Zulu cultural perspectives and experiences of mental health and occupational therapy in KwaZulu Natal, South Africa.

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Learn to do right; seek justice.
Defend the oppressed.
Take up the cause of the fatherless;
plead the case of the widow.
Isaiah 1:17 NIV

PLAGIARISM DECLARATION

I, Ashira Moonsamy (214515798), declare that

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

02 December 2022

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ABSTRACT

Background: *Healthcare systems are formulated utilising worldviews, specifically in mental health, where norms are created dictating what is normal versus abnormal. The era of coloniality promoted western dogma over collectivist cultures. Occupational therapy practice must consider the client's context during assessment and intervention for the process to be client centred.* ***Methods:*** *A qualitative descriptive design was utilised. Purposive sampling was used to recruit 10 participants. Data was collected through semi-structured interviews. Analysis was guided by utilising Braun and Clark's six phases of thematic analysis.* ***Findings:*** *Three themes emerged from the data, personal perceptions, cultural perceptions, and health-seeking behaviour. Sub-themes accompanied each. Personal perceptions explored how Zulu people made sense of mental illness or related behaviours through a modern or traditional lens. It also explored the importance of the strength of the Zulu individual. A dissonance occurs when faced with cultural norms and personal needs. Finally, their perspectives were altered through their experience with mental illness. Cultural perceptions were that problems were solved internally in families or communities, and progress was promoted as necessary for the Zulu individual. It also explored spiritual beliefs regarding mental illness, which could range between God, Ancestors or both and could be causal factors or healing mechanisms. Suicidality is seen as a weakness in the culture, and stigma was attached to mental illness. The final theme concerns the experience of the Zulu mental health care user dealing with their mental illness. Cognitive dissonance is prevalent in all three aspects not merely due to the difference between westernised mental health treatment and traditional healing systems but also due to the value found in each. The method of sharing vulnerability or issues with an individual outside the family contradicts cultural norms. However, participants expressed that being understood in group discussions and sharing vulnerability significantly improved their healing.* ***Conclusion:*** *Zulu individuals create their sense of self in an interdependent manner. The family and community are intertwined in their participation, reputation, and healing. There is an emphasis on strength and the following of norms in the Zulu culture, perpetuated by the importance of consulting elders or close family when faced with conflict. Disregarding these norms can outcast the Zulu individual who thrives on being included in the community. The study was conducted with a limited sample size and in an urban area. Further research within rural communities and diverse facilities would be beneficial. Occupational therapists working in communities such as KwaZulu Natal should understand the causal factors of mental illness for the Zulu mental health care user and their personal beliefs around healing when designing an intervention.*

Keywords: *Mental health; Mental illness; Zulu culture; Cultural Perspectives; Culturally appropriate healthcare.*

PREAMBLE

This thesis is formulated as a Masters via Manuscript, in line with the College of Health Sciences at the University of KwaZulu Natal's guidelines for submission. This thesis comprises an Introductory section (Chapter 1), which outlines the background, purpose of the study, the relevant literature review and an overview of the methodology; a Manuscript (Chapter 2) that reports the study in the format for submission to the South African Journal of Occupational Therapy and a Synthesis section (Chapter 3), that concludes with key findings, conclusions and recommendations. This is as opposed to a traditional monograph format.

The candidate essentially followed the same process in terms of planning, conducting and preparing the research for examination with the same key milestones as for a traditional thesis. A proportion of the literature and methodology from the introductory chapter may be displayed in the manuscript. This may lead to some repetition between the integrative material and the manuscript, which is necessitated by virtue of the manuscript format.

Please note that the following with respect to this particular thesis:

i) The APA referencing style has been observed in the integrative material, with the reference list for the chapter appearing at the end of the thesis.
ii) The manuscript (Chapter 2) is presented in the format required by the South African Journal of Occupational Therapy (Vancouver Referencing)

LIST OF ABBREVIATIONS

MHCU: Mental Health Care User

MI: Mental Illness

OT: Occupational therapy

KZN: KwaZulu Natal

EHP: Ecology of Human Performance

LIST OF APPENDICES

Appendix A: Gatekeeper permission letter……………………………………………..………69

Appendix B: Interview Schedule……………………………………………………………71

Appendix C: Participant Information sheet…………………………….…………………73

Appendix D: Consent Form…………………………………………………………………76

Appendix E: Gatekeeper approval…………………………………………………………77

Appendix F: University ethics approval……………………………………………………79

Appendix G: Researcher TRREE certificate………………………………………………80

LIST OF FIGURES AND TABLES

Figure 1: Architecture of the Literature Review……………………………………………….….5

Figure 2: Map of the research context……………..……………………………….………16

Table I: Participant Demographics……………………………………………………………31

Table 2: Thematic Analysis……………………………..………………………………….33

Figure 2: Thematic map ……………………………….…….………………………………35

OPERATIONAL DEFINITIONS

Key definitions that are understood by the researcher and utilised within this report are listed alphabetically below.

Western hegemony: Leadership or dominance by western culture over others (Kessi, Marks & Ramugondo, 2020).

Culture: a set of perspectives, beliefs, knowledge, values, attitudes, assumptions, norms and customs that are associated with belonging to a specific group of people, this, in turn, guides thinking, doing, understanding and behaviour (Whalley Hammell, 2013)

Worldview: a set of attitudes, values, beliefs, stories and expectations regarding the world that inform our actions (Gray 2011).

Ubuntu: An African proverb, "*umuntu ngumuntu ngabantu*", translates to "a person is a person through other persons" (Nwoye, 2017, p42).

Epistemic decolonisation: The focus on African worldviews and theories to dismantle the practices that perpetuate western hegemony (Kessi, Marks & Ramugondo, 2020).

Occupation: Daily activities performed by individuals within families or communities that occupy time and bring meaning and purpose to life (AOTA, 2020).

Table of Contents

PLAGIARISM DECLARATION *iii*

ACKNOWLEDGEMENTS *iv*

ABSTRACT *v*

PREAMBLE *vi*

LIST OF ABBREVIATIONS *vii*

LIST OF APPENDICES *viii*

LIST OF FIGURES AND TABLES *ix*

OPERATIONAL DEFINITIONS *x*

CHAPTER ONE **1**

1. INTRODUCTION 1

1.1 Background and Rationale 1

1.2 Research Question 4

1.3 Problem Statement 4

1.4 Aim and Objectives 4

2. LITERATURE REVIEW 5

2.1 The need for culturally appropriate mental health 5

2.2 African literature and beliefs 8

3. THEORETICAL FRAMEWORK 14

4. METHODOLOGY 16

4.1 Setting 16

4.2 Participants 17

4.3 Sampling 18

4.3.1. Inclusion Criteria: 18

4.3.2. Exclusion Criteria 18

4.4 Recruitment Process 18

4.5 Data Collection Tool 19

4.5.1 Pilot study 19

4.6 Data collection process 19

4.7 Data Analysis 20

4.8 Data Management 21

5. LIMITATIONS 21

6. SIGNIFICANCE AND NOVELTY OF THE WORK 22

7. ETHICAL CONSIDERATIONS 22

7.1 Beneficence 22

7.2 Informed consent 23
7.3 Confidentiality 23
7.4 Justice 24
8. TRUSTWORTHINESS 24
8.1 Credibility and Confirmability 24
8.2 Dependability 25
8.3 Transferability 25
CHAPTER TWO **26**
2.1 Summary 26
2.2 Journal Details 26
2.3 Status of manuscript 26
Manuscript 27
CHAPTER THREE **56**
3.1. Synthesis 56
3.2 Significance 59
3.3 Limitations 59
3.4 Recommendations 60
3.5. Dissemination 60
3.6 Conclusion 61
References 62
APPENDICES **68**
Appendix A: Gatekeeper permission request 68
Appendix B: Interview Schedule 70
Appendix C: Participant information sheet 72
Appendix D: Consent Form 75
Appendix E: Gatekeepers' Approval Letter 76
Appendix F: University ethics approval 78
Appendix G: Researcher TRREE Certificate 79

CHAPTER ONE

This chapter introduces the background of the study, the problem statement, research questions, aims, objectives and details the methodology carried out to obtain the data.

1. INTRODUCTION

1.1 Background and Rationale

Health care systems are created using worldviews, beliefs, customs, and techniques aimed towards good health, timely diagnosis, the cure of illness, and prevention of complications (Benedict, 2014). These systems were created during the colonial era, when people or societies were dominated to afford power and privilege to western culture and create western hegemony (Kessi, Marks & Ramugondo, 2020). Exploring the hegemonic discourse surrounding culture and its widespread use to guide practices without questioning their application in global contexts has become increasingly important (Castro, Dahlin-Ivanoff & Martensson, 2014). This necessitates reflecting on how practices are guided by a worldview, formulated with strong cultural influence, and consist of specific beliefs, attitudes, and definitions of normal versus abnormal. This worldview is deeply connected to how people perform occupations, and the meaning they derive or ascribe to their occupations; hence, culture is embedded in the client-centred occupational therapy (OT), profession (Castro et al., 2014). Considering mental health intervention specifically, these have been based upon beliefs that govern or define what is normal, abnormal, or requires intervention. These norms and ideals are essential to developing theoretical models and frameworks that guide psychiatric intervention.

The need to consider culturally appropriate intervention is essential in OT. Practitioners are required to recognise cultural beliefs, behaviours, and their influence on occupational performance within the contexts in which they practice. Culture refers to perspectives, beliefs, knowledge, values, attitudes, assumptions, norms, and customs that are associated with belonging to a specific group of people; this, in turn, guides thinking, doing, understanding, and behaviour (Whalley Hammell, 2013; Zango Martin, Flores Martos, Moruno Millares & Björklund, 2015). Cultural dimensions that may emerge need not be restricted to ethnicity or race but could include other factors of diversity, such as class, gender, sexuality, and ability (Whalley Hammell, 2013). These divisions influence the meaning that individuals attribute to and extract from occupations. Unfortunately, these divisions render individuals unequal in society and affect the privilege, power, and opportunities they are afforded (Whalley Hammell, 2013).

Mahoney and Kiraly-Alvarez (2019) acknowledge that western worldviews predominantly influence OT theory and practice, which has the potential to perpetuate social inequities. Analysing the theories in multicultural societies has become necessary for decolonising OT theory and practice to incorporate diverse worldviews (Ramugondo, 2018). Decolonising OT education and practice calls for disrupting the norm and questioning whether practice serves our cultures. This research contributes to the process of decolonising practice through epistemic decolonisation, where the focus on African worldviews and theories is used to dismantle the practices that perpetuate western hegemony (Kessi, Marks & Ramugondo, 2020).

Occupational consciousness is a central concept for occupational therapists focused on disrupting the cycle of oppression through occupation (Kessi, Marks & Ramugondo, 2020). It entails an awareness of the dynamics of hegemony and recognising how they might be sustained in everyday occupational performance (Ramugondo, 2015). Mahoney & Kiraly-Alvarez (2019) emphasize the need for occupational consciousness by analysing the power dynamics between the client and therapist. They acknowledge disparities in the relationship that may contribute to the client's perception of autonomy in therapy or the perpetuation of dominant practices. They also highlight cultural humility as the mechanism to foster occupational consciousness. They further describe the South African concept of *Ubuntu*, which is the recognition of interconnectedness between people and the ideology that people share in the process of becoming (Mahoney & Kiraly-Alvarez, 2019). This concept is reason enough for South African OT to move away from Eurocentric approaches to practice.

Occupational therapists are expected to assess and conduct interventions that respond to specific clients' needs and values (Pooremamali, Perrson & Eklund, 2011). Ignoring this cultural dimension leads to inappropriate interventions, poor quality of care risks, premature termination of treatment, and miscommunication or misunderstandings that affect the client-therapist relationship (Castro et al., 2014; Park, Chesla, Rehm & Chun, 2011). OT models and theories have mainly developed under Western cultural influences and ideologies surrounding life, occupation, health, and wellbeing (Castro et al., 2014; Iwama, 2006; Mahoney & Kiraly-Alvarez, 2019; Nelson, 2007). A sense of ethnocentrism emerges from the idea that a particular culture holds superiority over others and is the norm by which all others are judged (Whalley Hammell, 2013). To provide culturally appropriate OT, occupational therapists are obligated to re-evaluate these core assumptions (Jull & Giles, 2012). The Kawa model, first developed by Japanese occupational therapists in the 1990s, is a product of this need for frameworks that socially and culturally depict cultural perspectives of occupation and well-being (Lim & Iwama, 2006). This model was an apparent deviation from western therapy

models. Instead of heavily emphasising independence and autonomy, it focused on a collective, shared interest between the client and community, which was more relevant to the Eastern perspective of the self.

A study exploring the experiences and perceptions of Swedish occupational therapists working with Middle Eastern immigrants explains that working with cultural diversity poses both a challenge and an opportunity to expand our knowledge (Pooremamali et al., 2011). Daily life is deeply rooted in culture, and so is how humans perceive or create their worldviews. The ideology that culture plays an imperative role in occupational performance, and is the foundation of occupation in context, is shared by this literature (Iwama, 2006). Middle Easterners in this study differed ethnically from the Swedish in that their culture encouraged interdependence rather than independence. This can also be relevant to the South African context, considering what is known about the Black South African collectivist cultures compared to the Western cultures, which value the idea of the individuals' independence. South African occupational therapists are compelled to deliver culturally appropriate care to the country's dominant culture. This study concluded that other frameworks are necessary to guide practice, as difficulties in responding to client needs do not merely arise from learning about different societal norms and attitudes but are also entrenched in the theories and structure of OT.

