensure valid trustworthy interpretation, the researcher used the criteria suggested by Shenton (2004) namely; credibility, dependability, confirmability and transferability. This criteria is further explained below;

##### *Credibility*

Research is deemed credible when its’ findings are convincing and believable (Durrheim & Wassenaar, 1999). This principle was achieved through ensuring that the participants’ views, including divergent ones were reflected in the presentation of both findings and analysis. The triangulation strategy was adopted to reduce bias and cross examine the reliability of responses given by the participants. The researcher focused on the triangulation strategies because this study involves more than one approach for data gathering, which is qualitative and quantitative approaches (focus group discussion and survey).

##### *Dependability*

According to Durrheim and Wassenaar, “dependability refers to the degree to which the reader can be convinced that findings did indeed occur as the researcher says they did” (1999, p. 64). The researcher ensured dependability by providing descriptions of steps taken and

justification taken during the execution of the study. Research questions were in line with the research design and study objectives.

### *Confirmability*

Confirmability is when the study findings are based on direct results of the study not the biases of the researcher (Babbie & Mouton, 2004). Reflexivity is crucial when using a qualitative approach. This is when the findings are corroborated by other researchers in the field. In this study, the researcher relied on maintaining and reviewing of field notes, voice recordings, field diary and reference to proposal notes, which enabled realignment with the study's original focus (Shenton, 2004). The process of data collection, data analyses and interpretation was detailed (Shenton, 2004).

### *Transferability*

According to Babbie and Mouton, transferability “refers to the extent to which the findings can be applied in [to] other contexts or with other respondents” (2004, p. 277). In order to ensure transferability, the researcher collected detailed data and reported on it with the necessary accuracy. This was done to allow the reader to make judgements about transferability, also known as extensibility, according to Ulin et al. (2004). The researcher purposively selected participants from the Psychology masters' class as they were best knowledgeable of the issues being investigated. However, attention should be given to contextual factors in the event that findings from this study are to be transferred to other contexts.

## **4.9 Ethical considerations**

It is essential that an investigator use precautions in their efforts to maintain the civil liberties of participants and establishments (Polit & Hungler, 2004). Whether steering investigations or partaking in an enquiry, academics and students similarly face ethical concerns. Polit and Beck (2013) recommended that when the envisioned exploration encompasses human beings, ethical concerns should be dealt with prudently and with understanding. The ethical matters existing in this study require principally cautious deliberation. The topic of mental health difficulties is a complex one and with some conventional, old-fashioned individuals, it is an offensive theme with substantial dishonour (Guthrie et al., 2017). Throughout data collection,

two key philosophies were practised, namely; informed consent and voluntary participation. Also kept in mind was the reverence for human dignity and kindness.

According to Polit and Beck (2006), the belief of reverence for human self-respect denotes the right of participants to have full revelation and autonomy. In terms of independence, all participants had the right to choose, self-sufficiently and devoid of burden, whether or not to take part in the study. Contributors were given the right to hold back private facts, they did not need to answer all of the questions; and they were allowed to inquire and obtain elucidation about any characteristics that produced indecision or hesitation. No names were taken in any of the surveys in order to guarantee that discretion was upheld.

Polit and Beck (2006) state that the belief of kindness denotes independence from mistreatment and maltreatment. Finalising questionnaires did not expose participants to any corporeal injury, although there was the probability of participants experiencing emotional uneasiness owing to the nature of some of the questions. Participants were consequently knowledgeable, both in the information communication that was delivered to them and, once more, vocally preceding the circulation of the surveys, on the convenience of university therapy services should they turn out to be distraught. The next chapter is a presentation of the qualitative and quantitative data.

## CHAPTER 5: DATA PRESENTATION AND ANALYSIS

### 5.0 Introduction

The previous chapter provided descriptions on the research methods used to collect data. This involved a detailed account of the research design, sampling method and data gathering techniques. In the current chapter, data that was uncovered from the investigative process is presented. It brings to light the themes that emerged from the focus group discussions with the five participants. Furthermore, this chapter has a section entitled “the effectiveness of a Poster intervention in addressing the difficulties amongst the student population”. The evaluation within the Participatory Action Research approach where seventeen respondents were evaluated is also revealed. The second section was informed by a quantitative evaluation and data is presented as descriptive statistics. Further, discussions focussed on pertinent issues that arise from bringing awareness to mental health issues at the University of KwaZulu-Natal.

### 5.1 Focus group discussion

#### 5.1.1 Biographical information of master’s Psychology students

Pseudonyms were used to refer to the five master’s students who participated in the study (as indicated in Table 1). These students were registered at the University of KwaZulu-Natal, which was the site of this study. The table below summarizes the biographical profiles of the five respondents involved in the study.

**Table 5.1 : Participant’s demographic information**

<b>Respondent code</b>	<b>Age</b>	<b>Sex</b>	<b>Race</b>	<b>Province of residence.</b>
P00 1	25	Female	African	KwaZulu-Natal
P00 2	21	Female	African	KwaZulu-Natal
P00 3	24	Female	African	Eastern Cape

P00 4	32	Female	African	KwaZulu-Natal
P00 5	24	Female	African	KwaZulu-Natal

Based on the results from Table 1, all the participants were African females since all participants were female, the results are based on the female perspective. All the participants were aged 21-32 which implies maturity and experience. The focus group comprised of females only because the population comprised of 14 females and one male which only the females volunteered to partake.

**Table 5.2: Summary of themes and sub-themes**

Main theme	Organising theme
General understanding of mental illness amongst master's students	❖ African Traditional or Western perspective on mental illness
	❖ Culture and socialisation
	❖ Bewitched
Personal experience with mental illness	❖ Schizophrenia
	❖ Depression
Difficulties in knowledge and perceptions of mental illness	❖ Culture divide

	❖	Literacy and information
	❖	Stigmatisation
Difficulties in help-seeking behaviour	❖	Stigma and stereotypes
	❖	Awareness
	❖	Cultural
	❖	Access to services

These themes are informed by a plethora of sub-themes, each of which is unpacked in the sections below.

## **5.2 Main theme: General understanding of mental illness amongst master's students**

This primary theme examined selected students' understanding of mental illness based on their experiences. Field et al. (2012) assert that the concept of mental illness is hardly given attention, especially at university amongst the general student population. This section involved exploring the understanding of mental illness amongst selected participants in the context of a focus group discussion. Generally, the participants had varying views on the concept of mental illness.

### **African Traditional or Western perspective on mental illness**

Most of the participants felt that mental illness can be understood from both a Western and African traditional perspective. On the one hand, the Western context would view mental illness as a biomedical or genetic condition. On the other hand, the traditional context would view it as supernatural or ancestral. Some of the responses reflecting on participants' understanding of the origins of mental illness are indicated below:

*I understand it's based on both Westernised and traditional notions. My understanding is influenced by personal experiences and the experiences of others close to me. My understanding is that as much as mental illness can be explained through the Western or biomedical notions, I also understand it based on ancestral spirits, others being punishment/being bewitched. So, my understanding is merely on the presentation and family history (P00 3).*

*Mental illness can be either genetically or supernaturally caused. We have situations where people are born with mental illness, and also people who are bewitched or cursed. It depends, but I find it both applies in different circumstances (P00 5).*

However, for some of the participants, understanding of mental illness was largely informed by either a traditional or a biological perspective. According to Blood et al. (2011), mental illness is sometimes referred to as a neurological disorder. Their understanding of the cause of mental illness seemed to lean towards neurological imbalance. According to the Social representation theory, the understanding of mental illness is social constructed hence the participants in this study constructed their meaning of mental illness through attributing it to traditional or biological perspectives (Jorm, 2012).

*For me, mental illness is rooted in neurological imbalance, which can be caused by natural and or unnatural causes. It is more about what is going on neurologically than physically (P00 1).*

For those who were driven by a traditional understanding, they reflected on the importance of cultural beliefs that were used to explain the manifestation of mental illness. One participant narrated how they understood mental illness from an African traditional perspective. They had the following to say:

*I understand mental illness based on the presentation and viewing the person holistically in terms of family beliefs and treatment route the family believes in. This is so because there are cultural rituals like Ukuthwasa in my culture, which in a hospital setting could be viewed as mental illness. However, if it is presented to a traditional healer, he would perform the rituals and the person could be treated (P00 3).*

Other participants who also supported the African traditional understanding of mental illness also emphasized the important role played by one's beliefs, particularly the influence of ancestral spirits. Participants explained that:

*So, growing up in that context there were no laboratories that could account for mental health, we ended up believing into mystical causes such as ancestors being angered by the mentally ill person, mental illness as a result of the failure to appease the ancestors or merely a result of witchcraft. So, growing up in such a community one cannot understand mental illness in any other way, than it being an illness that needs traditional healers to treat (P00 5).*

*I also understand it [mental illness] based on ancestral spirits. The traditional and spiritual factors surrounding mental illness are based on the belief structure and the family values (P00 4).*

Based on the above responses, it was clear that cultural and spiritual components are important for some people in terms of understanding mental illness. According to Mbawayo and colleagues (2013), communal beliefs play a significant role in diagnosing and treating an illness. It comes across as though that the spiritual and traditional beliefs that participants held were influenced by one's background and family values. Culture and socialisation were perceived to be important factors in the understanding of mental illness, especially within the African context. The African and cultural understanding of mental illness also extended to beliefs in witchcraft. This is consistent with SRT, which indicates that individuals describe mental illness in line with societal values. Hence the above participants understood mental illness from an African traditional perspective. Some of the responses indicating the importance of culture and socialisation are indicated below:

*Mental illness is based on a person's culture and socialisation (P00 3).*

*Yes, that is true. For Africans, we have mental illness that are better culturally understood and treated (P00 4).*

Another participant added the following:

*The way we are socialised by our different communities or cultures will have an impact on how we perceive mental illness. For one, in my culture, mental illness is associated with punishment...for this man to be mentally ill, the whole community believed that he cheated a businessman who then bewitched him to be mentally ill (P00 3).*

Generally, most Africans view mental illness as a result of an external attack on the person. Those who suffer from mental illness are thought to be bewitched. People talk about evil spirits when describing the condition of a mentally ill person.