A wide variety of research thus far has focused on the occupational therapists' challenge of working in diverse societies rather than understanding the client's culture and how it influences their understanding of health, health-related behaviour, and experiences (Zango Martin et al., 2015). A study by Zango Martin et al. (2015) looked into the worldviews around human occupation and the link between occupation, health, and well-being with people from rural Honduras, Morocco, Burkina Faso, Tanzania, and Ecuador. The overall findings were that occupations were often social practices and that there were both individual experiences and collective or community experiences of occupation, health, and well-being. This strengthens the argument that incorporating diverse worldviews into practice and theory is imperative to developing more appropriate OT practice.

Much research on traditional theories of ill health was conducted more than ten years ago. An example is research done by Edwards et al., which highlighted the different theories of psychiatric illness in Durban, South Africa (Edwards, Grobbelaar, Makunga, Sibaya, Nene, Kunene & Magwaza, 1983). This study compared their psychiatric illness theories to modern international psychiatric diagnostic taxonomy. A latter study by Crawford & Lipsedge (2004) highlighted Zulu cultural definitions of illness. They found that Zulu people consult with both

medical doctors and traditional healers. Research into culture must consider that culture is not static but dynamic and will change over time and with exposure to other cultures (Kirmayer, 2012). With this dynamic nature of culture, occupational therapists are obligated to continuously seek understanding around how it impacts our population's occupations and health. Whalley Hammell (2013) suggests that if researchers engage in research with the utmost respect for the perspectives and experiences of diverse cultures, they will move toward culturally safe theories that are inclusive of indigenous knowledge. This research aims to reflect upon the question critically: *are mental health services appropriate for this dominant cultural group?*

1.2 Research Question

This research posed the following question:

1. *"How do isiZulu speaking, Black South Africans perceive mental illness and experience multidisciplinary mental health interventions at a private mental health facility in South Africa?"*

1.3 Problem Statement

The multicultural and predominantly collectivist South African context follows a western medical model when designing mental health intervention, and a gap in culturally appropriate care exists. In the appreciation of diversity, we understand that models or methods of treatment are not simply generalised from one context to the next. This type of undertaking contributes to evening out the imbalance created by western hegemonic practices.

Thus, this study will explore the mental illness (MI) perspectives and experiences of mental health interventions among isiZulu speaking, Black South African mental health care users (MHCUs) who participated in western-based OT programmes.

1.4 Aim and Objectives

Aim

This research aimed to explore the perspectives and experiences of **Black, isiZulu speaking, South Africans** who had utilised multidisciplinary services at a private psychiatric facility under a western-based therapy model (i.e., Dialectical Behaviour Therapy), in KZN.

Objectives

The objectives were:

- To explore and describe how MHCUs of the isiZulu speaking Black South African culture perceive MI.

- To identify activities, practices or traditional methods related to MI in Zulu culture.
- To identify the benefits and challenges experienced by Black, isiZulu speaking, South African MHCUs within a private mental health facility in KZN.

2. LITERATURE REVIEW

The existing literature related to this research has been divided into four sections, as shown in Figure 1 below:

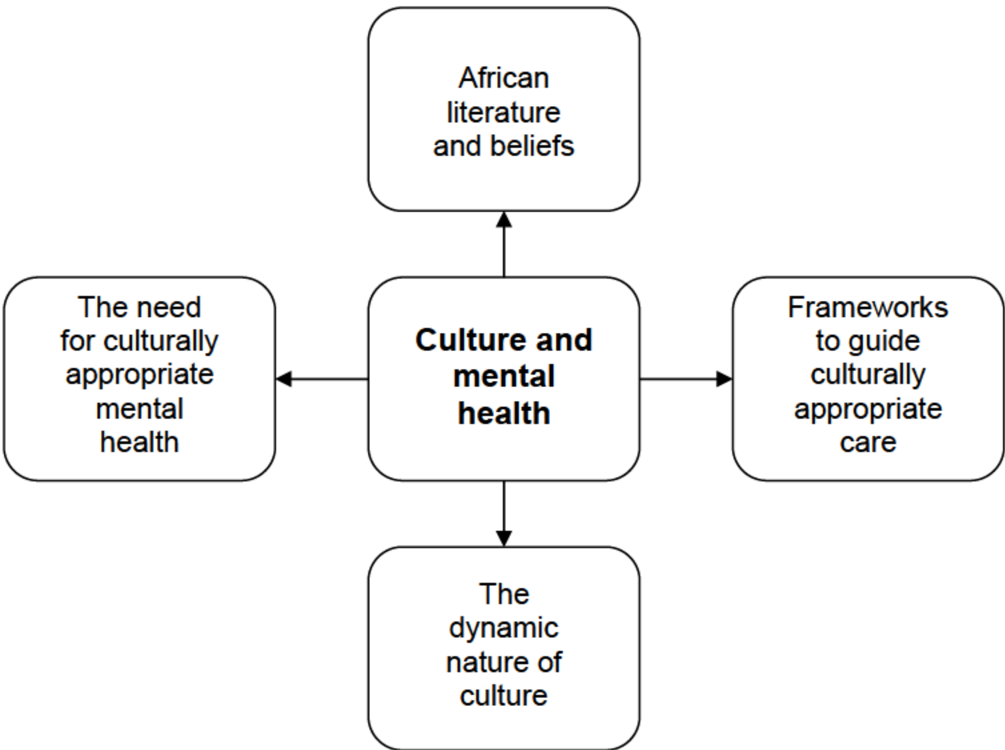

Figure 1: Architecture of the Literature Review

2.1 The need for culturally appropriate mental health

South Africa is a multicultural country, housing predominantly indigenous African and Asian and Western cultures. Before 1994, the apartheid government strongly disseminated the Western worldview as an ideal without determining the value and truth of African worldviews, specifically regarding traditional or indigenous practices of healing and spirituality (Mokgobi, 2014). However, this imposition of the western worldview did not cause the abandonment of traditional practices among Africans. Instead, it seemed to cause them to seek healing and choose between both health systems (Mokgobi, 2014). This is potentially a reflection of the meaning they still find in traditional practice. In 1979, the American Psychological Association highlighted this imposition of worldviews, stating that mental health in South Africa was not just racially inequitable, inadequate or absent but also posed a hazard to clients' health and may have helped reinforce apartheid ideologies (Vogelman, 1990).

A significant construct in occupational therapy is occupational adaptation. When faced with change, a process of adaptation occurs within the person (Grajo & Boiselle, 2018). Stress, impairment or disability can negatively affect the adaptive capacity of a person (Ramafikeng, 2011). The occupational therapist and client collaboratively work to problem solve regarding options and strategies for occupational adaptation. This has potential to create a power dynamic between the healthcare professional and the vulnerable client. Understanding the boundaries of culture for the client is important in that they are given an appropriate range of options concerning participation and occupational roles.

Cross-cultural literature

Multiple studies around the world have collected evidence of how culturally inappropriate mental health services or support had adverse effects on the people they were meant to serve (Greene, Jordans, Kohrt, Ventevogel, Kirmayer, Hassan, Chiumento, van Ommeren & Tol, 2017). These studies clearly show the damage that can be done by well-intentioned services that do not consider the perspectives and worldviews of their clients. An example was a counselling service for gender-based violence in Albania by a foreign psychologist. This service led to victims of abuse being identified and affected their familial honour, which, culturally, could be detrimental to the victim (Wessels 2009). The same article outlined how Angolan traditional healers were undermined by foreign psychologists who provided reintegration programmes and a debriefing space for trauma, which was dealt with differently from the traditions. In Sri Lanka, voluntary organisations delivering psychosocial interventions following the 2004 tsunami neglected to consult the community or employ qualified providers. This worsened the distress of community members and compromised the success of the existing local programs (Greene et al., 2017).

Individuals from these cultures seemed to have lacked the power and privilege to perform in the way deemed suitable in their context, succumbing to superior western knowledge and performing in ways that may not have been entirely culturally appropriate. One can deduct from this that critical reflection and research should be conducted with the people at the grassroots level before going in and providing services. If not, it risks undermining traditional methods and cultural beliefs or practices that may be deeply meaningful to the community.

Al Busaidy & Borthwick (2012), exploring the impact of cultural dissonance in Oman, found several cultural differences between Eastern Islamic cultural values and the Western OT methods practised in Oman. The qualitative research indicated the necessity for such research was that OT frameworks were developed utilising Western cultural values. Therefore, they posed a challenge and risk when implemented in a country with a collectivist

culture. The study found that family duty, gender roles, and religious, cultural and traditional beliefs all significantly influenced the occupations that people engaged in. Hence occupational therapists in Oman faced the challenge of practising in ways that would respond to and respect the Omani culture.

In the efforts to understand diversity and mental health, five critical components from diverse cultures were suggested to play a significant role in mental health (Hechanova & Waelde, 2017). Firstly, in Africa and Southeast Asia, emotional expression manifests as a reluctance to use talking therapy lest it leads to more suffering. The second is shame which causes reluctance, especially among Asians, with a similar collectivist cultural ideology to African culture, to seek professional help. Thirdly, power relations or the gap between therapist and client. The fourth is collectivism as their preferred method of support or its importance in developing resilience and coping skills. Lastly, religion or spirituality and how it may be the cause or be used as a coping mechanism (Gopalkrishnan, 2018). It is essential to understand that these cultural aspects are excluded in therapy occupational therapists are limited when assessing and treating clients (Dwairy, 2009).

African Worldviews

Kpanake (2018) affirms that different cultures will hold different conceptualisations of the human, which contribute to culturally specific developmental theories and social behaviours. The author also posits that despite this knowledge of cultural diversity and mental health, most approaches toward intervention and counselling remain Eurocentric (Kpanake, 2018). Within mental health, healing and therapy focus on assisting the client in enhancing the quality of their lives, and it specifies a ‘normal’ way of doing this, guided by culture (Kpanake, 2018). A large portion of psychiatric or psychological theory and practice emerging from a Western knowledge base or culture have been helpful, however, they also pose risks when working with other cultures. This can be seen, for example, when the focus is placed more on the individual and less on the community or family processes.

Gender roles

Disparities exist between the construction of the Zulu male and the Zulu female. A Zulu female would be expected to possess and portray qualities that ensure she is desirable in a marital relationship (Zungu, 2016). Emphasis is placed on the Zulu female being respectful of elders and in-laws as well as toward male counterparts. Zulu women are required to be nurturers and protectors in the family (Zungu, 2016).

On the other end, Zulu males are depicted as intelligent. Emphasis is placed on strength and skill. The Zulu male is socialised to not display signs of weakness among their femal counterparts (Zungu, 2016). Their roles are to be the providers of the family. Such differences may account for their varied experiences and how they might be expected to handle difficult situations.

Ubuntu

An African proverb, "*umuntu ngumuntu ngabantu*", which translates to "a person is a person through other persons", is a good explanation of how the African person creates a sense of self (Nwoye, 2017, p.42). This is a shift from the western perspective of the self, which African people have been utilising as a lens through which they view themselves, hence research must account for African worldviews. African worldviews consist of both the material and spiritual planes. Thus, their understanding is that spiritual forces can contribute to the experiencing of illness or misfortune but also extends to biological, psychological and social factors.

Beliefs in African culture are that there are earthly and spiritual worlds in which communication occurs, and rituals or offerings to spiritual beings can be done to maintain health, status, or position. Fundamental moral values must be instilled in every person, such as patience, perseverance, ubuntu, modesty, industriousness, obedience, and respect for elders. The human being is multidimensional and must achieve success in all those dimensions of health, wealth, offspring, joy, peace, and life (Nwoye, 2017). Hence sources of motivation to participate for the African individual include bringing honour to their name or clan, overcoming limitations of their background, competing with others of their age to achieve worth, pleasing ancestors, and a desire to be a part of the community and enlist social support. (Nwoye, 2017).

Thus, each person cannot be understood in isolation and dealt with individually but as embedded within a collective. The Black African collectivist culture is deeply rooted in the context or community, whereas western culture differs in terms of placing more emphasis on the individual rather than on the community. This study acknowledges the differences between a collectivist and individualistic culture and seeks to understand how mental health OT could be more appropriate, specifically for Black South Africans who are still being treated within westernised models of therapy.

2.2 African literature and beliefs

South African literature

A local study revealed that stigma against persons with MI has proved to be a factor affecting the health-seeking behaviour and overall mental health or recovery of individuals (Egbe, Brooke-Summer, Kathree, Selohilwe, Thornicroft & Peterson, 2014). The study, conducted in the North West province of South Africa, demonstrates that persons with MI were stigmatised on an internal level, a family/community level, and in their contact with health care providers. Stigma was linked closely to beliefs and attitudes around MI and cultural beliefs, which significantly influenced how persons with MI were perceived and reacted to in their communities. Moreover, this stigma caused persons with MI to relapse and reduced their adherence to treatment or health-seeking behaviours (Egbe et al., 2014). This stresses the importance of recognising and understanding cultural beliefs and practices in mental health intervention, as it enhances the understanding of stigma and how it could impact MHCUs when they attempt to integrate into their communities. Understanding the community is intrinsically linked with understanding the individual.

An older but relevant study within a rural KZN town confirmed that Zulu beliefs concerning ill health and suffering are closely linked to their religious beliefs, history, social relationships, and cosmology (Crawford & Lipsedge, 2004). Beliefs around medical doctors were that they could understand and treat disorders known as "*umkhuhlane*" but other disorders known as "*ukufa kwabantu*" were only recognised and treated by traditional healers. This ideology still exists in Molot's (2017) study of western versus traditional treatment of MI in KwaZulu Natal (KZN), where traditional healers, a psychiatrist, occupational therapists, and a psychologist participated. Through engagement with these practitioners, it was found that Zulu people differentiated between MI and stress, MI being characterised as psychotic disorders, such as schizophrenia and bipolar mood disorder, and stress being non-psychotic disorders, such as depression and anxiety. This reflects the findings of Sorsdahl, Flisher, Wilson, and Stein (2010), who studied explanatory models of distress in the Mpumalanga province and found that disorders with psychotic symptoms were considered mental illnesses but non-psychotic disorders were not.