When asked about their perceptions on mental illness in comparison with other illnesses, most participants perceived mental illness to be similar to any other illnesses. They stated that mental illness should be viewed in the same light as physical illness as people who suffer from mental illness did not bring it upon themselves, which is in agreement with Rohner and Khaleque (2014) that mental illness can occur naturally, traumatically or due to personal strain. One of the participants said the following:

*Mental illness is just like any other illness, just like cancer or any other physical illness. It is something that you experience, not because you have chosen to experience it (P00 5).*

Another participant added that:

*I see it just like any other physical illness. It is a serious condition that has a huge impact on a person's daily functioning. It is something that you cannot help, something that you cannot control (P00 1).*

Most participants felt that mental illness was similar to other illnesses, whereby it was seen as something that occurs naturally. Furthermore, people need not feel embarrassed and should receive equal and unrestricted medical attention as explained by the participant below:

*I see it just like any other physical illness. But to me, everyone with mental illness should be able to freely go to the doctor just like anyone else because it needs equal attention as physical illness (P00 2).*

However, some of the participants were of the view that mental illness was a different from other illnesses mostly due to the stigma experienced by people diagnosed with this illness. One participant explained that:

*The level of stigma and stereotypes attached to mental illness is simply beyond me. Have you seen how mental illness is portrayed in the media? Even on television shows, whenever they include mental illness, they will portray that character as*

*someone that is dangerous, and unstable. With all the information we have on mental illness, people still remain shameful to disclose mental illness diagnosis as opposed to physical illness (P00 4).*

In terms of what informs the knowledge and perceptions of mental illness amongst the student population, participants indicated that African culture expounds on the value of community and community beliefs. In the African context, mental illness is often perceived as a spiritual and cultural issue, rather than a medical condition (Chikomo, 2011). Africans' perceptions of mental illness are based on their cultures and traditions, which tend to regard mental illness as a source of suffering resulting from witchcraft and spells (Atilola, 2014). The exo-system within the ecological systems theory links mental illness to social framework that make connections to occasions and possibilities. This is in line with the findings of this study as the participants make connections to possibilities that mental illness may be attributed to spiritual and cultural issues (Harkonen, 2003).

### **5.3 Difficulties in knowledge and perceptions of mental illness**

The participants provided insight into the perceptions and knowledge of mental illness amongst students. The participants believed that the student population was mis-informed about mental illness and that they did not have adequate knowledge on mental health issues. They extended their perceptions on mental illness in terms of how media and society portray mental illness. Most participants concurred that both the media and society present mental illness as instability, the individual as having intent to cause harm, and cultural beliefs such as witchcraft being responsible for insanity (Clement et al., 2015). This key theme examines the potential difficulties in knowledge and perceptions of mental illness amongst students. The various difficulties identified by the participants included the cultural divide, stigmatisation, and lack of accurate information.

#### ***Cultural divide***

The cultural divide was a highly ranked factor. It presented difficulties in knowledge and perceptions of mental illness. There remains a Western and African view of mental illness, which can blur the definition, understanding, and knowledge of mental illness. How mental illness is defined in a cultural or African traditional setting, may differ from a Western setting

and vice versa. In relation to understanding mental illness, some of the participants explained that:

*I think culture shapes the underlying experience of psychological distress to such an extent that depression and anxiety are not defined or may not be meaningful, or understood in the same way they are understood in the African or Western culture (P00 5).*

*The confusion between mental illness as it is viewed from a Western and African perspective creates difficulties in knowledge and perception of mental illness (P00 4).*

*In my culture, mental illness is categorised as being crazy, and psychological services are viewed as treatment for the Westernised population (P00 3).*

The cultural divide largely influenced how participants understood the behaviours surrounding mental illness. From an African perspective, all mental illnesses were perceived as a form of insanity and people who presented with any symptoms related to mental illness were regarded as weak. One of the participants stated that:

*I didn't even know there were different diagnosis in mental illness because in my culture, call everyone with mental illness "insane". Strange enough, when someone presents with symptoms of depression, they are thought as being weak, seeking attention, and someone who does not have self-love (P00 5).*

For most of the participants, mental illness was culturally defined. Psychology was associated with elitism. In the African culture, especially in poor rural communities, obtaining mental health services is seen as a luxury or a privilege whereby the person will be labelled as rich or being a member of the elite. Furthermore, they are also labelled the mentally ill as people who were are weak and could not solve their own problems and thus seek Westernised interventions. This position is illustrated in the responses below:

*In my culture, seeing a psychologist is considered as privilege. In rural communities, that person battling with mental issues would be labelled as being incapable of working through one's own problems. Remarks such as 'you think you are better' or 'you have money to waste' would be made to someone seeing a psychologist (P00 3).*

Individuals with such mental illnesses as anxiety and depression, and would seek mental health services were perceived as being weak. A participant shared what her friend said when she told her she was experiencing symptoms of depression and sought psychological services:

*She accused me of being lazy and advised that I should stop feeling sorry for myself; should just get up and focus on my academic work. She down played my symptoms, said it was normal, and I was just tired. She indicated that every student felt that way (P00 1).*

Unlike people who suffer from other chronic illnesses, people with mental illnesses are often hidden for long periods of time. Mental illness is considered taboo in some African communities and cultures. Hence, it is hardly spoken about. One of the participants said:

*I come from a culture where mental illness is a taboo. People do not even talk about it. It is not something that is publicly discussed (P00 5).*

Africans' perceptions of mental illness are based on their cultures and traditions. Sometimes mental illness is regarded as caused by witchcraft and in some instances viewed as weakness. Mental health remains a taboo in Africa, which prevents patients from accessing the much-needed professional help.

### **Lack of accurate and comprehensive information**

Jorm (2000) introduced the term 'mental health literacy' and defined it as knowledge and beliefs about mental disorders, which aid their recognition, management or prevention. In this study, lack of knowledge was widespread. Whilst information was abundant in society, 'appropriate' information on mental illness was. This could have been a result of ignorance about mental illness, as opposed to other illnesses. Some of the responses highlighted lack of comprehensive and accurate information. This is reflected in the responses below:

*The student population is mis-informed when it comes to mental illness. They might be educated in some spheres of literature, but they lack appropriate information on mental illness. I am not sure if its ignorance or what really, because mental illness is as serious just like any other illnesses (P00 2).*

*That is true, they don't have basic mental health literacy... (P00 1).*

One of the participants added the following:

*Come to think of it, the student population might be educated but they all come from different cultural backgrounds, religions, socio-economic status, and the general stigma attached to people with mental illness (P00 1).*

The framing of messages in some media outlets seems to dwell on painting people with mental illnesses as being dangerous and unstable. Entertainment and news media provide dramatic and distorted images of mental illness that emphasise criminality and unpredictability. This presentation of mental ill people in the media models negative reactions to the mentally ill, including fear, rejection, and ridicule (Stuart, 2006). This negativity is explained below:

*Have you seen how mental illness is portrayed in the media? Even on television shows, whenever they include mental illness, they will portray that character as someone that is dangerous and unstable (P00 4).*

Focus group discussions deliberated on how mental illness is portrayed by the media. This is a profound finding because the media is a powerful platform, given that people are influenced by what they see in the media. However, the media may also be an important tool for challenging public prejudices. It can be a means of improving public education and awareness (McGivern, 2016).

One factor that has contributed to the lack of comprehensive knowledge regarding mental illness is that there is a lack of prioritisation of mental health issues in Africa. Mental illness does not seem to be given the same priority as other medical conditions. There is a need for more campaigns and global recognition of mental health. It was believed that:

*Another difficulty in knowledge of mental illness could be due to the fact that mental illness not being prioritized like other medical conditions, globally. There are less mental health campaigns, compared to other illnesses (P00 1).*

Individuals with the proper knowledge and background in mental illness can assist people who are not fully aware of the causes and treatment of mental illness. This alludes to the importance of mental health awareness programs and interventions that should be widely conducted throughout communities, both urban and rural.

## ***Stigmatisation***

Stigma seems to be the intertwining factor when it comes to the difficulties in knowledge and perceptions of mental illness. The stigma and discrimination that people with mental experience can exacerbate their problems, making it difficult for recovery to occur. The fear of being stigmatised may lead to people with mental health issues failing to access the help they need. Furthermore, people with mental illness are stereotyped as dangerous and volatile. Stigma was a common experience identified by the participants. One of the participants narrated her own ordeal related to the fear of being stigmatised:

*I remember during the undergraduate phase when I told my friend that I wanted to go to the Psychology department as I found it difficult concentrating on my studies after my grandmother's death. She just nodded her head and said "yoooooooooh people are going to think you are going crazy if they see you near that clinic". We both laughed, and I ended up not going because of the stigma attached. I thought of how people would react after seeing me there (P00 1).*

In relation to stigma, another participant also explained that:

*The level of stigma and stereotypes attached to mental illness is just beyond me. I think the stigma associated with mental illness creates difficulties for people to evolve, even with new knowledge. It is difficult for people to think of mental illness without thinking of instability, and being dangerous (P00 4).*

People battling with mental health illness may be ashamed to disclose their condition due to the stigma that is attached to mental health. As compared to physical ailments, people are afraid to disclose their mental illness, fearing that they may be judged, ridiculed and shunned by others. As a result, many individuals live in silence striving to suppress their undiagnosed mental health disorder. One participant stated that:

*People still feel ashamed to disclose their condition when it is related to mental illness, rather than physical illness. With all the information we have on mental illness, people still remain shameful for disclosing mental illness diagnoses, as opposed to physical illness (P00 4).*

Mental health has historically been neglected, relegated to the periphery on Africa's health and development policy agenda (Jacob et al., 2007). This trend is often compounded by ignorance about the extent of mental health problems, stigma against those living with mental

illness and mistaken beliefs that mental illnesses cannot be treated (Becker & Kleinman, 2013).

#### **5.4 Help-seeking behaviour**

Participants in this study revealed that stigma and stereotypes make it difficult to seek help, considering that one may be treated differently. This stems from the notion that mental illness causes one to become unpredictable, violent and impulsive (Clement et al., 2015). This sub-theme examined how knowledge and perceptions of mental illness impact on help-seeking behaviour. Some of the participants shared personal experiences of how friends had discouraged them from seeking professional help. One of the participants narrated that:

*Still to this day, my friend discouraged me for seeking a psychologist. She thinks people will doubt my capability of being a good psychologist. She said “how you expect people to relay on with their problems, if you cannot handle your own” (P00 2).*

The construction of people suffering from mental illness as “*unpredictable, violent and impulsive*” (P001) and “*crazy*” (P003) contribute to the stigmatisation of people living with mental illness. The stigma and stereotyping of mental illness leads to people suffering from mental illness being treated differently, which affects their health seeking behaviour. It was explained that:

*With stigma and stereotypes attached to mental illness, help seeking behaviour is disadvantaged because I know that once you disclosed that you have mental illness, people start treating you differently even without understanding the diagnosis (P00 1).*

The fear of being treated differently limits many people from seeking mental health services. It seemed that the fear of stigma was bigger than the mental illness itself. Thus, it was revealed that people are “*afraid of the stigma that comes with the fact that one has a mental problem*” (P005). Although there have been significant advances in treatment of various diseases, over the past decades, the stigmatization and discrimination of people with mental illness has remained a constant (McGinty et al., 2015).