Explanations for the causes of MI by traditional healers strongly included ancestors, who helped to differentiate between MI and stress. If ancestors were not honoured or appeased through rituals, they would cause MI, but stress, accidents, not heeding the call to become a sangoma (*thwasa*), and dishonourable actions such as stealing could also cause one to experience MI. An example of a dishonourable act such as stealing could cause a person to get bewitched by those they may have angered, which presents as a MI. Traditional healer also reported that only they could treat a person who is bewitched or in trouble with the ancestors through methods such as burning *imphepho* (incense), cleansing, or traditional

medicines. Medical doctors were for illnesses like HIV, TB, congenital conditions, accidents, diabetes, and high blood pressure (Sorsdahl et al., 2010). Traditional healers also reported that they often referred to medical practitioners but did not receive referrals from them. Furthermore, they expressed a willingness to work with medical practitioners. It was found that due to this unilateral referral pathway, most Zulu people started at the traditional healer before utilising mental health services, as traditional healers were more accessible than psychiatrists (Molot, 2017).

A later study looking into the effect of culture on the utilisation of rehabilitation services, such as physiotherapy, occupational therapy, and speech therapy, in rural contexts, also yielded similar findings. This study, looking into the experiences of therapists working in rural contexts, found that clients often reported that their pain or disease emerged from spiritual disturbances or displeasure of their ancestors and that western medicine would not remedy this. This caused them to turn toward traditional or spiritual healing (Wegner & Rhoda 2015). The study confirmed that clients from a Zulu cultural background sought symptom relief from medical health practitioners but utilised traditional healing to understand their issues. Traditional healers would provide culturally specific explanations linked to their beliefs of needing to be in harmony with society, nature, and the spiritual realm (Wegner & Rhoda, 2015).

Ancestor reverence

Ancestors are important in African culture, especially when discussing spiritual beliefs. Ancestors are highly regarded and often linked to the wellness of the Black African individual and family (Crawford & Lipsedge, 2004; Kpanake, 2018; Molot, 2017). Ancestors were described as the souls of the deceased, mainly the married elders who had passed on and then came to reside within the rafters of the family home to guide the living regarding familial issues, traditions, ethics, and other activities. When ancestors wanted to express displeasure with the family or communicate, they would do it in the form of physical or mental illness, suffering, dreams, or nightmares, which would have to be appeased by a specific ritual carried out by those affected (Kpanake, 2018).

For the African individual and family, these rituals are extremely significant. The case of a young Togolese man who sought help at his university's clinic for anxiety, sleeping and concentration problems, and chronic fatigue (Kpanake, 2018) displays how the ancestral spiritual realm influences the African individual and is linked to mental health. This man, baptised as a Catholic, was part of a polygamous family that emphasized following tradition and completing rituals. In consultation with medical doctors, it was deemed a mental health issue linked to his father's physical ill-health. The family sought assistance from a traditional healer and described the issues to mental health practitioners as being a curse placed upon

the family by one of the deceased wives of his father. The young man himself, being a Catholic, did not participate in the ritual but still deemed it necessary to be completed on his behalf of him and, after a month, reported to psychotherapy stating that his symptoms had improved and that he felt an inner peace knowing that he carried out the correct tasks (Kpanake, 2018). To ensure this man's mental well-being, it was imperative to understand his collectivist culture, involving his family and respecting their need to turn to traditional practices. Research into this is necessary to understand the culture and experience of Zulu people accessing western developed healthcare and more appropriately respond to such situations rather than requiring them to conform to western ideals.

Spiritual beliefs are important to consider in the Zulu culture. Spiritual understandings of issues experienced are highly regarded. Spirituality acts as a motivation to occupational participation. Thus, occupational therapists need to understand how it contributes to their state of wellbeing and overall health (Mthembu, Wegner & Roman, 2018).

Research has shown that what is deemed good or bad health and what is viewed as a threat to health are also culturally formulated. Each ethnic group and culture define illness differently, which comes with different symptoms and causal factors (Benedict, 2014). Previous research has shown that cultures differed even when considering the prevalence of mental health disorders between an African and Western context. In 1976 Crisp et al. found that Anorexia Nervosa in a Western context was a leading cause of concern among adolescent females, while later it was found that it was much less prevalent in Kenyan females as psychiatrists recorded a mere 20 cases of Anorexia Nervosa over a cumulative period of 320 years (Njenga, 2007).

Research concerning eating disorders and attitudes in South Africa shows that the first recorded cases among African women only emerged in 1995, previously known as a disease that affected only white women. Since then, with urbanisation and the mixing of cultures as opposed to apartheid segregation, these figures rose, and eating disorders became more common among African women, specifically those in urban areas (Szabo, 2019). Such evidence is proof that culture and values or beliefs held within the culture will dictate how people experience and exhibit MI but is also indicative of the change that occurs when ethnic groups acculturate, which is undoubtedly existent in the South African context.

2.3 Frameworks to guide culturally appropriate care

Theories and models or frameworks commonly utilised in OT practice possibly achieved that dominant status due to the influence and power harnessed by the western culture rather than a superior theory base (Whalley Hammell, 2013). Although significant, culture and its impact on occupation and well-being have been afforded remarkably lower levels of recognition and focus in OT literature (Whalley Hammell, 2013). It is vital that methods or frameworks and their application within our health system are not simply disregarded, as these allow us to understand the quality and suitability of services provided to South African citizens. Thus, bridging the gaps in understanding what mental health means to Black, isiZulu-speaking South Africans and what occupations they believe heal MI to provide contextually relevant and culturally appropriate care.

Initially, cultural competence was proposed and utilised as a framework for mental health professionals to recognise culture and practice efficiently within culturally diverse settings. It required practitioners to become familiar with the cultural values, customs, and traditions of the people they served. However, research has indicated that these cultural competence models are insufficient and can be problematic due to their ignorance of the dynamics of power and oppression, as well as their disregarding the participation of individuals and communities, and do not account for the dynamic nature of culture (Gopalkrishnan, 2018; Whalley Hammell, 2013). A study in the United States of America (Park et al., 2011) looked into the strategies used by mental healthcare professionals in their work with Asian American clients, a minority group in the country but a culture that is also defined as collectivist. It initially explored the ideology that cultural competency is necessary for healthcare worker education and that delivering culturally sensitive care and adapting interventions to culturally diverse clients is essential. Cultural competence was intended to provide quality healthcare to a diverse range of people, differing in race, ethnicity, culture, or language (Park et al., 2011). Moreover, the researchers contended that a lack of this competency could lead to misdiagnosis, ineffective treatment, and poor healthcare.

The study's findings indicated that cultural competency as a model is problematic in that it ignores organisational or structural issues and puts more emphasis on the individual level. The study also explored why Asian Americans differed in their use and perspectives of mental healthcare. Some of the significant factors that emerged were the family involvement in illness management, the communication styles among different role-players in the family, and cultural

expectations of care for family members that inhibited help-seeking for MI (Park et al., 2011). When faced with Asian American clients, healthcare providers in this study explored cultural meanings with them and creatively incorporated them into interventions. Healthcare providers engaged in a two-way education that allowed them to learn about their client's cultural beliefs and practices and educate them about the dominant cultural beliefs and practices surrounding mental health. This greatly assisted the provider in accounting for the clients' emotional struggles, improved their empathy, and created strong therapeutic relationships (Park et al., 2011). However, it was also found that this was time-consuming and would be ideal in a system where healthcare providers were not overburdened with their workload and could take the time to understand each client deeper than their diagnosis. Thus, more innovative ways are needed to bridge the cultural gaps in healthcare (Park et al., 2011).

Cultural humility has been proposed as more appropriate as it calls for therapists to become critical thinkers, evaluating their positionality and recognising that cultural differences will exist within client-therapist relationships and not solely on the client's side. Evaluating positionality will redress the imbalance of power within a client-therapist relationship and enhance the therapy process (Whalley Hammell, 2013). Such critical thinking is necessary; this means scrutinizing our assumptions and beliefs and the knowledge defined as truth and operated from (Whalley Hammell, 2015). Thus, a study that does not merely explore perceptions of MI and traditional treatment and their experiences of the mental health system, which essentially affords us a lens into the client-therapist relationship, is vital. The focus of research cannot be unilateral and reflect only on knowledge and skill as it further highlights inequity between therapist and client, but the focus also needs to extend to the client-therapist power dynamic.

2.4 The dynamic nature of culture

Culture is dynamic, and what is defined as MI at one point in time in one particular context may not be classified the same way at a future stage. Take homosexuality, for example, which was once classified as a MI, but the understanding of which has radically evolved (Njenga 2007). Like the dynamic nature of conceptualising MI, one must also acknowledge that culture is not static but rather dynamic. It continuously evolves and develops as different cultures tend to coexist in shared spaces (Whalley Hammell, 2013), much like the South African 'rainbow nation.

Hassim & Wagner (2013) state that research into culture is pivotal to understanding mental health and will create more holistic approaches to health care as there is evidence of culture influencing the development and understanding of psychopathological symptoms. However, they also acknowledged that none of these cultural formulations had been incorporated into

academic literature as much as western-based perspectives. Their study suggests that diagnostic classification fails in its consideration of culture and that culture and psychopathology are so profoundly intertwined that without culture, MI cannot be precisely diagnosed and treated (Hassim & Wagner, 2013).

Furthermore, they stressed the importance of understanding that culture is dynamic and not merely dependent on ethnicity. It is not necessarily inherited but will transform over time, altering beliefs, worldviews and experiences. Moreover, culture significantly influences what is defined as normal or abnormal (Hassim & Wagner, 2013). Simply considering the varied manifestation of MI displays cultures' significant role in mental health. Focusing on culturally appropriate or culturally sensitive care is essential, as it will allow for rapport between therapist and client and culturally relevant intervention.

Fernando (2014) posits that one must begin by understanding what is of importance or relevance to the people and then integrate positive resources from the community into services. It should begin with evaluating the cultural safety and appropriateness of the OT practices, and this information can only come from the source themselves (Whalley Hammell, 2013). So, at this point, the question arises, where does transformation in mental health OT begin? The response is simple: building an understanding of and listening to the people themselves! Hence the purpose of this study was to delve into the perceptions and experiences of Zulu MHCUs.

3. THEORETICAL FRAMEWORK

The Ecological Human Performance Framework guided the interpretation of the findings in this study

The Ecological Human Performance (EHP) Framework

The primary constructs of the EHP include the person, tasks, context, and personal context-task transaction (Fathipour-Azar & Hejazi-Shirmard, 2019). The person comprises experiences, sensorimotor, cognitive, and psychosocial skills and abilities (Dunn, Brown & McGuigan, 1994). The framework also highlights the life roles as essential aspects of the person. Tasks performed by a person, as described by the EHP, are defined as objective sets of behaviour directed toward achieving a specific goal. The person utilises their skills and abilities to perform these tasks.

The EHP explains that the individual does not exist within a vacuum but is impacted by physical, environmental, social, cultural, and temporal factors that create their context. This research is specifically interested in the cultural elements of this context and their link to the

person's occupational performance specifically within mental health. Furthermore, the formulation of the EHP is defined by a non-linear and dynamic perspective, explaining that individuals may lean toward specific behaviour patterns and that they adapt or alter these if any change to them or their context occurs (Dunn, Brown & McGuigan, 1994).

The client with MI could find themselves in dysfunction due to a lack of skills and abilities to function within a specific context. Thus, a profound understanding of the cultural context is essential so that adaptations or alterations posed are contextually relevant and embedded. This decreases the risk of dictating a prescribed standard way of being. This could cause a disconnect between the person and their context and impede their occupational performance.

Application of the EHP

This framework was drawn upon for its significant emphasis on context and the relationship between context and human performance. It was developed to enhance the occupational therapist's conceptualisation of human performance in context. This framework posits that context is a lens from which individuals create their viewpoint and that the person-context relationship determines which tasks fall into the person's performance range (Dunn, Brown & McGuigan, 1994).

The research utilised this model to understand that the Zulu culture guides how the people of this cultural group formulate perspectives around MI. Constructs were utilised to direct questions and probe into the aspects of the person, tasks, context, and interaction.
The participants in this study were viewed through a contextual lens, understanding how they participated within context, how they were affected by context, and how they made sense or meaning through context.

Several modern OT frameworks emphasise the importance of context and call for tools created to be inclusive of inquiring about contextual factors in the assessment. By understanding the cultural context with this study, tools and interventions can be developed that are better suited to Zulu people. With this emphasis, it can be understood that the individual could not be viewed, in this study, without this deep comprehension of their context-culture being a solid feature of context and socialisation of the human self, their behaviour, and conceptualisations.

Critical analysis of the EHP framework

The EHP was designed in response to the gap in OT theory and practice, considering the inclusion of context as a critical factor in occupational performance (Dunn, Brown & McGuigan, 1994). This framework acknowledges that context, in this study, the cultural context, is a lens

through which persons view their performance or ability to perform. It further confirms that context is not static and will change, requiring adaptation to personal behaviour to enable performance. It implies that intervention in OT is a collaboration between the individual, family, and therapist to achieve functionality.

4. METHODOLOGY

This study employed a qualitative descriptive approach, a particularly beneficial design to study healthcare phenomena (Kim, Sefcik & Bradway, 2017). The study provides insight into a question or concept that is not widely researched. A qualitative design was best suited to such a study that sought to enquire into concepts of meaning and experience or views from the point of view of a participant in the healthcare system (Hammarberg, Kirkman & de Lacey, 2015).

4.1 Setting

This section will present the research context.

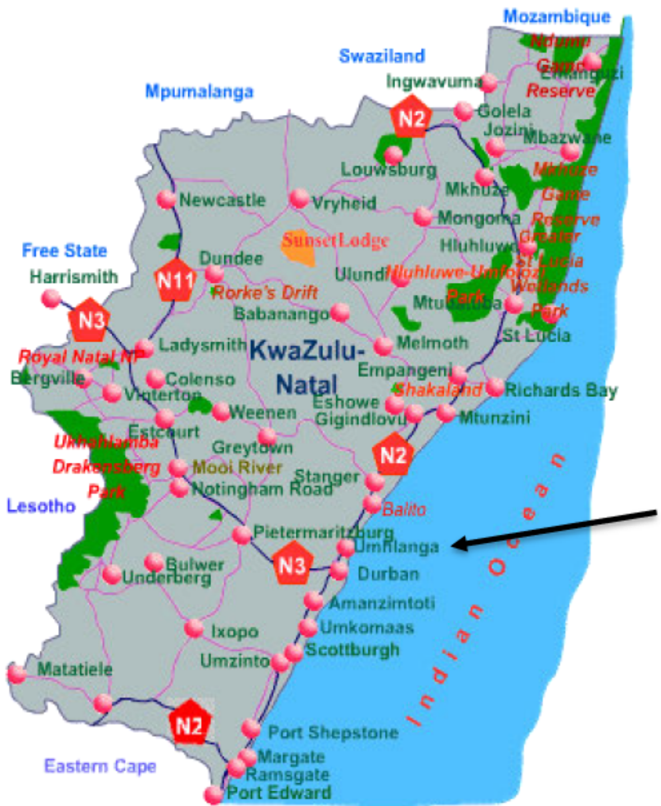

Figure 2: Map of the research context (africangamesafari.com, undated)

This study took place in South Africa, a country that has been exposed to inequality and injustice throughout apartheid. Specifically, it occurred in the province of KwaZulu Natal, in the city of Durban, known for being one of the largest cities in South Africa. The predominant

cultural group residing in KZN is the Zulu people. The isiZulu language is the most commonly spoken language of the 11 official South African languages (Alexander, 2018).

More specifically, the study focused on MHCUs who had previously been admitted to a private psychiatric facility. The facility is based in one of the more upmarket areas of Durban- usually inhabited by people with higher socio-economic standing in terms of income and standard of living. However, the client population arises from all over the city and province; some even reside in neighbouring provinces. The facility provides a service to MHCUs with various diagnoses, including depression, anxiety disorders, substance use disorders, eating disorders, Post-Traumatic Stress Disorder, and bipolar mood disorder, to name a few.

The facility provides individual and family-focused intervention with a multidisciplinary team of social workers, occupational therapists, occupational therapy technicians, psychologists, psychiatrists, and nurses. The service users can access individual and group intervention predominantly based on western models of intervention.

4.2 Participants

Ten participants were selected. The study participants were Black, isiZulu speaking, South African females and males with a history of being admitted to a clinic for psychiatric intervention. The sample consisted of young to elderly adults, above 18, in the Zulu culture. They were considered to be the group most exposed to the mental health system and more similar in their cultural beliefs, rituals, and age-related experiences of culture.

Table I: Participant Demographics

Participant	Gender	Age	Occupation	Pseudonym
1	M	30	Lifeguard	Thabani
2	F	44	Educator	Gugu
3	M	34	Police Officer	Muzi
4	F	57	Former Crèche Owner	Mbali
5	F	28	Educator	Ntokozo
6	F	36	Administrative Clerk	Zandile
7	M	38	Student Advisor	Bheki
8	F	50	Receptionist	Thokozile
9	M	42	Police Officer	Menzi

10	M	33	Plumber	Sifiso

4.3 Sampling

Purposive sampling was used, where a group of people was intentionally selected to best answer the research question (Cresswell, 2013; Moser & Korstjens, 2018). The participants were selected based on a criterion, thus allowing the research to yield in-depth results from informed or experienced participants around the phenomenon being studied, i.e., the Zulu participants' perspectives and experiences within the mental health system.

A smaller sample size and a limited setting were chosen to obtain in-depth information (Moser & Korstjens, 2018). A total of 10 participants were selected, five males and five females over the age of 18.

4.3.1. Inclusion Criteria:

- Participants were Black South African females and males of Zulu cultural heritage.
- Participants were above the age of 18, as they could give consent to participate in the study.
- Participants should have access to a calling/video-call compatible device such as a laptop, computer, or cell phone.

4.3.2. Exclusion Criteria

- Black South Africans not of the Zulu cultural group who were admitted to the facility.
- Those not in attendance (exclusion or refusal) of the group therapy programme during their stay as they would not have experienced the model in depth or may not have received OT.
- Those admitted for less than one week at the clinic had limited engagement with the group therapy programme, and so were excluded.

4.4 Recruitment Process

Participants were recruited once ethical clearance to conduct research and permissions from the research site were gained (*See Appendix A for Gatekeeper Permission Request*). Ethics was obtained from the Biomedical Research Ethics Committee at the University of KwaZulu Natal. The ethical clearance number is BREC/00002882/2021. Permission was gained from the facility to access MHCUs and to identify and contact potential participants. The social worker at the facility agreed to provide potential participants, during their discharge and

outpatient groups, with an information sheet (*See Appendix C*). Interested MHCUss provided their contact details. Hospital records were accessed with an employee who provided ages and diagnoses to assist in identifying suitable participants. Participants were contacted using their provided contact details, i.e., telephonically or via electronic mail. The information sheet, which served to fully inform participants about the study before opting to participate, was discussed telephonically or emailed to participants. Once informed consent (*See Appendix D*) was received from participants, interviews were scheduled.

4.5 Data Collection Tool

The researcher drew up a semi-structured interview schedule (*See Appendix B*) to guide the conversation. Open-ended questions were formulated to answer the specific research question, but it also allowed participants to diverge into new concepts that arose within the conversation and proved essential to understanding the topic. This interview format was conducive as it guided the course of discussion in a specific direction but allowed for flexibility and delving deeper into concepts brought up by the participants that the researcher would not have previously thought of as essential (Moser & Korstjens, 2018). Interview questions explored attitudes and beliefs surrounding MI, mental health-related practices, and experiences of current mental health programmes. The questions were open-ended and allowed for the flow of conversation as this was an attempt to explore new knowledge and understanding. An interviewer matching the description of Black, isiZulu-speaking South African was contracted to conduct the interviews. This created a more comfortable interview space for the participant and allowed participants to easily describe any concepts that were difficult to translate from isiZulu to English. The interviewer was a colleague who was fully informed about the study and bound by confidentiality.

4.5.1 Pilot study

A pilot study involving two initial participants was conducted, by the researcher, to ensure that questions would be understandable to participants and that they would elicit the responses required to answer the research question. The pilot study revealed that questions were appropriate and would yield answers congruent to the research question.

4.6 Data collection process

Initially, participant demographic data was collected as well as data regarding their admission to the psychiatric facility. After confirmation of participation, interviews were arranged and conducted. The participants were allowed to participate in the interview telephonically or via video call- both of which were recorded via in-call recording on a computer or a cell phone.

Each participant participated in one interview and results were clarified with them over instant messaging when necessary. This was only necessary in the case of one participant.

A computer and cell phone were utilised, with the informed consent of the participants, to create the audio recordings of the interviews. Names of participants were omitted from the recordings as much as possible, and participants were asked to utilise pseudonyms in their responses if they wished to. Raw data were transferred to a password-protected computer that only the researcher could access. Raw data was also available to the research supervisors.

4.7 Data Analysis

A thematic analysis of the data was conducted, allowing for a robust and comprehensive description of the findings (Braun & Clarke, 2006). The six steps of thematic analysis were followed as outlined by Braun & Clark (2006).

1. Raw data were collected in the form of audio recordings of the interviews that were conducted. During the interviews, notes were also taken by the researcher to supplement the audio recordings. These audio recordings were then transcribed into a document by the researcher, which allowed the researcher to immerse herself in the data from the first phase. Transcriptions were a verbatim account of the conversation. They were combined with non-verbal cues noted down by the researcher, such as tone of voice or expression if the participant opted for a video call.
2. Thereafter coding was done so that significant parts of the data could be extracted and organised. The number of codes was not restricted and equal attention was given to each data item.
3. The coding was completed manually by the researcher. Similar codes were clustered into categories, and then into themes and subthemes.
4. A thematic map was constructed and analysed to verify if it was an accurate representation of the data set. Member checking occurred to ensure the data was interpreted correctly.
5. Immersion continued as the researcher re-read through data actively and searched for meaning while noting down what was initially considered significant.
6. Themes were reviewed and refined, by re-reading through the data and the codes to verify patterns initially detected. Finally, they were written up into the final report in a way that accurately reflected the essence of each one and provided a convincing and meaningful account of the data. Direct quotes from the participants were included to support the themes.

The researcher used a reflective journal to separate her perspective from the participants, which allowed for reflexivity.

Deductive data analysis was used, which is a top-down approach to test whether the theory, or in this study the conceptual framework, can be used to frame the findings (Bingham & Witkowsky, 2022).

4.8 Data Management

Raw data, in the form of voice recordings, was transferred from the recording device to a password-protected computer to which only the researcher had access. Files containing the transcription, coding, and themes were kept in a folder within the password-protected computer. According to the South African POPI Act (2013), personal information records cannot be kept longer than is needed to achieve the purpose for which data was collected or processed. Sensitive information, such as names of participants and the facility, was left out of transcriptions and other documentation. The researcher only shared coding and themes with the research supervisors, and these parties were all bound by confidentiality.

5. LIMITATIONS

1. Culture consists of sub-cultures, and each participant's identities and experiences will further account for differences in their perspectives. Hence this study merely scratches the surface of beginning to understand the cultural perspectives and experiences of Zulu people utilizing current mental healthcare.
2. However carefully the sample has been selected to be representative of the population, it cannot be expected to be generalised to all Black South Africans practising the Zulu culture. The aim of qualitative research is not to be confirmatory but rather to build an understanding of a complex phenomenon or meaning in a specific context that cannot be quantified (Queiros, Faria & Almeida, 2017).
3. Although the data was collected by an interviewer fluent in the isiZulu language, certain concepts that may have deep meanings in isiZulu may have been lost in the attempt to translate them to English.
4. Interviews were conducted once with each participant; thus, information was limited to what the participant shared during their interview.
5. Focus groups would have been the preferred data collection method as shared experiences prompt deeper information to be shared between participants; however, due to the current COVID-19 pandemic, the safety and health of the participants and researcher took priority and did not allow for the use of this method.

6. Connectivity and mobile data issues affected data collection. Video calls often froze while participants spoke and concepts or questions often had to be repeated.

6. SIGNIFICANCE AND NOVELTY OF THE WORK

This study will be relevant to OT assessment and intervention when working with Zulu people. IsiZulu is the predominantly spoken language in the country and the largest cultural group with many similarities to other South African cultural divisions. It will inform occupational therapists in mental health care concerning the experiences of the client-therapist relationship from a Zulu cultural viewpoint. This will contribute to more culturally appropriate and contextually relevant care. This will improve reflection and practice. It will inform us about cultural beliefs and how this influences stigma. It fosters critical thinking about challenges and opportunities within the clients' context. This type of study in South Africa is relatively unique as there is limited research.

Occupational therapists in South Africa must be therapeutically effective and appropriate to this dominant culture. Western models cannot continuously be applied to a collectivist culture. This is a commitment to authentic client-centeredness.

7. ETHICAL CONSIDERATIONS

This section outlines the measures taken to ensure the study is ethically sound.

7.1 Beneficence

This refers to the need for research to maximise the benefits of the study and minimise any possible harmful effects of participation (Fujii, 2012). It is also essential to identify a topic of study that will benefit the participants involved (Cresswell, 2014). The study aimed to enhance contextually appropriate care of Black South African mental healthcare users, a dominant cultural group in South Africa, by not merely collecting their perspectives but also capturing their experiences.

Participants were not forced to recollect experiences that could cause significant discomfort and were allowed to refuse to answer a question that would have triggered a deeply unpleasant memory. Interview questions were worded in an open-ended way and allowed participants to respond with whatever they felt necessary and comfortable to share. The interviewer contracted was skilled at facilitating discussions and handling principles necessary, such as empathy or validation when a participant shared sensitive information. This is due the interviewer being trained in these principles and skills.

Individual interviews were a more comfortable atmosphere for the participant to share details and experiences without running the risk of confidentiality being broken by fellow participants. Telephonic or virtual interviews minimised the risks associated with the rapidly spreading COVID-19 pandemic. It was also a more cost-effective measure for participants as travel costs were eliminated and could be done in an informal environment.

This was a minimal risk study where no deception was necessary- participants were very clearly informed about the purpose. No experimentation was required, and participants faced no physical harm directly related to the study.

7.2 Informed consent

Informed consent requires participants to be fully informed about the study and then volunteer their participation, no participant should feel coerced into signing consent (Cresswell, 2014; Fujii, 2012). Participants' stress was minimised by fully informing them about the procedures, aims, and possible risks and benefits of the study (*See Appendix C*). They participated out of willingness and reserved the right to withdraw their participation at any time before dissemination of the results. The inclusion criteria stated that participants should have been able to understand and respond in English, guaranteeing that each selected participant could provide informed consent in English after understanding the study's purpose and possible risks. The consent (*See Appendix D*) and confidentiality agreements they signed were in simple language, free from jargon or ambiguous terms.