The social construction of mental illness and the act of seeking professional mental services as being Western practice and only for the rich has also contributed to the lack of health seeking behaviour among the African population group. Mental illness is seen as foreign to African people (Foster, 2011). Hence, it is difficult for one to seek help for a condition that

does not exist in their culture. This social constructionism of mental illness is illustrated below:

*Mental illness is seen as an illness for White people. Psychological services are viewed as treatment for the Westernised population. Seeing a psychologist is a luxury. Someone seeing a psychologist or psychiatrist would be viewed as having lots of money and not knowing what to do with it (P00 3).*

Another factor identified as a challenge in terms of seeking mental health services was the belief in traditional cultures. Traditional beliefs such as belief in the existence of ancestors seemed to influence how African people explain mental illness, and subsequently seek help. For example, some participants believed that:

*When a person presents with mental illness, their ancestors are either upset or require a ceremony to appease them (P00 5).*

*The way we are socialised by our different communities or cultures will have an impact on how we perceive mental illness. For one, in my culture, mental illness is associated with punishment. I grew up knowing that people will act out of character because of what they had done wrong (P00 3).*

Furthermore, most African societies are patriarchal in nature and gender roles are strongly enforced. Males are perceived as dominant and strong. As such, it is commonly accepted that men do not experience physical illness easily, and more so expressing emotional pain is a sign of weakness (Addis & Mahalik, 2003). Thus, African men are not expected to experience mental illnesses such as depression. This indicates that it may be more acceptable for females to seek help for their mental illness than their male counterparts due to stereotyping as stated below:

*Yeah and with the approach used, African males would find it even more difficult to seek help even when they know they are depressed, with the fear of being seen as weak by fellow Africans (P00 3).*

There was also a general perception that community awareness regarding mental health illness was lacking, especially when compared to physical ailments. The issue of mental illness was hardly spoken about, making health-seeking behaviour a challenge. The lack of awareness is affirmed by one of the participants who stated that:

*Even when there are health campaigns, one would see huge flyers of HIV/AIDS and other illnesses, but you seldom see a huge poster or flags on mental illness. This basically makes it [mental illness] seem like a taboo, unspoken illness and as a result, help-seeking behaviour will be affected, especially amongst students. (P00 1).*

This lack of awareness contributed to people not knowing the symptoms of mental illness. As a result of lack of awareness and basic information on mental illness, one of the participants argued that:

*I really think that because of the lack of information on mental illness, students can never tell when it is healthy or unhealthy stress (P00 3).*

Madzie, Mashamba and Takalani (2014) assert that many mental illness sufferers are unaware that they have an illness that is diagnosable and can be managed through use of effective treatment. An awareness that mental illness can be treated results in a reduction in issues of non-detection in general practitioner or primary care settings. Lack of adequate knowledge and awareness of mental illness, symptoms and where to seek help could be the reason for the high incidence of patients with psychiatric disorders who are undiagnosed and therefore go untreated.

Access to mental health services seemed to be limited, thereby also negatively impacting those with mental illnesses and seeking mental health services. The visibility of the services at university is limited, with clinics being situated in uncondusive places. With regards to the location of the Psychology clinic at the university campus, some of the participants commented that:

*I actually had not realised that we had a Psychology clinic within campus, until last year when I applied for a master's degree (P00 2).*

*Why is the clinic even in the basement of the building? It is right at the far end (P00 3).*

Participants were also of the opinion that accessibility and availability of mental health services in rural areas and even across the country was limited;

*The health system in this country has made access to mental healthcare treatment not easily accessible, especially in rural areas and even around campus. (P00 2).*

*Rural areas are deserted when it comes to service delivery especially with mental illness, and this exacerbates the lack of awareness and understanding. The urban areas are prioritised and this hinders help-seeking behaviour for those from the rural areas (P00 3).*

*The healthcare system within the rural communities is dominated by traditional healers; they are the primary healthcare providers (P00 5).*

Across South Africa, mental health resources are unequally distributed among communities. South African psychologists and psychiatrists are not evenly distributed across the country as they are mostly concentrated in large cities (Cape Town, Johannesburg, Pretoria and Durban), leaving large rural areas of the country without such services (Burns, 2011). A lack of resources and access to mental healthcare also limits people's awareness of the available treatment options.

### **5.5 Personal experience with mental illness in an African context**

Experiences with mental illness were either directly by personal experience or indirectly by having significant others that had or are currently experiencing mental illness. Murray et al. (2003) and the WHO (2011) state that globally, there is a high prevalence of schizophrenia as it affects over 25 million people (Murray et al., 2003; WHO, 2011). One participant had an uncle who was diagnosed with schizophrenia. However, in the place where he was residing, it was rumoured that his condition was a result of ancestral 'punishment'. The following was shared:

*My uncle was diagnosed with schizophrenia. We do not stay in the same area but where he stays, it is rumoured that its punishment from ancestors because he did not introduce his second wife to the ancestors (P00 2).*

Another participant also narrated her personal experience with a close relative who was diagnosed with schizophrenia:

*Someone very close to me was diagnosed with schizophrenia. Before he was taken to hospital as a last resort, we first tried the traditional route, but he was eventually helped by psychiatric medication. A lady who was a nurse that lives across our home came to the family to let the elders know that they needed to take him to the hospital, given that his condition needed psychiatric treatment, and not traditional healers (P00 3).*

The narratives above demonstrate that although mental illness may be common in African cultures, indigenous ways of understanding causes and treatment take precedence over western remedies.

In addition to schizophrenia, depression also seemed to be a common mental illness in the African context. One participant went through depression due to various life stressors such as financial hardships and losing a loved one. This impacted on her health and academic life as narrated below:

*I also went through depression during my undergraduate studies; nothing seemed to be working out for me. I lost my grandmother who was like a mother figure for me, my marks were dropping, and I could not find any sponsorship to fund my studies. It got bad to the point that sometimes I would stay in bed all day and abscond lectures. My friend discouraged me from seeking psychological help. She said that I was lazy and I should stop feeling sorry for myself and that I should just get up and focus on my academic work. She downplayed my symptoms, said it was normal, I was just tired. She actually said every student felt that way. (P00 1).*

The burden that men have as financial providers can be insurmountable, particularly when they do not have the means to provide for their families. Failure to fulfil their role as providers can be a source of depression as they may feel inadequate. In most, if not all African cultures, some people may not seek professional help when experiencing symptoms of mental illness as narrated below:

*My father lost his job in 2017. He would stay in bed all day. He was depressed and at some stage, he started speaking about himself as if he was going to die. It seemed as if he was planning to kill himself. He was so helpless and felt ashamed for being unable to take care of his family. Being the African man that he is, he refused to seek psychological intervention. He opted to go to a herbalist, I am not sure of the process but he stayed at his house for about two weeks, and he came back better (P00 5).*

The above narration reflects the belief held by some African societies that certain “illnesses” can only be addressed through traditional ways of treatment, rather than counselling and pharmacology. The lack of indigenous names relating to mental illnesses further deepens the challenges that African people encounter in seeking professional help as the names of most mental illnesses are foreign to them. One of the participants had the following to say:

*The saddest part was having to explain to my family that he was depressed because we do not even have a term for depression in my language. It was the toughest time, but I was just glad the herbalist could help (P00 5).*

### ***The Participatory Action Research intervention process***

The intervention of the participatory approach to this research study aimed to involve the participants in generating practical knowledge about mental illness issues and through this promoting personal and social change. This study was presented to Psychology master's students who were excited and interested. However, due to the nature of this study, emphasis being on commitment and equal involvement from the initial stage, through the process and till the final stage (McTaggart & Curro, 2009), only five Black African females were able to commit as co-researchers till the final stage. The focus group had to learn to facilitate the research project within a collaborative framework, there was respect for the knowledge of all participants and importantly, mutual learning amongst participants. After the first session, researcher analyzed data using thematic analysis. The second session of the focus group entailed providing feedback on themes that emerged during data analysis of the first focus group session.

McTaggart and Curro (2009) argue that participatory action research (PAR) reflects an endorsement of the belief that the parties affected by the research should be engaged throughout the research process and have the right to influence the way the topic of concern is conceptualised, researched, and practiced. There were various ideas on interventions to implement, such as making a YouTube video on mental illness awareness and have students evaluate the intervention online. However, participants voted for the poster intervention. Participants believed that the poster intervention would provide an opportunity for interacting with respondents, which would enable the researchers to answer those questions that were not addressed by the poster. Further, human contact was considered as the best since other benefits such as verbal cues could be derived from physical interaction. Thus, the poster intervention was designed and implemented as jointly planned by the co-researchers. Participants worked together with researcher to priorities information necessary for the poster. Information gathered in the first session was used as guidance. This was a small group, decisions were made democratically. The outcome of the poster intervention follows in the next section.

## 5.6 Evaluation of intervention

This section seeks to establish whether the poster intervention was seen as an effective intervention in addressing the knowledge gap in mental illness. This was done using a quantitative evaluation and was conducted with 17 respondents. There was a pre-intervention questionnaire and a post intervention questionnaire. Three YES/ NO questions were also included at the end of the questionnaire.

### 5.6.1 Biographical information of evaluation respondents

The respondents were registered students at the University of KwaZulu-Natal. The table below summarises the biographical profiles of the 17 respondents involved in the study. The 17 respondents belong to the age group of 21-29 years. In total, there were six Indian respondents, two White respondents and nine African respondents. Most respondents (n = 14) were females and three (n=3) were males. Among the 17 respondents, 10 were originally from KwaZulu-Natal (KZN) ten respondents indicated that KwaZulu-Natal (KZN) was their province of origin, while three were from the Eastern Cape (EC). Two respondents originally resided in Mpumalanga Province (MP), while two originally resided in the Gauteng Province (GP).

**Table 3: Socio-demographic information of the respondents**

Characteristics	Number	%
<i>Gender</i>		
Male	3	18
Female	14	82
<i>Age groups</i>		
20-22	9	53
23-25	7	41
25+	1	6
<i>Race</i>		
African	9	53

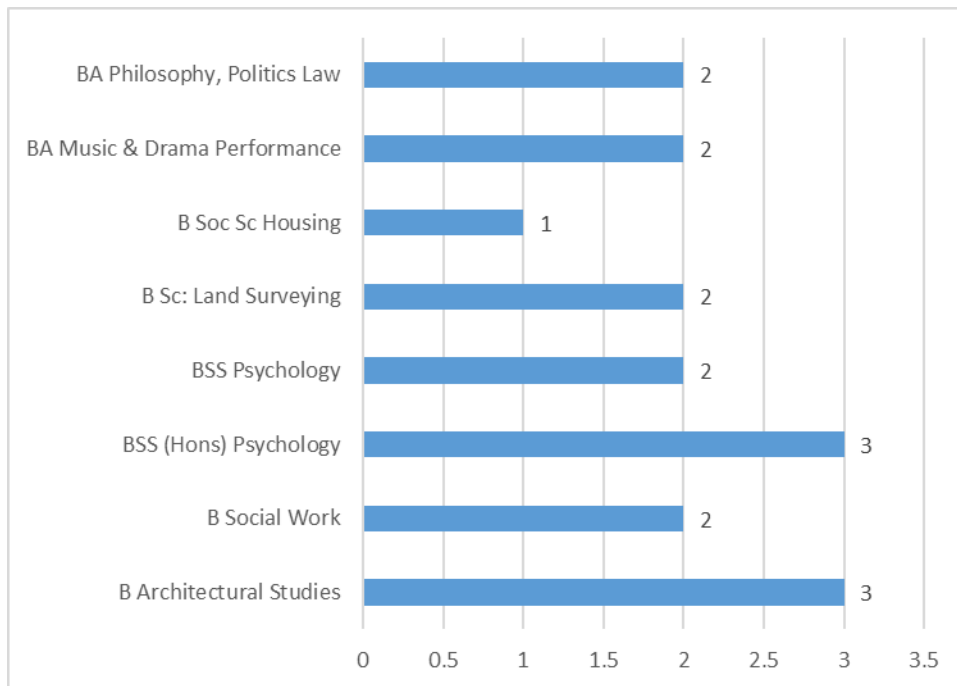
White	2	12
Indian	6	35
<i>Province</i>		
KwaZulu-Natal	10	58
Gauteng	2	12
Eastern Cape	3	18
Mpumalanga	2	12
<i>Level of education</i>		
Undergraduate	3	18
Postgraduate	14	82

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### **5.6.2: Respondents' field of study**

Most of the respondents were from the Faculty of Humanities. The fields of study were as follows: Bachelor of Social Science Housing (n=1); Bachelor of Architectural Studies (n=3); Bachelor of Social Sciences Psychology (n=2); Bachelor of Arts in Music and Drama Performance (n=2); Bachelor of Social Sciences Honours in Psychology (n=3); Bachelor of Arts Honours in Philosophy, Politics and Law (n=2); Bachelor of Social Work (n=2); Bachelor of Science in Land Surveying (n=2) (see Fig 5.1).

**Figure 1: Respondents' field of study**

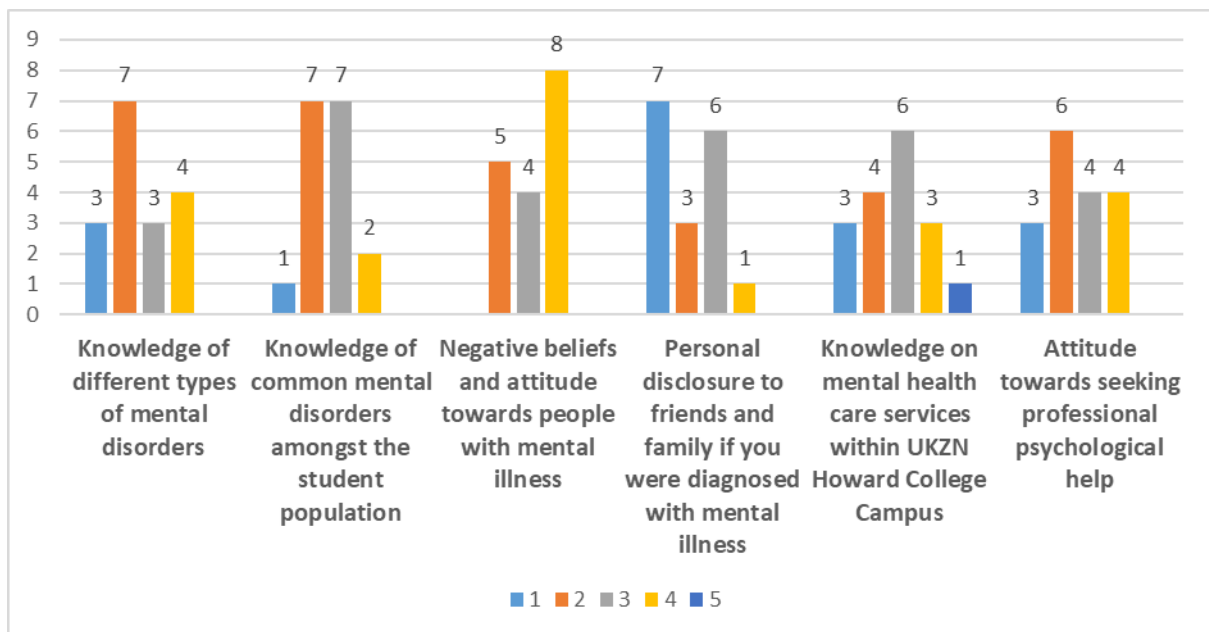


## **5.7 Evaluation feedback on the poster intervention**

### **5.7.1 Evaluation feedback prior to reading the poster**

The study is small, thus descriptive statistics were used to determine the impact of the intervention. The respondents' opinions were scored on a Likert scale ranging from 1-5, with a score of 1 representing poor knowledge and negative attitude whilst a score of 5 represented excellent knowledge and positive attitude towards people with mental illness.

**Figure 2: Pre-intervention feedback**

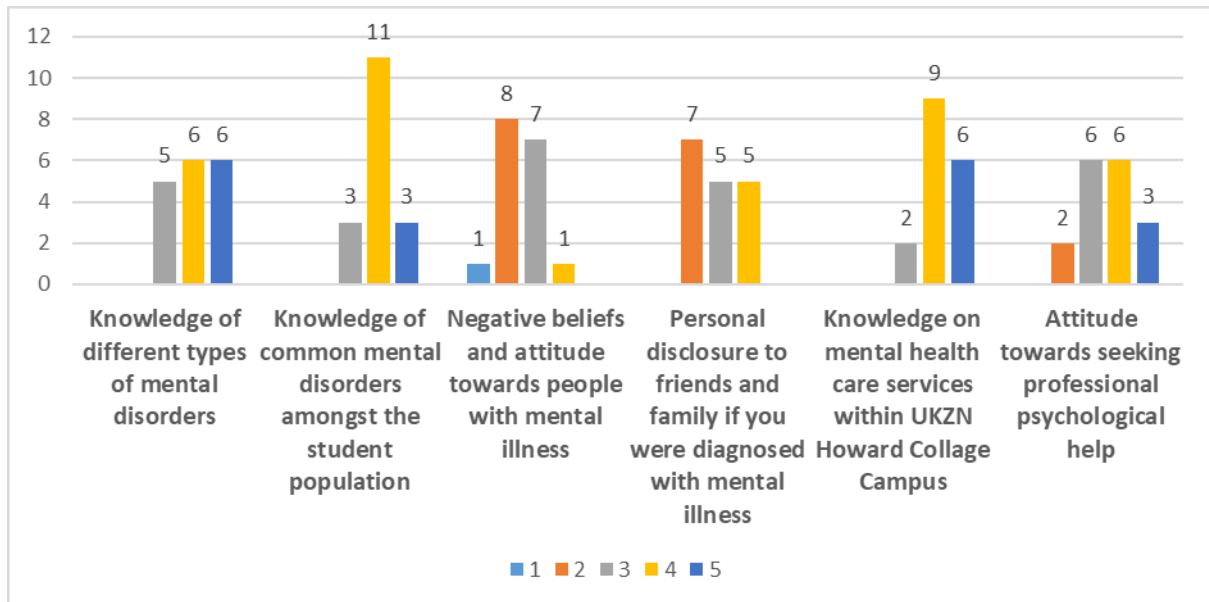


Prior to reading the Poster, the results imply a weaker and more limited understanding of mental illnesses. This can evidently be seen from the higher number of respondents with lower rankings of fields (1, 2, 3). None of the respondents reported having excellent knowledge on mental disorders before the poster. The figures above indicate that approximately 50% of the respondents had poor knowledge of common mental disorders amongst the student population before the poster was introduced.

The figures above show that prior to reading the poster, negative beliefs and attitudes were high. Prior to the poster, only around four respondents were fully aware of the mental healthcare services within the University KwaZulu-Natal’s Howard College campus. More than half of the respondents had negative attitudes towards seeking professional psychological help.

### 5.7.2 Evaluation feedback post reading the poster

**Figure 3: Post-intervention feedback**



After reading the poster, results showed that respondents were more knowledgeable and aware of mental illness based on their rankings (more rankings were towards 4 and 5). The increase in the number of respondents who reported excellent (4 and 5) indicated that the poster was helpful in providing knowledge on the different types of mental disorders. Eleven respondents leaned towards ‘excellent’ by choosing the rating of 4, while three of the respondents chose the rating of 5, being excellent to express their knowledge of common mental disorders after exposure to the poster.

Undesirable attitudes and opinions towards people with mental illness became poorer after the poster was introduced. This could be due to the respondents being exposed to accurate and appropriate information, which changed their opinions on mental illness. After exposure to the poster, all respondents were aware or had an improved understanding of the mental healthcare services at UKZN Howard College campus.

The figures above show that respondents were more inclined to seeking professional psychological help after they had been exposed to the poster. This seemed to suggest that exposure to accurate information may motivate individuals to seek professional psychological help. However, one aspect that seemed not to have changed even after exposure to the poster

was the intention to disclose mental illness diagnosis. This can be as a result of the stigma and negative attitudes associated with people suffering from mental illness.