7.3 Confidentiality

Confidentiality is the need to ensure privacy and protect the identity of the participants and avoid disclosing information that may be harmful to the participant (Cresswell, 2014; Fujii, 2012). Participant confidentiality is of utmost importance, and all measures to protect their identities were taken.

Data from interviews or forms were protected and access controlled- audio files and transcriptions were saved on a password-protected computer.
Participant names and any other identifying features were not included in reporting, significant events that may identify a particular participant were analysed but not reported in detail to protect the participant’s identity. The name of the facility was also omitted from the final report. The contracted interviewer is also bound by confidentiality.

7.4 Justice

Justice refers to all individuals being treated justly, their rights being upheld, and their dignity. It also refers to an unbiased selection of participants (Fujii, 2012). The study attempts to make Black, South African viewpoints apparent in healthcare literature. Research such as this is important in an attempt to redress power imbalances that affect people's occupational opportunities and well-being.

Participants were treated and responded to with respect and sensitivity, and their cultural viewpoints were respected.

8. TRUSTWORTHINESS

It is essential in qualitative studies to employ techniques that ensure data is interpreted well and meaning is derived correctly. Due to the nature of qualitative data, trustworthiness techniques are used (Korstjens & Moser, 2018). This study employed methods to ensure credibility, confirmability, dependability, and transferability.

8.1 Credibility and Confirmability

A study's credibility refers to measures put into place to ensure that the study investigates what it intends to and that accurate interpretations of the raw data are extracted (Korstjens & Moser, 2018). The interview schedule questions are vital to redirect participants who stray off the topic. Questions were rephrased to confirm or enhance the understanding of either interviewer or the participant.

Participants being allowed to decline or withdraw participation at any time before, during, and after data collection and while the report was being drawn up, ensuring that only willing participants entered the study and provided honest answers. The interviewer established rapport with participants during the interview and created a sense of comfort through a brief introduction and enquiring into their wellbeing. The researcher was present for the interviews and the role of the researcher, i.e., taking down notes and providing prompts, was clear to participants. The interviewer pointed out that there were no correct answers to questions.

Peer reviews occurred, this included allowing informed peers (in this study, the research supervisors and interviewer are considered informed peers) to comment on the processes and data gathered or analysed. The researcher worked through transcriptions and interpretations multiple times and debriefed with supervisors. Member checking was then conducted with participants, by the researcher, before concluding the results- giving them a chance to verify the data provided to them. One participant was contacted to clarify their statements.

Strategies for credibility are also congruent with confirmability, which is the researcher's ability to account for their subjectivity or to be objective in their interpretation of the data (Korstjens & Moser, 2018). The researcher engaged in extensive reflection through journaling to become familiar with preconceived ideologies and assumptions and identify how this may have impacted interpretations of the data.

8.2 Dependability

To ensure the dependability of a study, the question of whether the study should be replicated and whether it would yield the same or consistent results must be posed (Korstjens & Moser, 2018). To ensure dependability, a thick or detailed description of the methodology is provided in the reporting of the study. An audit trail of the recordings and transcriptions was kept for evaluation.

8.3 Transferability

Transferability is the extent to which the results can be applied or transferable to other groups or populations (Korstjens & Moser, 2018). A thick description of the context is helpful here to allow the reader to decipher the contexts in which it may be generalizable.

This qualitative study was conducted to answer the research question, *"How do isiZulu speaking, Black South Africans perceive mental illness and experience mental health interventions at a private mental health facility in South Africa?"* Aiming to explore the perspectives and experiences of the Zulu MHCU. The following chapter, chapter two, is a manuscript drawn up for publication in a scientific journal. The findings of this study are outlined in chapter two.

CHAPTER TWO

Zulu cultural perspectives and experiences of mental health and mental health occupational therapy in Kwa-Zulu Natal, South Africa.

2.1 Summary

The findings of this research study are outlined in the format of a scientific journal article. The article outlines the lack of integration of the Zulu cultural perspective or worldview into healthcare frameworks or theories, and the findings reflect these neglected perspectives. It further explores the experiences of individuals of the Zulu culture who have accessed the inpatient services of a mental health facility.

2.2 Journal Details

The South African Journal of Occupational Therapy (SAJOT) is the official Journal of the Occupational Therapy Association of South Africa (OTASA) and is a leading publication for research into OT in Africa. This manuscript has been written specifically within the SAJOT guidelines for publication.

2.3 Status of manuscript

To be submitted to the South African Journal of Occupational Therapy for publication.

Manuscript

Zulu cultural perspectives and experiences of mental health and occupational therapy in Kwa-Zulu Natal, South Africa.

Abstract:

Background: *Healthcare systems are formulated utilising worldviews, specifically in mental health, where norms are created dictating what is normal versus abnormal. The era of coloniality promoted western dogma over collectivist cultures. Occupational therapy practice must consider the client's context during assessment and intervention for the process to be client centred. This study aimed to explore the perspectives and experiences of Black, isiZulu speaking, South Africans who had utilised multidisciplinary services at a private psychiatric facility under a western-based therapy model in KwaZulu Natal.* ***Methods:*** *A qualitative descriptive design was utilised. Purposive sampling was used to recruit 10 participants. Data was collected through semi-structured interviews. Analysis was guided by utilising Braun and Clark's six phases of thematic analysis.* ***Findings:*** *Three themes emerged from the data, personal perceptions, cultural perceptions and health-seeking behaviour. Sub-themes accompanied each. Personal perceptions explored how Zulu people made sense of mental health or related behaviours through a modern or traditional lens. It also explored the importance of the strength of the Zulu individual. This dissonance occurs when faced with cultural norms and personal needs. Their perspectives also altered through their experience with mental illness. Cultural perceptions were that problems were solved internally in families or communities, and progress was promoted as necessary for the Zulu individual. It also explored spiritual beliefs regarding mental illness, which could range between God, Ancestors or both and could be causal factors or healing mechanisms. Suicidality is seen as a weakness in the culture, and stigma was attached to mental illness. The final theme concerns the experience of the Zulu mental health care user dealing with their mental illness. A cognitive dissonance is prevalent in all three aspects not merely due to the difference between westernised mental health treatment and traditional healing systems but also due to the value found in each. The method of sharing vulnerability or issues with an individual outside the family contradicts cultural norms. However, participants expressed that being understood in group discussions and sharing vulnerability significantly improved their healing.* ***Conclusion:*** *Zulu individuals create their sense of self in an interdependent manner. The family and*

community are intertwined in their participation, reputation, and healing. There is an emphasis on strength and the following of norms in the Zulu culture, perpetuated by the importance of consulting elders or close family when faced with conflict. Disregarding these norms can outcast the Zulu individual who thrives on being included in the community. The study was conducted with a limited sample size and in an urban area. Further research within rural communities and diverse facilities would be beneficial. Occupational therapists working in communities such as KwaZulu Natal should understand the causal factors of mental illness for the Zulu mental health care user and their personal beliefs around healing when designing interventions.

Keywords: *Mental health; Mental illness; Zulu culture; Cultural Perspectives; Culturally appropriate healthcare.*

Introduction

Healthcare systems are formulated using worldviews, beliefs, customs and techniques for good health, appropriate diagnosis, and the prevention and cure of illness[1.] Systems such as these were created during the colonial era when power and privilege were afforded to western culture and created western hegemonic discourse[2]. The hegemonic discourse surrounding culture and its use in guiding practice has become critical to explore[3].

This necessitates reflecting on worldviews or cultural influences guiding practice, specific beliefs, attitudes, and definitions of normal versus abnormal. Worldviews are deeply connected to how people perform and the meaning they ascribe to their occupations; hence, culture is of great interest to the client-centred occupational therapy profession[3]. Considering mental health interventions specifically, these have been based upon attitudes and beliefs that govern or define what is normal and abnormal or requires intervention. These norms and ideals are essential to the development of theoretical models and frameworks that guide psychiatric intervention both globally, as well as locally in South Africa.

Culture refers to perspectives, beliefs, knowledge, values, attitudes, assumptions, norms, and customs associated with belonging to a specific group of people, which, in turn, guides thinking, understanding, and behaviour[4,5]. Cultural dimensions that may emerge need not be restricted to ethnicity or race but could include other factors of diversity such as class, gender, sexuality, and ability[4]. These divisions, which influence meaning attributed to occupation, also, unfortunately, render people unequal in society and affect the privilege, power, and opportunities they are afforded[4].

Analysing the theories in multicultural societies has become necessary for decolonizing occupational therapy theory and practice to incorporate diverse worldviews, mainly from the

global South[6]. Decolonisation calls for disrupting the norm and questioning the appropriateness of practices. Occupational consciousness becomes a central concept for disrupting the cycle of oppression through occupation[2]. It entails building an awareness of the dynamics of hegemony and recognising how this might be sustained in everyday occupational performance[7].

Unfortunately, a wide variety of research thus far focused on the occupational therapist's challenge of working in diverse societies rather than understanding the client's culture and how it influences their understanding of health, health-related behaviour and experiences[5].

Furthermore, much research that looked at traditional theories of ill health has become outdated. One such study was done by Edwards et al. in Durban, South Africa. It highlighted various theories African clients presented of their psychiatric illnesses compared to western theory. They found differences between traditional and western theories but also congruency in the differentiation between psychotic and non-psychotic disorders[8]. A latter study by Crawford & Lipsedge[9] is highlighted later on in the study's literature review for its in-depth information about Zulu cultural definitions of illness. This study highlighted the role that ancestors are believed to play in the construction of illness among Zulu people.

When researchers engage in research with the utmost respect for the perspectives and experiences of diverse cultures, they will move toward culturally safe theories that are inclusive of the truths that clients hold[4]. This study will explore the mental health perspectives and experiences of mental health interventions among isiZulu-speaking, Black South African mental health service users (MHCUs). The research specifically aims at those who have participated in western-based occupational therapy programmes. Thus, critical reflection will be engaged regarding the question: *are mental health services appropriate for this dominant cultural group*?

Literature

The existing literature is divided into four sections, as shown in Figure 1 below:

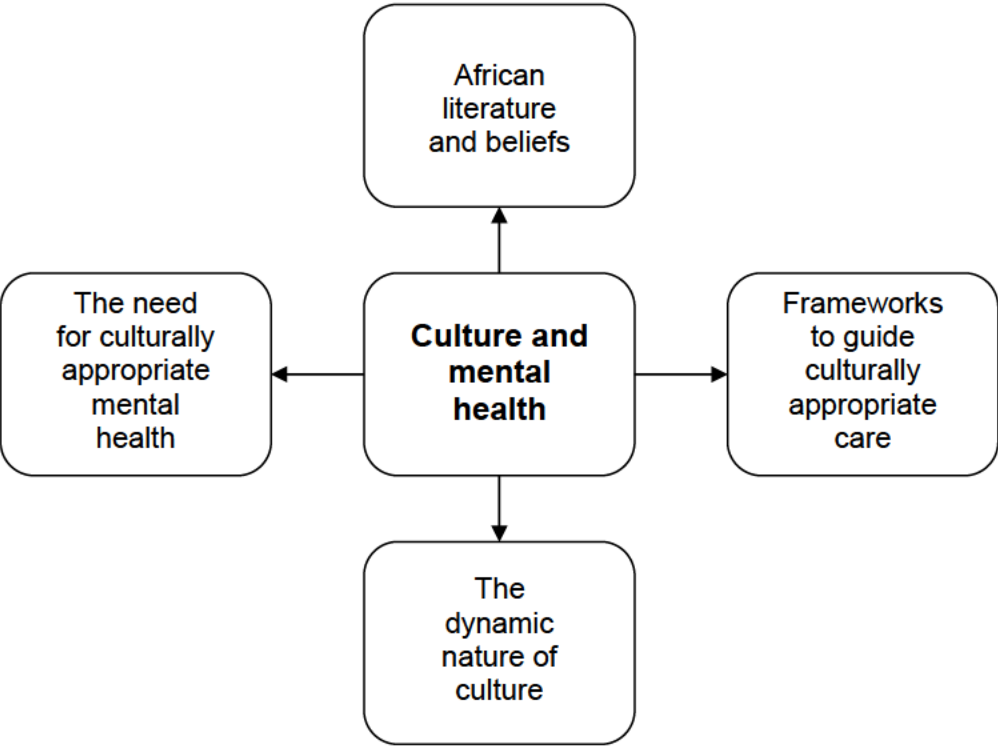

Figure 1: Architecture of the Literature Review

The dynamic nature of culture

Culture is dynamic, evolving and developing as the world evolves and develops, and as different cultures tend to coexist in shared spaces over some time[4] thus necessitating consistent re-thinking and re-exploration.

To comprehend what is of importance and relevance to the people, as well as to evaluate cultural safety and appropriateness of occupational therapy practices, information must come from the sources themselves[4]. This study aimed to gain insight into this for MHCUs from within the Zulu culture.

The need for culturally appropriate mental health

Preceding 1994, the apartheid government strongly disseminated the western worldview as the ideal[10]. This "epistemicide", or near destruction of indigenous terminology or explanations[11] did not result in the abandonment of traditional practices among Africans. Instead, it afforded a choice between both health systems[10], perhaps as a reflection of the meaning they still found in traditional practice.

Studies conducted globally have identified evidence of culturally inappropriate mental health services and their adverse effects on the people they were meant to serve[12,13]. These studies

depicted the potential damage caused by well-intentioned services that neglected the client's perspective. Collectivist cultures see themselves as interconnected with their communities and place less emphasis on autonomy or independence[14]. Critical reflection and research are imperative before providing services for collectivist cultures, or it risks undermining traditional methods and meaningful cultural beliefs and practices.

In efforts to understand this diversity manifesting within mental health, five critical components from collectivist cultures were found to play a significant role:

- A reluctance to use talk therapy in the case that it would lead to more suffering;
- The shame of having a mental illness causing further reluctance to seek professional help;
- The power distance between therapist and client;
- Collectivism as the preferred method of support; and
- Religion or spirituality as the root cause or utilised as a coping mechanism[15,16].