### 5.8 Three general Yes/ No questions

Question	Yes	No
Did you find the poster knowledgeable?	17	0
Would you appreciate more mental health campaigns in the future	17	0
Are mental healthcare services easily available at UKZN Howard College campus	9	8

The respondents were asked three general Yes/No questions regarding the usefulness of the poster, desire for more mental health campaigns in the future and availability of mental healthcare services at UKZN Howard College campus (see Fig 4). Respondents' opinions on the knowledge ability of the poster show that all of the respondents (n=17) found the poster to be helpful and that it helped them gain knowledge of mental illness. Respondents' opinions on whether they would appreciate more mental health campaigns in the future also indicated that all of the respondents (n=17) would appreciate more mental health campaigns in future. This could be due to their need for identifying mental illness within themselves and/or amongst fellow students. Furthermore, this would be an opportunity to gain more knowledge and information on treatment and possible psychological services that may be available to them. Almost half of the respondents (n=8) felt that mental healthcare services were not easily available at UKZN Howard College campus. This could be due to the lack of directions to the on campus physical facility or the lack of information on how to go about accessing the relevant information.

## **Conclusion**

This chapter presented the data collected using qualitative interviews and quantitative survey, with data analysis from the data collection process. The qualitative data was discussed along with the quantitative data, from the focus group discussion as well as the evaluation questionnaire. The discussion of findings was elucidated through main themes that traverse the data, as well as integrating key findings along with comparisons, especially in the case of the evaluative responses where respondents were asked to submit data before and after viewing the poster. Chapter 6 focuses on the discussion of the analysed data.

## CHAPTER SIX: DISCUSSION OF FINDINGS

It is important to highlight that this chapter focuses on discussing the findings obtained through the focus group discussion and quantitative data generated from the poster intervention. The first part of this chapter discusses the findings from the focus group discussion with five participants. The second part discusses the importance of Participatory Action Research (PAR) in which students participated in the formulation and implementation of a poster intervention.

In the African context, mental illness is regarded as a silent epidemic because of the stigma and stereotypes associated with this phenomenon. Therefore, it was important to capture the general understanding of mental illness amongst student participants. According to SRT, the meaning of mental illness is described through social construction within a particular social group, and therefore understanding of mental illness can be socially constructed the group of students as different social groups (Harkonen, 2003). The participants presented different perceptions of mental illness, which were largely influenced by either the African traditional perspective or Western ideologies illuminating mental illness. This is in line with the social representation framework, which is of the notion that individuals from a social grouping share socially constructed beliefs, values and knowledge (Moscovici, 2000).

On the one hand, the African traditional perspective associated mental illness with someone who would have been bewitched or punished by the ancestors. Leavey, Loewenthal and King (2016) assert that Africans tend to conceptualise mental illness as being socially constructed. According to Semrau et al. (2015), most Africans' understanding of mental illness is deeply rooted in cultural belief and value systems that are based on the inherited spirits that exist, which are perceived to affect a person's health and wellbeing. The cause of mental illness in many traditional societies is understood to be the reason for life hardships and ill-health caused by the activity of supernatural agents (Akomolafe, 2012). Akomolafe (2012) also stated that there was a general belief of psychiatric illness not being a disease, but a curse that is caused by witchcraft and evil spirits. Similarly, Elise (2006) agrees that traditional communities believe that mental illness is caused by spirits and curses from the ancestors. This is in line with the exo-system within the Ecological systems theory that underpins that mental illness is understood through a social framework attributing mental illness to occasions and possibilities.

On the other hand, some of the participants indicated that mental illness is caused by biomedical or genetic conditions. Participants who subscribed to this school of thought based their understanding on a Western perspective. The meso-system in the ecological systems theory bring to light that mental illness can also be understood by making associations and connections, hence the participants' understanding of mental illness is associated with the cause as being biomedical or genetic conditions (Paquette & Ryan, 2001). Similarly, Chikomo (2011) mentions that studies have shown that in the Western world, mental illnesses are generally caused by psychosocial factors, such as environmental stressors and biomedical conditions. Jorm (2000) demonstrated that mental illnesses such as schizophrenia have a greater likelihood of being linked to genetic causal factors in comparison to common mental disorders such as depression. This is linked to the biomedical model of diagnosis, which is popularly used in the Western countries. The bio-medical model advocates that mental illnesses or disorders are generally neuro-physiological (Deacon, 2013). It is not surprising that some of the participants ascribed the causes of mental disorders to biomedical causes since they were masters' students who were exposed to various avenues of knowledge regarding mental illness. Thus, their educational background influenced their knowledge of the causes of mental illness.

In general, the participants directly or indirectly had a personal experience with mental illness. For some of the participants, understanding of mental illness was largely influenced by personal experiences. One of the participants had a close relative who was schizophrenic. Globally, there is a high prevalence of schizophrenia as it affects over 25 million people globally (WHO, 2007). Depression was another mental illness that was identified by the participants. It was indicated by one of the participants that her father had depression caused by environment stressors such as job loss. Okasha (2002) posits that a considerable section of the population in African countries is vulnerable to mental illness due to psychosocial and socioeconomic stressors such as poverty, unemployment and job losses.

In addition, studies have shown that mental illnesses are generally thought to be caused by psychosocial factors such as environmental stressors or childhood events (Chikomo, 2011). According to the micro-systems in the ecological systems theory, mental illness may develop because of the impact of the micro-system. The micro-system includes environmental setting as well as relational connection in a specific setting (Paquette & Ryan 2001). Due to stigma and discrimination, many people with mental illness suffer in silence and will not disclose or seek treatment thereby increasing their marginalisation in society.

The Coronavirus pandemic has also contributed to the economic and social hardships in South Africa, which are associated with a broad range of psychopathologies (Subramaney et al., 2020).

In some African countries, there are certain subjects that are not spoken, openly (Amuyunzu-Nyamongo, 2013). Mental illness is one of those subjects. It is socially constructed, implying that different societies, groups and cultures, have diverse ways of conceptualising its nature and causes (Dixit, 2005). The high prevalence of social stigma in African communities demonstrates that mental illness is a hidden issue equated to a silent epidemic (Amuyunzu-Nyamongo, 2013). Poor knowledge and negative perceptions of mental illness is considerably high in Africa. Participants in this study indicated that university students lacked knowledge of mental illness and they were largely misinformed in terms of their interpretation of mental disorders. Similarly, Cadge, Connor and Greenfield (2019) found that students lacked the necessary knowledge and had various misconceptions about mental illness.

The lack of adequate knowledge about mental illness contribute to the various misconceptions about mental illness (Jorm, 2012). Another study in Eritrea found that students had negative attitude towards mentally ill people because of the misconceptions they had about mental illness, which was informed by their cultural beliefs (Tesfamariam et al., 2018). Thus, there is a clear relationship between lack of knowledge, negative beliefs, and cultural beliefs of mental illness. This relationship points to the need for providing adequate knowledge on mental health to alleviate misconceptions and negative beliefs associated with mental illness.

People who suffer from mental illness are often stereotyped (Stout, Villegas, & Jennings, 2004). Some of the participants indicated that stereotypes relating to mental illness were reinforced by the media. The messaging and portrayal of people with mental illnesses in mainstream media is primarily negative, which exacerbates the stigma associated with mental illness. Studies consistently show that both entertainment and news media provide overwhelmingly dramatic and distorted images of mental illness that emphasize dangerousness, criminality and unpredictability (Stuart, 2006). Many movies portray mentally ill characters as significantly violent and one in four mentally ill characters kill someone, and half are portrayed as hurting others, according to Diefenbach (1997). The same negative portrayal of mentally ill people is found in the print media. Reporters emphasize the

violent, delusional and irrational behaviour of people with a mental illness, and often sensationalise headlines or story content in order to attract attention (Olstead, 2002; Stuart, 2006).

Negative depictions of mental illness by the media have immense and unfavourable consequences for people diagnosed with mental illness. Numerous studies show that heavy exposure to media of mental illness does not only cultivate misinformation about crime and misconceptions about those who commit crimes, but engenders intolerance towards people with mental illnesses and negatively influences the way in which the public evaluates mental health issues (Stout, Villegas, & Jennings, 2004). This suggests a need to change the characterisation of mental illness in media and positively portray mental illness as another form of illness that can be managed well, with proper treatment.

The consequences of negative stereotypes and stigma suffered by people who have mental illness are profound. These negative repercussions may include impaired self-esteem and negative help-seeking behaviours (Stout, Villegas & Jennings, 2004). In the current study, participants reported that the stigma attached to mental illness has resulted in people with mental illness avoiding treatment and hiding from healthcare services. Stigma and discrimination against people with mental illness remain barriers to help seeking and the full recovery of people in need of mental health services, globally and in particular South Africa.

Findings similar to the above were obtained by Egbe et al. (2014) in South Africa, that various forms of externalised stigma were experienced by mentally ill people from primary health facilities, family members, neighbours, friends, church members and the general community, which resulted in them avoiding treatment. A matter of concern is that even those that are supposed to provide professional help to people with mental illness also stigmatise and discriminate them, hence it becomes difficult for them to access treatment. Egbe et al. (2014) reported that it was disturbing that health care staff had negative stereotypes of people with mental illness. Consequently, those with mental illness suffer in silence, become isolated and marginalised as they are discriminated by almost everyone in their communities, which inhibits their capacity to lead normal lives. Therefore, stigma is a major barrier to health care and good quality of life for mentally ill individuals.

Importantly, participants in the current study indicated that there are other factors that contribute to negative help seeking behaviour among people with mental illness. Some of these factors include belief systems, lack of resources, and limited access to mental health

facilities. In the South African context, mental health facilities are inaccessible by those people with mental illness especially those living in rural areas. According to Petersen and Lund (2011), studies have shown that people with mental illness are often marginalised and discriminated against. Several barriers at societal level contribute to this marginalisation, including lack of affordable mental health services, and a general shortage of human resources for mental health care (Corrigan, 2004).