Regardless of this knowledge of cultural diversity and mental health, most of the approaches toward intervention and counselling remain Eurocentric on a global level.

African literature and beliefs

A discourse analysis[17] solidifies the necessity of African research into cultural perspectives. Findings indicated a contradiction between traditional Zulu and western theories of mental illness (MI), leaving African individuals with the complex decision between two healthcare provision systems. The researchers suggest that colonial power perpetuated the ideology that resilience entails the passive acceptance of suffering among African people.

Stigma toward mental health care users (MHCUs), developed through cultural beliefs and attitudes, also significantly influenced how they were perceived and reacted within their communities. Moreover, this stigma caused individuals with MI to relapse, reducing their treatment adherence and health-seeking behaviours[18].

An older but relevant study in rural KZN identified that Zulu beliefs concerning ill health and suffering were closely linked to their religious beliefs, history, social relationships, and cosmology[9]. Beliefs around medical doctors were that they could understand and treat disorders known as "*umkhuhlane*", but other disorders known as "*ukufa kwabantu*" were only recognised and treated by traditional healers.

This ideology still exists in Molot's[19] study of western versus traditional treatment of MI in KZN. Explanations for the root causes of MI by traditional healers often included ancestors. Traditional healers also reported that they exclusively treated those bewitched or in trouble with their ancestors through methods such as burning *imphepho* (incense), cleansing, or traditional medicines. Ancestors are highly regarded and often linked to the wellness of the Black African individual and family[9,19,21]. Ancestors are the souls of the deceased elders who guide the living. When ancestors express displeasure or communicate with the family, they usually do so in the form of illness, suffering, dreams, or nightmares that must be appeased by specific rituals[21].

African culture reveres fundamental moral values such as patience, perseverance, modesty, industriousness, obedience, and respect for elders[22]. An individual creates their sense of self through others. The proverb "*umuntu ngumuntu ngabantu*", which translates to "a person is a person through other persons", is a good explanation of this[22]. Hence sources of motivation for the African individual include bringing honour to their name or clan, overcoming the limitations of their background, competing with others in their age group to achieve worth, pleasing the ancestors, and having the desire to be part of a community and receive social support[22].

Frameworks to guide culturally appropriate care

Frameworks utilised in occupational therapy practice possibly achieved dominant status due to the influence and power accrued by the western culture[4]. Initially, cultural competence was utilised as a framework for mental health professionals to practise efficiently within culturally diverse settings. It required practitioners to become familiar with the cultural values, customs, and traditions of the people they served. However, research has indicated that these cultural competence models are insufficient and can be problematic due to their ignorance of the dynamics of power and oppression[4,15,24]. Cultural humility has been proposed as more appropriate as it requires therapists to become critical thinkers. This entails evaluating intersecting identities and scrutiny of generally taken-for-granted knowledge that is defined as truth and operated from. This redresses the power imbalance within a client-therapist relationship and enhances the therapy process[4,24].

Methodology

Study design

This study employed a qualitative descriptive approach. A qualitative design was best suited to the study that sought to enquire into concepts of meaning, experience or views from the participants' point of view in the healthcare system in KZN[25].

Selection and sampling strategy

Purposive sampling was used, where a group of people are intentionally selected to best answer the research question posed[26,27]. There were 10 participants in this study as data saturation was reached at this point of the data collection.

Table I: Participant Demographics

Participant	Gender	Age	Occupation	Pseudonym
1	M	30	Lifeguard	Thabani
2	F	44	Educator	Gugu
3	M	34	Police Officer	Muzi
4	F	57	Former Crèche Owner	Mbali
5	F	28	Educator	Ntokozo
6	F	36	Administrative Clerk	Zandile
7	M	38	Student Advisor	Bheki
8	F	50	Receptionist	Thokozile
9	M	42	Police Officer	Menzi
10	M	33	Plumber	Sifiso

Research setting

This study occurred in the KwaZulu Natal province of South Africa, specifically the city of Durban. The predominant cultural group residing in KZN is the Zulu people. IsiZulu is also the most commonly spoken language of the 11 official South African languages[28].

The study focused on MHCUs from the Zulu culture previously admitted to a psychiatric facility. The facility is based in one of the more upmarket areas of Durban, usually inhabited by people with a higher socio-economic standing in terms of income and standard of living. However, the client population arises from all over the city and country. MHCUs seeking assistance at the clinic may present with depression, anxiety disorders, Post-Traumatic Stress Disorder and psychotic disorders, among others.

Data collection procedure

A semi-structured interview schedule drawn up by the researcher was used to guide the conversation. Open-ended questions were designed to elicit responses relevant to the research question and allowed participants to diverge into new concepts that arose within the

conversation. Interview questions explored attitudes and beliefs surrounding mental health, mental-health-related practices and experiences of current mental health programmes. A pilot study was conducted with 2 participants to ensure that questions would be understandable to participants and that they would elicit the responses required to answer the research question. The pilot study revealed that the questions were appropriate. An interviewer matching the description of a Black, isiZulu-speaking South African was contracted to conduct the interviews. Thus, creating a more comfortable interview space for the participant and allowing them to express themselves when it proved difficult to translate from isiZulu to English and vice versa.

Trustworthiness

The semi-structured interview schedule questions were utilised to redirect participants who strayed off the topic. Questions were rephrased to confirm or enhance the understanding of either interviewer or the participant. Participants reserved the right to withdraw their participation at any time before disseminating the results. Thus, they would only have participated out of willingness. Peer reviews occurred, where informed peers commented on the processes and data gathered or analysed. The researcher worked through transcriptions and interpretations multiple times, and debriefed with informed peers. The researcher engaged in reflection through journaling to evaluate her positionality as an Indian female who was an outsider to the Zulu culture, to uncover preconceived personal ideologies and identify how it may impact interpretations of the data. A detailed description of the methodology is provided. An audit trail of the recordings and transcriptions was kept for evaluation. The detailed description of the context can be utilised to decipher the contexts in which it may be generalizable.

Ethical considerations

This research study was approved by the Biomedical Research Ethics Committee (BREC) at the University of Kwa-Zulu Natal (Ref. no. BREC/00002882/2021). The research process was carried out according to the research guidelines to ensure scientific integrity. Gatekeepers' permission was obtained from the facility, and participation in the research study was voluntary. Telephonic or virtual interviews were more cost-effective. Individual interviews provided participants with confidentiality as they were blind to each other. Participants' stress was minimised by fully informing them about the study. Participant names and any other identifying features are not included in reporting. Participants were treated and responded to with respect and sensitivity, and their cultural viewpoints were respected.

Data analysis and Findings

Data Analysis

A thematic analysis of the data was conducted. Thematic analysis has the potential to reflect the current reality and uncover what underlies this reality which is in line with the aim of this research. The six steps of thematic analysis were followed as outlined by Braun & Clark[29]. Thereafter a deductive analysis was conductive.

Table 2: Thematic Analysis

Thematic Analysis	
Step 1 Familiarising yourself with data	Raw data were collected in the form of audio recordings of the interviews that were conducted between the interviewer and participants. These audio recordings were then transcribed into a document by the researcher. The researcher immersed herself in the data Transcriptions were a verbatim account of the conversation and were combined with non-verbal cues noted by the researcher.
Step 2 Generating initial codes	Coding was completed so significant parts of the data could be extracted and organised. The researcher conducted coding manually, allowing for further immersion and context maintenance.
Step 3 Searching for themes	Codes were grouped into themes, allowing codes to fit into more than one theme
Step 4 Reviewing themes	A thematic map was generated. The researcher returned to the research question and matched the data to the explored concepts. Sub-themes emerged as similar codes were grouped.
Step 5 Defining and naming themes	Immersion continued as the researcher re-read through the data set actively and searched for meaning. Themes were reviewed and refined by re-reading through the data and the codes to verify patterns initially detected.
Step 6 Producing the report	Findings were written into a report with verbatim quotes to support the themes and sub-themes.

Findings

This section will present the themes that emerged in the study. Three themes emerged, Personal perspectives, Cultural perspectives, and Health-seeking behaviour. Each theme is accompanied by sub-themes, as described in the diagram below.

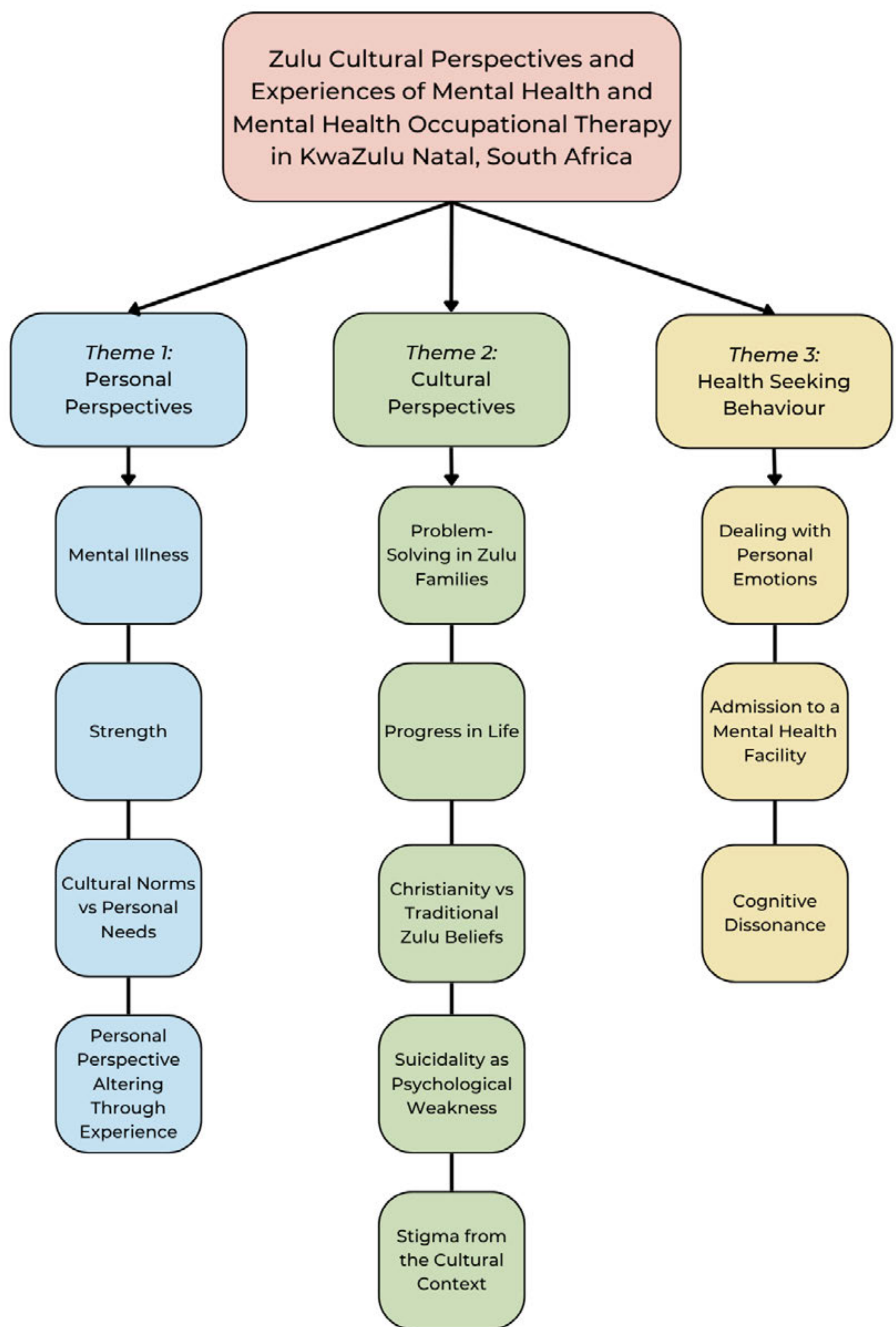

Figure 2: Thematic map

Theme 1: Personal Perspectives

This theme considers the aspects of the Zulu individual's perspectives concerning MI and some of the causal factors described by participants. The sub-themes that emerged under this theme were MI, strength, cultural norms versus personal needs and personal perspective altering through experience. These sub-themes will be discussed individually.

Mental illness

The concept of MI does not naturally emerge in Zulu culture and is regarded as a western concept. This makes it difficult for MHCUs to be understood and supported as needed.

Healthcare for physical ailments is recognised, but mental health services are not. Many are not aware that the western medical model includes these services.

> *"Oh, before I came here, I didn't understand, I didn't know that there was a hospital that was meant for mental health. The only thing that I know is that you just go to hospital when you are sick."* (Thokozile)

This lack of recognition of MI within their communities can turn into invalidation for the Zulu MHCU.

> *"That is why I am here, my husband wasn't supporting me, he started not speaking with me, he started ignoring me, he started telling me…he started like rejecting me because I was suffering from depression and anxiety and he told me that "No you don't have a problem, it's just that you want attention from us and you won't get it".* (Zandile)

Mental health, when recognised, is seen as a white person's problem.

> *"Then when it comes to mental health, according to our culture there is no such a thing called stress or depression, if you said you are stressed or you are having a depression, they think that you are having a drama, you are westernised, you are colonised, they think all of those things, they think maybe you think you are a better person than them."* (Thokozile)

Strength

Strength is presented as a core quality required of the Zulu individual. It is expected to be displayed in different ways by each gender.

In traditional Zulu families, the eldest male is regarded as the family's provider, decision maker and leader. Male participants expressed that this role required them to present as emotionally strong and thus worthy of respect. A man must not disclose incapacity to lead the family or handle situations that arise lest he loses respect.