Findings from a study conducted in the Eastern Cape by Schierenbeck, Johansson, Andersson and van Rooyen (2013) found that there was lack of physicians and psychiatrists in the local health facilities. Further, there was also lack of facilities to assess patients suffering from mental illnesses in most clinics. In addition, Schierenbeck et al. (2013) reported that lack of access to affordable public transport as a challenge, hence, healthcare users were forced to walk to health facilities to seek treatment. Therefore, lack of transport might be a contributing factor for mental ill people not to access health care. The participants further indicated that mental health care was expensive and not affordable to the general public, hence they considered it a rich people's disease. A study conducted by Jacob and Coetzee (2018) in Western Cape Province confirmed that the costs of health care for mental illness was extremely exorbitant. Similarly, Plastow (2015) had earlier indicated that in South Africa, the high cost of treatment means that effective and appropriate care is frequently inaccessible to people using the country's public health system. Therefore, it is important for health facilities catering for patients suffering from mental illnesses to be accessible in terms of affordability, adequate staff and reachable health facilities, as this encourages positive health-seeking behaviour (Plastow, 2015).

Most Black Africans tend to view mental illness as a 'White man's disease', meaning that it does not apply to them as such they will not seek treatment. A common understanding of the cause of mental illness in the community was the belief that people with mental illness were bewitched. Due to this belief system, many families seek care from African traditional healers (sangomas) before they consider visiting the clinic (PlusNews, 2010). This belief in witchcraft also results in delays in seeking medical help or even not seeking treatment at all. Most Black South Africans seek treatment from traditional healers for solutions that are related to mental illness (Richter, 2003; Peltzer, 2009). It is also important to note that symptoms of mental illness are sometimes viewed as a sign denoting a call by the ancestors to take up the role of a traditional healer ('sangoma') or as being gifted (Egbe et al., 2014).

Therefore, family members would rather take a person suffering from mental illness to a traditional healer first before taking him/her to the clinic.

Some of the participants believed that consulting traditional healers was effective in treating mental illness. Natrass (2005) suggests that alternative practitioners may play an important role in addressing mental health care needs in South Africa by offering culturally appropriate treatment. In many African traditional belief systems, traditional healers and religious advisors are viewed as having the expertise to treat mental illness. In a country where there is limited access to mental health care services, African traditional healers are often more accessible than Western forms of mental health care. Black South Africans were seven times more likely to seek help from a traditional healer as compared to Coloured, White or Asian/Indian population group (Sorsdahl et al., 2009). Acknowledging the possible role of traditional healers in providing care together with educating and working with them may be an important way forward in improving mental health care among African people. African traditional healers are widely dispersed throughout South Africa and are knowledgeable of the various cultural norms, making it important to educate traditional healers on common mental disorders as they may serve as a referral resource (Peltzer, Mngqundaniso, & Petros, 2006).

Some of the participants highlighted that African men were both sceptical and ashamed to seek treatment for mental illness. African men that seek treatment appear weak in the eyes of broader society because men are socialised to be strong. Addis and Mahalik (2003) posit that dominant conceptions of masculinity depict and encourage boys and men to be assertive, strong, competitive, and independent. Men are supposed to be providers and failure to undertake this role because of job losses or unemployment causes significant stress and depression. The stressful nature of male breadwinner expectations or not being able to fulfil this role may lead to negative health outcomes, according to Springer (2010). Men are less likely than women to seek help for mental health problems (Galdas, Cheater, & Marshall, 2005).

There is a belief that men often hide mental illness and are not willing to report its symptoms (Lee & Owens, 2002; O'Brien, Hunt, & Hart, 2005). Hence, Real (1998) suggests that there is a "silent epidemic" among men particularly regarding depression. In addition to expectations of assertiveness, dominance, aggression, independence, and risk taking, men are expected to keep hidden any emotion that might be defined as effeminate or weak (Smith,

Mouzon, & Elliot, 2018). Consequently, men with mental illness will not seek treatment because this exhibits some form of weakness on their part. The findings highlighted the need to break away from dominant gender stereotypes particularly regarding health seeking behaviour. Men should be socialised to embrace seeking health care without feeling inadequate or weak.

The participants further demonstrated that the difficulties in knowledge and perceptions of mental illness amongst students was a result of lack of adequate knowledge, coupled with the stigma associated with this epidemic. One of the participants was stigmatised by a close friend after disclosing her mental illness. These findings are corroborated by previous studies that were done on mental illness, globally. Seeman et al. (2016) found that stigma in mental illness creates mental distress for individuals, which fosters stigmatising attitudes, making it an unrelenting force. There are many negative and vastly damaging stereotypes attached to people with mental illness. These include being perceived as dangerous and unpredictable and solely to blame for their illness (Angermeyer & Dietrich, 2006). Most importantly, prejudice occurs when individuals sanction such stereotypes, and discrimination becomes the behavioural result of prejudice (Corrigan, Druss, & Perlick, 2014). Monteiro's (2015) study reported that stigma contributes to discrimination from others and internalised negative self-perceptions in the form of self-stigma.

An interesting finding of the current study is that, whereas other behaviours such as knowledge on mental health and attitudes towards seeking professional help improved greatly, personal disclosure to friends and family if one was diagnosed with a mental illness did not result in any significant change. This may not be surprising considering the prevalence of stigma, stereotypes and negative beliefs identified by the participants. Previous research outcome found that when a person is diagnosed with mental illness disclose, it is usually selective disclosure with family members and friends found to be the primary confidants about an individual's mental illness because of an increased likelihood of obtaining support and resources (Pahwa, Fulginiti, Brekke, & Rice, 2017). Fear of disclosing a mental health condition is a potential barrier to accessing health services. Hyman (2008) postulates that self-disclosure has advantages such as not having to worry about hiding experiences with mental illness, finding others with similar experiences, and it promotes one's recovery process by allowing one to seek help and join a self-help group. This finding points to the need to develop and implement potential disclosure interventions as evidence indicates that interventions targeting mental health disclosure are more effective than those

targeting internalised stigma (Carpenter & Greene, 2013). According to Kelly et al. (2007), mental health can be achieved through providing the youth with mental health literacy, which could be done through facilitating early help-seeking behaviour or through assisting adults identify early signs and symptoms of mental health disorders.

### **The Participatory Action Research**

The researcher ensured that the participants were fully involved in the formulation of the contents of the poster intervention. This is consistent with Nota's (2019) assertions that PAR assumes that the people who live the experiences that are being studied are the experts, and that knowledge is something that is produced through the active engagement and interaction of all members of a research group. By nature, Koch and Kralik (2009) iterate that PAR is a qualitative inquiry that is considered democratic, equitable, liberating, and life-enhancing, and which remains distinct from other qualitative methodologies, particularly concerning the roles played by the researcher and the participants (Gibson, 2002). By using PAR, McIntyre (2002) suggests that there may be the formation of public spaces whereby participants and researchers can reshape their knowledge of how political, social, economic, and familial contexts in communities may impact daily life. This is particularly important to decreasing the stigma associated with mental illness in South African communities.

Participation by study participants is central to poster interventions since the inclusion of ideas, opinions and perceptions of those involved is significant (Wakkary, 2007). Unlike other participatory settings of data collection, poster intervention provides a platform where the participants and the researcher actively learn together and negotiate meanings. What becomes critical in this setting is openness from both the researcher and the participants. From the researchers' position, openness relates to the ability to allow the participants to influence the course of the intervention and allow for unexpected findings. The researcher created a supportive environment, where participants felt safe to participate and share ideas, openly. Participants were able to express themselves honestly and freely. The significance of poster intervention was manifested in the collaborative element that it brought to the research process, where the researcher and the participants came together to learn and share knowledge on mental illness. The collaboration of individuals with diverse knowledge, skills, and expertise fosters the sharing of knowledge development, as postulated by Chandler and Torbet (2003) and Kelly (2005). This was immensely important in the development of the

poster intervention as the researcher and the participants contributed to the contents of the poster collaboratively.

After designing the poster intervention, the researcher and the student participants presented the poster in Shepstone Building, which is one of the busiest buildings at the UKZN Howard College campus. The rationale behind this was to enable more students to access the poster and be able to participate. Respondents were asked to review the contents of the poster intervention, assess their knowledge before reading the poster and ultimately, after reading it. An evaluation was made on the impact of the poster intervention in addressing the students' difficulties with obtaining adequate knowledge of the mental illness. A total of 17 students at the selected UKZN campus participated in the poster intervention, and these were drawn from various disciplines. The project aimed at getting more respondents, however, students were reluctant to participate, which could also be due to the stigma around mental illness.

Before reading the poster, the results demonstrated a lack of adequate knowledge and limited understanding of mental illnesses by the respondents. Most respondents in the poster intervention had a poor understanding of common mental disorders amongst the student population before the poster was introduced. After reading the poster, results demonstrated that respondents were much more knowledgeable and aware of psychological illness. Attitudes and beliefs were found to be negative towards individuals with mental illness were non-existent after the poster was introduced. The reason for the shift in negative attitudes and beliefs by the respondents was as a result of exposure to accurate and appropriate information. After the poster intervention, all respondents were aware or had an improved understanding of the mental healthcare services available at UKZN Howard College campus.

The results further indicated that the respondents developed positive health-seeking behaviours and became willing to seek professional psychological help after they were exposed to the poster. This suggests that exposure to accurate information may motivate individuals to seek professional psychological help. This is consistent with a study by van der Ham et al. (2017), which found that adequate knowledge about mental illness contributed immensely to positive health seeking behaviours. However, one aspect that seemed not to change even after exposure to the poster was the intention to disclose mental illness diagnosis. This can be attributed to the stigma and negative attitudes associated with people

suffering from mental illness. This is in line with findings by Mitchell, McMillan and Hagan (2017) that stigma and embarrassment were barriers to disclosure of mental illness.

It was noted that the poster intervention was very effective in increasing knowledge on mental illness among students. Students became aware of the different types of mental illnesses, and they were also keen to seek professional psychological help after they were exposed to the poster. Ilic and Rowe (2013) confirmed that poster interventions achieve success in increasing knowledge, changing attitudes and behaviour on mental illness. Available evidence provided by Corrigan and Watson (2003) and Henderson, Evans-Lacko and Thornicroft (2013) indicates that improved knowledge about mental health and mental disorders, better awareness of how to seek help and treatment, and reduced stigma against mental illness at an individual, community and institutional levels may promote early identification of mental disorders, improve mental health outcomes and increase the use of health services. Hence, the poster intervention is an essential and useful tool in increasing knowledge on mental illness amongst students.