> *"…in difficult moments as a male you're not supposed to cry. People are looking up to you and must find hope in you so you must find a coping mechanism. If you're the one crying, what about the children, what about the wife, the sister or someone. So, if you cry, you go into a corner somewhere and cry alone. But in front of everyone, everything should be ok."* (Bheki)

Strength in a female was defined as sustaining their marital household despite any hardship experienced. Weakness would be described as leaving the marital relationship. Even in times of injustice, Zulu females were expected to remain as caregivers and submissive wives. While this ideology is still present, they are currently afforded opportunities to education and work, supporting themselves and their families.

> *"I think it's because most of the Zulus' mothers, they are housewives, that's why…not now before it used to be that they are housewives. Most of them, now they are working, they can stand for themselves."* (Zandile)

With temporal shifts, the expectation of financial provision is no longer restricted to males, as females now have the opportunities to education and work and are expected to provide for their families financially. This occurred even when fellow household members earned salaries, and irrespective of responsibilities, the female, has beyond the family.

> *"Like this month I said I won't buy groceries for them at home because I was staying with my in-laws for the whole holidays so I have to buy for my in-laws because I was using their food. But when I got home there was nothing, no food, nothing and my sisters will tell me ooh I bought this jersey it's so…Serious! You bought a jersey while there is no food in the fridge!"* (Ntokozo)

Thus, both males and females are held to the expectation of being strong and not expressing hardship.

> *"...to us in our culture, mental illness does not exist, it does not exist because we have this belief or this expectation that nothing is bigger than you, nothing is impossible, we are like warriors."* (Bheki)

Cultural norms versus Personal needs

Culture promotes collectivism and the practice of *Ubuntu* which can override or conflict with the needs of an individual in this interdependent culture.

It was expressed that in a Zulu family, people were raised to be givers and helpers. A popular act was self-sacrificing for the well-being of others, even when one was not in a position to assist. Participants, therefore, struggled with setting healthy boundaries.

> *"What I can say about what led me here is firstly I wanted time out. I give and I give and I give and I give until there is no me." ... "We call it in isiZulu, nika nika."* (Ntokozo)

This also materialised as "black tax, " defined as an unspoken obligation to help others or extended family when you have achieved well yourself[29].

> *"Black tax is when you, they feel you are, same word, obligated to do certain things because you are earning more or you are more educated. Black tax is like blackmail towards your mind, towards your soul and how you see things. "Ey but you know", they will look up, "Ey but you know the ceiling is not there" and then you like "Eish, I need to buy ceiling next month" and then you put the ceiling up."* (Ntokozo)

Due to the Zulus being a collectivist culture, informational support usually came from someone in their network who had experienced the facility or mental health services. Alternatively, they would get referred to a traditional healer.

> *"Uhh, okay, to me, one of my friends told me, cos we uh, especially I was getting lot of headaches, not sleeping at night, maybe I will sleep like an hour or two at most"* (Sifiso)

Personal perspective altering through experience

Participants saw a need to adapt their mindsets after their experience of a mental health service.

> *"We are not in the era where our grannies, grandfathers and ancestors were. We are in an era whereby we need to use the tools that are there, yeah. So, we need to shift our mindset, not forget our roots but shift our mindset and try to accommodate the new change that is around us."* (Ntokozo)

Going through the programme at the facility altered their perceptions of MI from being non-existent within Zulu culture to being existent and treatable.

“Uhm mental health for me…Uhm I think it's going to be different now for me because I’ve been to a mental institution, like a mental health institution so obviously my perspective now is a little bit different compared to uhm before I went there.” (Muzi)

The older generation, who had different educational opportunities or grew up in rural contexts, were not easily convinced about the benefits of seeking mental health services.

“I don’t think I’d even try with him (participant’s father) *because that absolutely… it never existed in his mind so I think now with the younger generation the more we go to school… eh…the better we understand. But with the elderly people or with the people especially from rural areas… like real real rural areas, they’ll not attend a psychologist. I don’t think you can convince one to attend.”* (Bheki)

Theme 2: Cultural perspectives

The following theme considers how Zulu people are socialised to behave by their cultural context, specifically when it concerns hardship or MI. The sub-themes that emerged were problem-solving in Zulu families, progress in life, Christianity versus traditional Zulu beliefs, suicidality as a psychological weakness and stigma within the cultural context. These will be discussed individually.

Problem-solving in Zulu families

Problems are dealt with collectively within the Zulu culture. Maintaining honour and reputation in a family are important[21], and thus issues would not be expressed outside of the family space. This is contradictory to the westernised mental health system.

Issues experienced by the Zulu person must be taken to the elders, who will advise that they must be dealt with internally. Discussing problems with an individual external to the family is regarded as shameful.

“Normally the elders they come together and then they said these things should be for the family and must not go out”. (Thokozile)

As noted above, it was also expressed that, often, the elders in the family would instruct them to remain silent about what they were experiencing:

“...they don’t want, like outsiders to know what is happening in the family… they pretend as if everything is okay while everything is not okay until maybe that person comes out saying

that no enough is enough. And then when you said that (revealed the problems*), they will say that you are mad.*" (Thokozile)

Progress in life

Zulu individuals and, subsequently their families value progress in terms of social status, finances and assets. The progress of the individual means progression for the family. Thus, there is an unspoken expectation and drive to progress.

The pressure is felt through subtle societal expectations or comparisons with their age mates.

"...you want to progress in life. Can you imagine you grew up and you 35 or 40 years and you still stay at home? That's not right, by that time you need to have your own house, have your own family." (Menzi)

Debt is sometimes accumulated to be deemed as progressive in society

"I am in debt, there are things I cannot afford, I am turning 30 in December and I don't have a car and I know a car, it doesn't mean anything but you know it's something which I wish I could have. I don't have a car and I don't have the finest and nicest clothes ever and I'm always making ends meet…" (Ntokozo)

Christianity vs Traditional Zulu beliefs

Each participant expressed some form of spiritual and belief system.

Many behavioural shifts or changes in a person are initially attributed to spiritual causes in the Zulu culture.

"Oh! They think maybe you are crazy or you are a witch because they don't know anything about mental illness." (Gugu)

Spirituality is an essential concept to all Zulu people, some believing in God, some in ancestors and others combining the concept of God and ancestors. For some individuals, a conflict exists between cultural beliefs and God, which is seen as a western concept.

"Some people chose to pray only to God and then obviously the majority uh, stayed with the ancestors and the rituals. Uhm, and then a part of the people would just mix the two, they would have like, they would pray to God, for God to help them connect with their ancestors or the other way around…" (Muzi)

Ancestors were either regarded as protectors and providers or as negotiators between the tangible and intangible realms or God.

"We do these things to make sure they protect us from sicknesses, illnesses…" (Menzi)

"Our thing is they negotiate. They are like the negotiator between us and God. It's how we grew up." (Ntokozo)

Participants who believed in their ancestors, believed that they could express dissatisfaction with them through MI and specific rituals needed to be completed to appease them.

"…there were certain things that were done at home, rituals and maybe now you are the older one or you have your own family we are not following those proceeding stuff so whatever that is not right that is happening to you, it might be pinned to that…if she can do this and this because it's what was required to her, then things will come back to normal.

Whether they described themselves as Christians or revering ancestors, most participants had expressed a sense of respect for their ancestors. Some combined the belief systems, while others merely acknowledged their ancestors.

"I am a Christian. But praying to God but that doesn't mean I cannot do uh our cultural things… there are things that as Zulu nation you need to do… whether you are Christian or not, you need to do it, it's a must." (Menzi)

"The only thing that I believe is that there is God, and if you pray, you will receive what you are praying for." (Thokozile)

Suicidality as psychological weakness

The unavailability of coping skills and adequate support leads to a sense of hopelessness and possibly suicidality which is then deemed a weakness in the Zulu culture.

Due to the requirement to be emotionally strong and the expectation for one to persevere through hardship, it is difficult to ask for help. Suicide is a major concern stemming from this, as many people turn to it after feeling there was no way out of their problems. Multiple participants expressed that suicide is seen as a weakness, and the underlying causes are often overlooked

"...some people they even commit suicide you know. Because whatever that they going through they think they can handle it until they cannot handle it anymore and then their only solution is to take their life." (Menzi)

Participants expressed that a specific ritual of beating the dead body of a person who commits suicide must be carried out to ensure that the spirit of the person who committed suicide does not infect the other family members. This solidifies the concept of suicide being seen as a weakness instead of an act of hopelessness.

> *"Like for example if someone dies in your family by suicide and then they believe that the person, they have to beat that person, the dead body so that there will be no other person in the family does same thing."* (Muzi)

Stigma within the cultural context

Participants expressed that stigma within their cultural context emerged in the form of names to describe MI.

Names for MI include

"uhlanya", (Zandile), which translates to crazy,

"islima", (Zandile), which translates to stupid,

"ustupito", (Zandile), which also indicates stupid,

"ziyarara", (Zandile), which is understood as a person having bees buzzing in their head,

"domorosa", (Thokozile), which translates to "you are *dom"* (stupid),

"uyatagata", (Mbali), which translates to someone practising witchcraft.

These words encompass stigma, misrepresent MI and outcast the MHCU. MHCUs are labelled by these words and are often not taken seriously due to these labels. Therefore, most Zulu MHCUs do not disclose their MI.

Adverse or invalidating reactions to emotional expression adversely impacted participants' mental health.

> *"They will think that you are a dramatic person, you just want attention."* (Thokozile)

Theme 3: Health-seeking behaviour

This theme outlines the task of dealing with MI for the Zulu individual when it became overwhelming and difficult to ignore. The sub-themes discussed hereafter include dealing with personal emotions, admission to a mental health facility and cognitive dissonance.

Dealing with personal emotions

This subtheme looks at how overwhelming emotions were dealt with by the Zulu MHCU prior to admission.

Initially, the Zulu MHCU will attempt to cope with their MI in isolation. Often this can manifest in unhealthy coping mechanisms.

> *"Yeah, but sometimes alcohol, it helps me to sleep. Cos' when I'm drunk, I sleep the whole night and wake up at 5 or 6 o'clock and look at the time and…. oh, it's time to go to work…but when I'm sober… ah it's difficult… cos I'm dealing with a lot, yeah."* (Sifiso)

Another primary coping mechanism, especially displayed by Zulu males, was aggression as an outlet for their emotions.

> *"Because if your father comes home and was upset about something or something didn't go right. Whatever wrong that is happening here, it's a fight. Then they will burst in anger. But it's not because they're generally…like that. It's because there's too much pressure. They are keeping it inside."* (Bheki)

Many participants reported that they only noted a decline in their health once they experienced physical symptoms of MI or irregular behaviours such as isolating themselves.

> *"...losing weight, having headache, not feeling to talk to other people, most of the time I was sleeping, not wanting to talk to anyone…They didn't find what make me sick until they brought the psychiatrist."* (Thokozile)

These symptoms are what often prompt health-seeking behaviour.

Admission to a mental health facility

This subtheme details the experience of Zulu MHCUs who were admitted to an inpatient programme.

Zulu individuals were initially reluctant to access the mental health services they learnt about, and when they did, they described an internal conflict.

> *"The first time I attended a psychologist, I felt terrible in a sense. I asked myself, am I ok? What's wrong with me? Something's wrong with me. I'm attending a psychologist and now I need to say and open up to someone and maybe that person will also see me and think "No, this guy is weak"."* (Bheki)

A profound response from each participant was that they were astounded by the fact that they were not alone in what they were experiencing.

> *"I think I realised that it, it's like whatever that I'm going through I'm not alone in this and all these people are also dealing with so many things and that's why they are here."* (Muzi)

Participants felt relief at the validation they received from each other.

> *"So, they uhm, they talk about things and they share and you find yourself laughing and nodding and saying that is true and stuff."* (Sifiso)

They found that understanding the problem and solving it practically with support was helpful. Speaking to someone who can provide perspective or understanding improves their wellbeing.

> *"...it makes me feel better. Too much. I am feeling better because of it. Those activities as well as the talking with others, but before I went to* (the facility), *I don't get to do all that."* (Mbali)

The facility was seen as a healthy distraction from their challenging or sometimes toxic environments, and they could think more rationally.

> *"...you forget because the whole idea is to get away from people who are causing you more stress and then just be yourself, and that is where you think clearly and that is where you make decisions and then you starting already, I need to try this… and I need to try this …and try this."* (Muzi)

The facility needed to be a safe space to express their vulnerability, where someone would listen attentively, care about what was being expressed and be non-judgemental.

> *"She* (psychologist) *was listening to everything I was saying and she would ask me a question about what I said and I'm thinking maybe she is not listening but no, she was, and there was no situation where she was judgemental so she is open-minded."* (Ntokozo)

Participants found value in the diversity of group therapies available.

> *"I think they cover everything cos' when you go to the different classes you learn something to each class."* (Mbali)

The facility allowed and encouraged a focus on the self, specifically allowing them to express themselves without fear of criticism or judgement for going against cultural norms.

"And I get a chance to learn about so many things that will boost my self-esteem and also that will help me find out who I was and what I really want." (Thabani)

Participants recommended that spirituality be integrated into the care they received due to it being so pivotal to most of their lives. However, this is acknowledged as difficult to navigate due to the diversity of spiritual beliefs.

"Yes, spirituality, yes yes yes. We need that, it's lacking, but I think so…not exactly Christian but someone must be fair…you can't just bring Christianity and leave others. We need some spirituality. Yes, I would suggest that." (Zandile)

There are culturally specific issues that need to be expressed. To truly express oneself, the isiZulu language is necessary.