The importance of poster interventions is that they represent what would not have been easily expressed in words (Mitchell & Sommer, 2016). The researcher's experience of using poster intervention in this study proved to be an effective approach to engaging students in efforts to increase knowledge on mental illness. The poster intervention allowed the creation of an interactive, co-learning environment that enabled students to speak freely about the challenges they were facing in terms of stigma and how it affects their health-seeking behaviour. This methodology allowed both the researcher and the participants to understand the students' experiences of the mental illness that would not have been easy to express in an interview setting. The use of a poster intervention in this study through the PAR approach sought to give the students some form of control and inclusion in the research process. It provided them with a space to voice their concerns and share their perspectives on a sensitive and largely stigmatized topic - mental illness.

### **Methodological challenges**

It is critical to briefly focus on the challenges that the researcher faced in implementing the poster intervention through PAR. One of the challenges was getting many students to participate because PAR is time-consuming and requires the commitment of the entire research team. Most students were busy with their lectures and tutorials thus, they were not keen to be part of the study since PAR has been cited for lengthening the research process

(Danley & Ellison, 1999). The researcher finally conducted the focus group with five (=5) participants and 17 respondents for the poster intervention.

The researcher was able to identify increased ability in facilitation skills as well as project management skills. The researcher also experienced the greatest growth in the areas of methodology and shared decision making. After the design and implementation of the intervention, participants shared that the process was challenging, yet fulfilling as they contributed to increased awareness of mental illness.

## **CHAPTER SEVEN: RECOMMENDATIONS AND CONCLUSIONS**

### **7.0 Introduction**

This study set out to explore the difficulties and challenges in the knowledge and perceptions of mental illness amongst the student population at the University of KwaZulu-Natal, Howard College campus. The study was a Participatory Action Research (PAR) project, first section sought to identify the difficulties in knowledge and perceptions of mental illness amongst the student population and the effect it has on help-seeking behaviour, through a focus group. Thereafter, the focus group came up with a health promotion method to increase awareness and help-seeking behaviour amongst the general student population, through a poster intervention project. An evaluation was carried out amongst the general student population on their perceptions of the poster as a health awareness tool. The findings of the study were presented in the previous chapter while the present chapter focuses on the major findings in relation to the research objectives and study questions outlined in the first Chapter. Limitations of the study is discussed followed by recommendations and conclusion.

### **7.1 Limitations of the study**

This study was based on views of a particular group in a particular context thus the findings, conclusions and recommendations of the study cannot be generalised. It is difficult to generalise qualitative research. The focus group's composition lacked diversity, black African only. The conclusions drawn from the study may not be applicable to all universities or places of higher education and may also not be representative of a larger general population. Several higher education populations in the province of KwaZulu-Natal could have been included. However, this would have been financially intolerable and time consuming and, outside the scope of this study. In the focus group at first, social desirability was main concern, however, researcher took measures to minimise the social desirability by ensuring anonymity and openness to enhance relevance and quality of data.

### **7.2 Major findings of the study**

The key research questions involved knowledge and perceptions of mental illness, personal experiences with mental illness, help-seeking behaviour and an intervention that could be put in place to deliver knowledge on mental illness amongst students.

**Research question 1:****What difficulties exist in the knowledge and perceptions of mental illness amongst the student population?**

The findings revealed that students lack knowledge on mental illness and that misinformation is rife amongst students. Traditional and cultural beliefs are given the same priority as Western thoughts on mental illness, and treatments are combined as well. The fact that mental illness is not discussed openly amongst members of the community leads to misinformation turning into fact, and being absorbed by the community, even students who are a part of that community. The lack of mental health awareness programs adds to this misinformation.

**Research question 2:****How are difficulties in the knowledge and perceptions of mental illness impacting help seeking behaviour?**

The findings revealed that cultural methods of dealing with mental illness are favoured since psychological and psychiatric consultations are believed to be the domain for people who adopt a Western lifestyle. Additionally, help-seeking behaviour is hindered by the fear of stigma and stereotyping. The other factor that affects help-seeking behaviour is the inadequate number of accessible treatment options, which is likely attributable to third world infrastructure insufficiency. Lastly, participants lacked sufficient information on mental illness, which affects their help seeking behaviour.

**Research question 3:****What interventions are recommended by students to address the difficulties in their knowledge and perceptions on mental illness?**

Open dialogues and discussions were the two interventions that were considered to be of value to combat difficulties in knowledge and perceptions on mental illness at the university. This will provide an engaging platform to relay information on mental illness. Furthermore, a suggestion was made to have clear indications on the location of the Psychology clinic on campus to encourage help-seeking behaviour. The immediate intervention was the creation of a poster that provides information on mental illness and how help can be accessed.

#### **Research question 4:**

#### **How effective was the intervention in addressing difficulties in obtaining knowledge amongst the student population?**

The effectiveness of the poster was revealed by the respondents indicating that they had a good grasp of mental illness after viewing the poster. The evaluators were able to differentiate between common mental disorders and other types of mental diagnosis. They felt more comfortable revealing their mental health issues to family and friends. Further, they had an improved attitude towards seeking professional help, and had an improved understanding of the health care services that were available at UKZN Howard College campus. Overall, the evaluators felt that the poster was informative and they looked forward to more mental health campaigns.

#### **7.3 Conclusions of the study**

The study makes a strong contribution in the chosen area of mental illness in the South African context. This study examined the difficulties in the knowledge and perceptions of mental illnesses amongst Psychology master's students at UKZN Howard College campus.

The following implications and conclusions are drawn from the findings:

1. There are many classifications of the phrase mental illness but it primarily comes down to 'Western' and 'Traditional' views, which are informed by social representations in their communities.
2. Most research participants in the focus group had personal experiences with mental illness either personally or through a loved one.
3. The findings of this study showed that there lack of knowledge about mental illness was rife.
4. There is a high prevalence of stigma among those who experience mental illness.
5. Those who seek help for their mental health issues, from a traditional African cultural orientation are stigmatised.
6. Men that seek help for mental illness risk being stigmatised and discriminated against.

Moreover, the evaluation for the intervention showed that the poster was useful in informing the general student population of the different types of mental illnesses, symptoms, detection and where to obtain the necessary help.

### **The findings in the intervention project were as follows;**

1. Most of the study participants still hold stereotypical images of, or negative attitudes towards patients with mental illness. However, this seemed to have improved after reading the poster.
2. The student population was not uniform in their knowledge about the various mental disorders.
3. The student population needed to improve their mental health literacy. They indicated that they would appreciate more campaigns and awareness programmes on mental illness.
4. It was interesting to see that even after all the literacy gained about mental illness, a most respondents indicated a low self-disclosure of mental illness diagnosis.

This study revealed that there is need for mental health awareness programs both on and off university campus. These awareness programmes are crucial seeing as cultural beliefs are prominent amongst students and misinformation abounds amongst community members. There is need for more health facilities that address mental health needs.

### **7.4 Recommendations of the study**

The recommendations are aimed at increasing the knowledge and help-seeking behaviour of students who experience mental health issues.

- Since public knowledge of mental illness and treatments are poor in developing countries, it is recommended that extensive interventions are implemented regularly within communities, public spaces, secondary schools and universities/ colleges.
- The health care systems currently in place in South Africa should be assessed and incorporate aspects of addressing cultural beliefs and also address misinformation that may be taken as fact;
- There should be an increase in notices and signs regarding the location of the mental health clinic on campus so that students are encouraged to visit the clinic for their mental health needs;
- On campus interventions should support open dialogue, which would act to inform students on mental health issues and would additionally reduce stigma and stereotyping amongst students and,

- Classes can be held at the campus by professionals for students and the general public to gain more knowledge on mental health issues and how to identify them. Additionally, information on the best possible treatment methods can be incorporated into these classes to reduce the barriers to help-seeking behaviour and to also discourage stigmatisation and stereotyping.

### **7.5 Suggestions for further research**

In this study, the difficulties in the knowledge and perceptions of mental illness amongst the student population at the University of KwaZulu-Natal was assessed, along with the evaluation and effectiveness of a poster intervention. Further, research should be undertaken at other universities students pursuing a Master's in Psychology programme. Future research should be conducted in other provinces to establish trends. Lastly, future research should be conducted on strategies that can be developed to address the knowledge gap in mental illness at tertiary institutions and broader society.

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## APPENDIX A: GATE KEEPER'S LETTER



24 July 2019

Mrs Maichosazane Felicia Mashabane (SN 218082744)  
School of Applied Human Sciences  
College of Humanities  
Howard College Campus  
UKZN  
Email: [218082744@stu.ukzn.ac.za](mailto:218082744@stu.ukzn.ac.za) [Cartwrightd@ukzn.ac.za](mailto:Cartwrightd@ukzn.ac.za)

Dear Mrs Mashabane

### RE: PERMISSION TO CONDUCT RESEARCH

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

*"Difficulties in knowledge and perceptions of mental illness amongst the student population: Perspectives gained from a participatory action research project by psychology masters' students from the University of KwaZulu-Natal".*

It is noted that you will be constituting your sample by conducting interviews with Masters students on all five campuses.

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

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

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

Yours sincerely

MR S S MOKOENA  
REGISTRAR

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Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)



Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

## APPENDIX B: HSSR (ETHICS LETTER)



19 September 2019

Mrs Makhosazane Felicia Mashabane (218082744)  
School of Applied Human Sciences – Psychology  
Neward College Campus

Dear Mrs Mashabane,

Protocol reference number: HSS/0441/019M

Project title: Difficulties in knowledge and perceptions on mental illness amongst masters' students: Perspectives gained from the participatory action research project by Psychology students from the University of Kwazulu-Natal

#### Approval Notification – Full Committee Reviewed Protocol

With regards to your response received on 21 August 2019 to our letter of 01 July 2019, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol 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 discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 1 year from the date of issue. Thereafter Recertification must be applied for on an annual basis.

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

Yours faithfully,

Dr Rosemary Sibanda (Chair)

/ms

Cc Supervisor: Professor Duncan Carwright  
cc Academic Leader Research: Professor Ruth Teer-Tomaselli  
cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee

Dr Rosemary Sibanda (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag 204901, Durban 4000

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Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)

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Funding Campuses: Edgewood, Howard College, Medical School, Pietermaritzburg, Westville

## **APPENDIX C: PARTICIPANT CONSENT FORM**

### **School of Applied Human Sciences- Master of Social Sciences in Clinical Psychology**

#### **Participant Informed Consent**

Dear Prospective participant

My name is Makhosazane Felicia Mashabane, from the Discipline of Psychology in the Applied Human Sciences, Howard College, University of KwaZulu-Natal. I will be conducting a research study in partial fulfilment of a Master of Social Science in Clinical Psychology degree under supervision of Professor Duncan Cartwright who is also under the Discipline of Psychology, at the University of KwaZulu-Natal.

You are being invited to consider participating in a study that involves exploring difficulties in Knowledge and perceptions on mental illness amongst the student population: Perspectives gained from the participatory action research project by psychology masters students from the University of KwaZulu-Natal. This letter is to request that you participate in the above-mentioned study, details of the study will be addressed hereunder. This study is expected to evaluate the project implemented by the psychology masters students. The duration of your participation if you choose to enrol and remain in the study is expected to entail one session, 10 to 20 minutes, to be a respondent on the survey questions based on the knowledge prior and post the poster project.

The purpose of the study was explained to me and I understand what is expected of my participation. I understand that this is a research project whose purpose is not to necessarily benefit me personally. I also, understand that my answers will remain confidential. Data will be stored in secure storage and destroyed after 5 years.

Please take note of the following:

- Your participation in this research study is voluntary and you may to withdraw from the study at any time. In the event of withdrawal or refusal of participation, you will not incur any penalties
- The information you will provide will remain confidential and anonymous as we will not request any personal identification. Moreover, a pseudonym will be used.
- The information will be used for research purposes and related publications where applicable.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committed.

In the event of any problems or concerns you may contact the research or the research offices on the following contact details:

Makhosazane Felicia Mashabane

School of Applied Human Sciences

Discipline of Psychology

University of KwaZulu-Natal, Howard College

Cell: 071 321 4132

Email: [sibiyafeliciam@gmail.com](mailto:sibiyafeliciam@gmail.com)

Supervisor: Duncan Cartwright

Email address: [cartwrightd@ukzn.ac.za](mailto:cartwrightd@ukzn.ac.za)

Contact no: 031 260 2507

HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

**Participant Declaration**

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I..... (Full names) have been informed about the study entitled *Difficulties in Knowledge and perceptions on mental illness amongst the student population: Perspectives gained from the participatory action research project by psychology masters students from the University of KwaZulu-Natal* by Makhosazane Felicia Mashabane.

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

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

If I have any further questions or concerns related to the study, I understand that I may contact the researcher or research office on the above stated contact details.

\_\_\_\_\_  
**Signature of Participant**

\_\_\_\_\_  
**Date**

**Additional Consent**

I hereby provide consent to:

Audio-record focus group            YES / NO

## APPENDIX D

### UNSTRUCTURED FOCUS GROUP GUIDE

#### **Biographical Information**

Name of the research participant \_\_\_\_\_ (Optional)

Gender \_\_\_\_\_ Age \_\_\_\_\_ Nationality \_\_\_\_\_

#### INTERVIEW GUIDE QUESTIONS

- What is your general understanding of mental illness?
- Why do you think you understand mental illness in this way?
- What do you think informs those perceptions?
- Have you had any experiences with mental illness that you would like to share?
- What do you think are the difficulties in knowledge and perceptions of mental illness amongst the student population?
- How do you think these difficulties in knowledge and perceptions of mental illness impact help seeking behaviour?
- What do you think could be done to address those difficulties?
- What ideas would you recommend for mental health promotion?

## **APPENDIX E: RESPONDENT CONSENT FORM**

### **School of Applied Human Sciences- Master of Social Sciences in Clinical Psychology**

#### **Respondent Informed Consent**

Dear Prospective respondent

My name is Makhosazane Felicia Mashabane, from the Discipline of Psychology in the Applied Human Sciences, Howard College, University of KwaZulu-Natal. I will be conducting a research study in partial fulfilment of a Master of Social Science in Clinical Psychology degree under supervision of Professor Duncan Cartwright who is also under the Discipline of Psychology, at the University of KwaZulu-Natal.

You are being invited to consider participating in a study that involves exploring difficulties in Knowledge and perceptions on mental illness amongst the student population: Perspectives gained from the participatory action research project by psychology masters students from the University of KwaZulu-Natal. This letter is to request that you participate in the above-mentioned study, details of the study will be addressed hereunder. This study is expected to evaluate the project implemented by the psychology masters students. The duration of your participation if you choose to enrol and remain in the study is expected to entail one session, 15 to 30 minutes, to be a respondent on the survey questions based on the knowledge prior and post the poster project.

The purpose of the study was explained to me and I understand what is expected of my participation. I understand that this is a research project whose purpose is not to necessarily benefit me personally. I also, understand that my answers will remain confidential. Data will be stored in secure storage and destroyed after 5 years.

Please take note of the following:

- Your participation in this research study is voluntary and you may to withdraw from the study at any time. In the event of withdrawal or refusal of participation, you will not incur any penalties
- The information you will provide will remain confidential and anonymous as we will not request any personal identification. Moreover, a pseudonym will be used.
- The information will be used for research purposes and related publications where applicable.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committed.

In the event of any problems or concerns you may contact the research or the research offices on the following contact details:

Makhosazane Felicia Mashabane

School of Applied Human Sciences

Discipline of Psychology

University of KwaZulu-Natal, Howard College

Cell: 071 321 4132

Email: [sibiyafeliciam@gmail.com](mailto:sibiyafeliciam@gmail.com)

Supervisor: Duncan Cartwright

Email address: [cartwrightd@ukzn.ac.za](mailto:cartwrightd@ukzn.ac.za)

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Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

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**Participant Declaration**

I..... (Full names) have been informed about the study entitled *Difficulties in Knowledge and perceptions on mental illness amongst the student population: Perspectives gained from the participatory action research project by psychology masters students from the University of KwaZulu-Natal* by Makhosazane Felicia Mashabane.

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

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

If I have any further questions or concerns related to the study, I understand that I may contact the researcher or research office on the above stated contact details.

\_\_\_\_\_  
**Signature of Respondent**

\_\_\_\_\_  
**Date**

## APPENDIX F: SURVEY QUESTIONNAIRE

### Biographical information

Age	Gender	Race	Field of Study	Level of Study	Province of origin
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**Please take few minutes of your time to read the poster pasted on the wall. Answer the questions according to 1= poor, 5= excellent**

### Rate according to prior reading the poster

Knowledge of different types of mental disorders	1	2	3	4	5
Knowledge of common mental disorders amongst the student population	1	2	3	4	5
Negative beliefs and attitude towards people with mental illness	1	2	3	4	5
Personal disclosure to friends and family if you were diagnosed with mental illness	1	2	3	4	5
Knowledge on mental health care services within UKZN Howard Collage Campus	1	2	3	4	5
Attitude towards seeking professional psychological help	1	2	3	4	5

### Rate according to after reading the poster

Knowledge of different types of mental disorders	1	2	3	4	5
Knowledge of common mental disorders amongst the student population	1	2	3	4	5
Negative beliefs and attitude towards people with mental illness	1	2	3	4	5
Personal disclosure to friends and family if you were diagnosed with mental illness	1	2	3	4	5
Knowledge on mental health care services within UKZN Howard Collage Campus	1	2	3	4	5
Attitude towards seeking professional psychological help	1	2	3	4	5

### Answer Yes Or No

Did you find the poster knowledgeable?	Yes	No
Would you appreciate more mental health campaigns in future?	Yes	No
Is Mental Health care services easily available at UKZN Howard college campus?	Yes	No

## APPENDIX G: POSTER PROJECT

# Mental Health Matters

**Mental illnesses** are health conditions involving changes in emotion, thinking or behavior (or a combination of these).

Mental illnesses are associated with distress and / problems functioning in social, work or family activities. Mental illness is common.

### Some Warning Symptoms of Mental Illness

- Long-lasting sadness or irritability.
- Extremely high and low moods.
- Excessive fear, worry, or anxiety.
- Social withdrawal.
- Dramatic changes in eating or sleeping habits.
- Thoughts of suicide
- Excessive use of drugs and/or alcohol
- Drastic changes in either academic and/or work performance

### MYTHS AND FACTS ABOUT MENTAL ILLNESS

**Myth:** People are born with a mental illness.

**Fact:** Mental illnesses, such as bipolar mood disorder, can run in families. But other people develop mental illness with no family history. Factors such as stress, bereavement, relationship breakdown, unemployment, social isolation, a major physical illness, physical and sexual abuse, or disability may contribute to the onset of mental illness.

**Myth:** Mental illness is incurable and lifelong.

**Fact:** With the right kind of help, treated appropriately and early, most people recover fully and have no further episodes of illness. For others, mental illness may recur throughout their lives and require ongoing treatment. This is the same as many physical illnesses, such as diabetes and heart disease. Like these other long-term health conditions, mental illness can be managed so that individuals live life to the fullest.

**Myth:** Having a mental illness means you are "crazy."

**Fact:** Mental illness might alter your thinking, destabilize your moods or skew your perception of reality, that doesn't mean you are "crazy." It means you are human and are susceptible to sickness and illness, the same as any other person.

**Myth:** People with mental illness are violent and dangerous.

**Fact:** People with a mental illness are seldom dangerous. Even people with the most severe mental illness, whose symptoms may cause them to act in bizarre or unusual ways are rarely dangerous. The unfortunate truth is that individuals with mental illness are more likely to be victims of violence than perpetrators.

**Myth:** Post-Traumatic Stress Disorder (PTSD) is only a military man's disease.

**Fact:** Anyone can have PTSD. A rape or sexual assault victim, a domestic abuse victim, a survivor of a natural disaster, someone who's suffered a loss or even a person who did not face any violence or physical threats themselves directly, but happened to witness someone else who did (i.e. vicarious trauma).

### Some types of mental disorders?

- Developmental Disorders; Autism Spectrum Disorder, ADHD and etc
- Anxiety disorders, including panic disorder, obsessive-compulsive disorder, and phobias.
- Clinical depression, bipolar disorder, and other mood disorders.
- Eating disorders.
- Sleep disorders
- Personality disorders.
- Stress related disorder, acute stress disorder, adjustment, PTSD
- Psychotic disorders, including schizophrenia.
- Substance-related disorder.

## PSYCHOLOGICAL SERVICES AVAILABLE AT UKZN

### UKZN PSYCHOLOGY CLINIC

Howard College: Memorial Tower Building (Lower Ground Floor)

Tel: 031 260 7425 | Email: [psychclinic@ukzn.ac.za](mailto:psychclinic@ukzn.ac.za)

**R50 for students**

Howard College 1st Floor, Desmond Clarence Building

Tel: 0312608060

**Free**

professional and confidential counselling, career and academic support service to all registered students of the CHS. Services are available from 08:00 to 16:00 Monday to Friday by appointment