"Yes, language plays a huge role, you know English is not our mother tongue so there are things that we want to say or express but we can't express them in English… So, what happens now? You keep quiet… So, you come to (the facility) *with a problem, you go home with the very same problem."* (Menzi)

Participants felt a need for an increased length of stay in the facility to enhance their understanding, identify problems, and improve their skills and coping strategies. There is also a need for support external to being admitted in the facility.

"It's a lot of things that are, are, you are given within a short space of time and then you have, you still need to go out there and practise these things, things that you learned within just two weeks (laughs)." (Muzi)

This type of experience is more accessible in private rather than public facilities, side lining those without access to medical aid or funds.

"…maybe they look at the kind of services that the government has and then they feel like what's the point." (Muzi)

Cognitive dissonance

Zulu MHCUs who had experienced a western mental health service expressed that their cultural norms and the perspective or experience gained at the facility differed.

This cognitive dissonance caused participants to express anger at their culture for not acknowledging and educating them about mental health and illness.

“Black culture! Black culture, what I can say…they are emotional abusers.” (Zandile)

Participants felt that culture acknowledged the change in tangible aspects but did not readily recognise or adapt according to intangible factors like MI.

“For example, like uhm having lobola, lobola used to be walking cows, it was a must that it must be walking cows. Now I live in (the city)*, there is no grass (laughter). I can’t make it a cow; it will be like eyoh what is she doing and the cows will be gone in the morning. So, what do I do? You must give me money instead of the cows. Each cow has its own money value so we adapt…change. Why can’t we adapt to that change and adapt to all changes concerning culture. When it comes to money we are like yes, yes, its fine but when it comes to uh certain things like mental health- no, no, no it's not okay.”* (Ntokozo)

Participants further expressed a need for education and awareness surrounding mental health.

“...its awareness. I just…the more we get people aware of these things, the more they can get help, the more they can be able to understand what really is going on with themselves.” (Muzi)

Beyond the treatment of the Zulu MHCU, there is a need for education with families who are core to their environment.

“So, what I would suggest, we need to go back to the families, to teach them about depression and anxiety and about triggers” (Ntokozo)

Discussion

The findings of this study were viewed through the lens of the Ecology of Human Performance model. The basic tenets of the model include the person, the context and the task[20]. In this section, findings relating to these concepts will be integrated and discussed.

Participants expressed that experiencing MI and participating in westernised treatment conflicted with their perceptions and restorative to their state of mind. MI and mental health services were described as unfamiliar to most Zulu people. Explanations for the behaviours related to MI were often linked to the belief in a spiritual dimension. These spiritual dimensions differ however, each participant expressed a form of spirituality, either revering God, ancestors or a combination. This confirmed their belief of a human and spiritual plane in which activity occurs[21]. Rituals participated in ranged from traditional, where the use of a *sangoma* or an *inyanga* was required, to religious offerings, where the church and prayer to God were leaned

upon for wisdom. Personal spiritual beliefs were a source of strength and a coping mechanism for the African individual[15,16]. Treatment in the facility often did not include spirituality being included. Participants felt strongly enough about this to recommend that it be introduced.

Another critical concept of the Zulu culture was the ideology that each individual must possess strength. Participants in this study specifically referred to an individual's emotional/psychological strength. It was found that each gender was expected to display strength in different ways. Traditionally, Zulu males feel the pressure to present as symbols of strength. They believe they are not to express emotions or vulnerability in front of others as this is considered a weakness[31]. Males generally dealt with their emotions through substance use which was seen as more acceptable or displayed aggression as an emotional outlet. Female strength was measured by persevering through marriage and family. Women are traditionally required to be submissive and dependent on the Zulu patriarch and are subjected to silence when enduring injustice for fear of loss of provision. With temporal shifts in the context, females now have access to education and work that they did not always access previously. Educated females then faced the issue of having to assume the role of the male and bear similar expectations of provision and strength within the household. However, educated females who provide for their families still do not receive the respect or honour afforded to a male provider.

The expectation of strength further tied in with the need to progress and improve the family's reputation. This progress would be measured in terms of the status, financial position or assets of the individual. However, the Zulu individual's reputation is linked to their family or community's reputation[22]. They are therefore required to follow customs or norms[22] lest they bring shame to their collective name. The issue arose where the need to progress in life is so entrenched that it necessitates creating more hardship to maintain the image of progression. An inability to admit to experiencing adversity emerges and, consequently a sense of helplessness. With a reluctance to ask for help and an inability to cope, some might turn to suicidal acts. Suicidality is not considered an act of helplessness but rather a weakness within the person. Participants expressed that they could not explain MI or psychological distress to their families. The Zulu individual creates their sense of self concerning their community[22], thus, silence and isolation can be counterproductive to the Zulu MHCU's healing.

Experiencing emotional hardship is thus not easily admitted to or spoken about. However, when admitted to the facility, talking about their issues and developing solutions were seen as an enhancement to their state of mind. If there is a need to talk about an issue, the Zulu individual must approach their close family, especially their elders. Elders in the Zulu culture pass on rich cultural knowledge but an insufficient understanding of mental health. Being a

historically marginalised group, the effects remain evident. Elders whose voices are central in advising or problem-solving promote strength and coping through endurance, strategies they were forced to implement under the apartheid regime and continue to pass on[17]. Thus, revealing issues within a mental health facility conflicted with their cultural norms.

This was concerning as family or community-related issues are often causal factors of MI for the Zulu community. Zulu people are raised to be helpers and givers, with the spirit of Ubuntu instilled within them[33]. However, this sometimes translated into a lack of boundaries and being taken advantage of by those who do not reciprocate the concept of Ubuntu. 'Black tax' emerging is an example of this. If you were advancing in your career or earning well, you were obligated to provide for the extended family, despite your capacity[30]. Participants expressed that this placed a significant burden on them but they did not know how to put in boundaries to manage taking care of their own needs versus their community's'.

The importance of forming part of a community was emphasised by participants. Stigmatised names within the community context, attached to MI, caused more reluctance to reveal illness or seek help for the Zulu individual[18]. Due to the fear of being cast out or labelled and not valued in their communities, many would remain silent. For younger or urban participants, perspective could alter through experience, but more entrenched cultural beliefs exist within rural communities and older generations. To avoid the loss of community, the Zulu individual may attempt to manage emotions in isolation. When negative emotions overwhelmed the Zulu individual, and no outlet for expression was available, they had to be suppressed. As previously described, unhealthy coping mechanisms were employed, such as substance use or displays of aggression.

Despite this reluctance to admit to experiencing hardship, this displays that support, in whichever form, is primarily sought from each other in the Zulu culture[16]. In communities, considering it a spiritual issue was often more acceptable than acknowledging it was mental health related. Thus, Zulu individuals and their families would seek help from their spiritual community. For the Christian Zulu, this would be their pastor; for the traditional Zulu, it would be a *sangoma* or traditional healer. As previously discussed, rituals or prayers that were performed did have a positive impact on the mental state of most Zulu individuals. Referral to westernised mental health services occurred either when symptoms manifested physically, such as headaches or poor appetite, and did not improve; or when experienced peers with mental health noticed their predicament. Being admitted to the facility left these isolated individuals relieved by the feeling of "I am not alone". Solidarity is advantageous to the Zulu MHCU's healing[32,] and this was found in the facility. Moreover, the facility presented healthy distraction and a safe space to learn, share and heal through vulnerability.

The cognitive dissonance was then heightened when realising they experienced MI, thus arousing anger toward their own culture when faced with western versus traditional healthcare systems. MI, initially regarded as ‘a white person’s problem’, was found to exist in theirs as well. Zulu culture cannot be blamed for the lack of recognition of mental health, especially when it was introduced by a culture that neglected to take their worldviews into account and silenced their voices[17]. However, considering it a white person's illness builds stigma and was preventative to health-seeking behaviour for the MHCU. Understanding that it exists within all cultures but can be treated differently due to the different causal factors and healing processes enhances health-seeking behaviour.

Time in the facility was often reported as minimal as the process of altering perspectives and improving their mental state, for the Zulu individual, is a more complex and time-consuming task. Many Zulu individuals expressed the need for more time to learn about MI, understand its causes and apply it directly to themselves before learning contextually appropriate skills. Most participants verbalised that their two-week stay was insufficient. This indicated a need for outpatient or community level mental healthcare services and resources.

Furthermore, the isiZulu language was inseparable from the culture and the interconnected issues they experience could, at times, only be efficiently described using the language. Being primarily isiZulu speaking, there were culturally specific issues that needed to be expressed in their home language. Participants expressed that there were cultural concepts that were interrelated with their wellbeing. One such concept was that of ‘black tax’ described earlier.

This kind of mental health service was not easily available in the government facilities and excludes those without access to medical aid. Thus, a large proportion of the Zulu community are unable to access healthcare for issues such as depression and anxiety. It was deemed that only the individual with ‘very severe’ psychotic features belonged in a public mental healthcare facility. This has the ability to perpetuate the discourse that mental health is a “white persons’ problem” and does not fit into their range of resources to utilise.

The Zulu culture has been subjected to adaptation with temporal shifts. However, the tangible adaptations tend to be more easily integrated, such as female and male roles, as well as payment forms like *Lobola.* Intangible shifts, such as the understanding of mental health, tend to be viewed as out of their control and not sufficiently recognising the intangible is a stumbling block to change.

To execute change, there came a significant outcry for the dissemination of mental health awareness and resources within the Zulu community as a result of their experiences. While

the causal factors and healing activities may differ for the Zulu culture, the understanding of mental health could significantly enhance the Zulu MHCUs mental health seeking and treatment. Both systems of healing, western and traditional, seem to be beneficial to the Zulu MHCU.

Implications

- It is a strongly collectivist culture where the individual and their participation cannot be understood in isolation to their family or community as their issues are inextricably linked back to their context and so is their healing. The family cannot be left out of the intervention of the Zulu MHCU.
- There is an ingrained idea of strength through silent endurance of hardship, which was appropriate under the apartheid regime, but is no longer beneficial to the Zulu community whose voices must be highlighted. The development of resilience and healthy coping strategies should be promoted in line with the cultural context.
- Spirituality should be considered in therapy for the Zulu individual and the related practices respected. Each individual will differ in belief, and therapists can explore this as a coping mechanism for their clients.
- Understanding spirituality and diversity are essential in occupational therapy education. This ensures holistic care and respect for diversity. Occupational therapists must be equipped to respond to spiritually diverse populations and promote meaningful participation.
- There are defined gender roles in the Zulu culture, and each has different issues. Groups or programmes, including gender-specific discussions, are necessary.
- Mental health awareness and resources need to be disseminated at the community level to decrease the doctrine of isolation and helplessness when experiencing MI. This will also enhance perspectives into MI and prove beneficial when admitted to a facility. The Zulu client can empower themselves by comprehending their situation and taking control of their healing.
- There is scope for further investigation into the link between strength of the Zulu individual and methods used to handle negative emotions.
- The isiZulu language is essential to the expression of issues experienced, and resources or therapies carried out in isiZulu would be beneficial.
- There is scope for research within rural communities to compare their constructs of MI to urban communities.
- Group centred therapy has been beneficial for Zulu MHCUs admitted to the facility, and these are an appropriate mechanism to foster healing.

Conclusion

Culture contributes to creating norms related to these dimensions and subsequently provides occupational constraints and opportunities depending on the person's identity. It must be anticipated that when exploring culture, these dimensions may emerge in discourse. It will be essential to understand how this interacts with mental health and related occupational performance. A significant cognitive dissonance occurs for the Zulu individual whose cultural norms differ from westernised mental health services. While these health services are beneficial, the Zulu MHCU risks going against cultural norms and does not want this to impact their inclusion into their communities. The privilege of safely and acceptably practising occupation in a way that is seen as appropriate within culture depends on the power afforded to that culture and the acceptance of it in society as well as the positionality of the person concerned. Zulu individuals certainly create their sense of self and engage differently from the western culture. This study helps therapists in contexts populated by Zulu people understand factors that affect the Zulu MHCU's mental health and how to better equip them with skills while maintaining cultural appropriateness in intervention. It is understood that the Zulu MHCU cannot be treated in isolation. Their community or families are essential to include within intervention, and confidentiality as well as healthy relationships are important to consider as therapists. With consistent research into the perspectives and experiences of the Zulu community an understanding of their participation can be built. This contributes to enhanced service provision and does not risk perpetuating the marginalisation of their viewpoints and knowledge.

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CHAPTER THREE

This chapter will present the synthesis and significance of the findings, the limitations attached to the research, and recommendations for practice and further research.

3.1. Synthesis

Thematic analysis was conducted on transcripts with the research question: *"How do IsiZulu speaking, Black South Africans perceive mental health and experience mental health interventions at a private mental health facility in South Africa?"* Three themes emerged in response, *personal perspectives*, *cultural perspectives,* and *health-seeking behaviour*.

Findings under personal perceptions revealed that mental illness (MI), is an unfamiliar concept for most Zulu people. Instead, there is an immense value placed on the strength to endure hardship in the Zulu culture.

> *"…we have this belief or this expectation that nothing is bigger than you, nothing is impossible, we are like warriors." Bheki.*

In Zulu culture, it is expected that life will be difficult, and one must expect and endure it. A long history of subjection to colonial and apartheid rule seems to contribute to creating this ideology (Daniels & Issacs, 2020). Even though Zulu cultural beliefs dictate that the Zulu individual is to bring issues forward to elders in the family, a lack of recognition of MI leaves the Zulu MHCU feeling invalidated or unsupported by their family members or community. The primary response to expressing issues, however, is to remain silent.

The importance of upholding family reputations and avoiding shame (Hechanova & Waeldle, 2017; Gopalkrishnan, 2018; Nwoye, 2017) leads to a reluctance to admit to suffering in the first place. This translates into suffering or enduring hardship in silence which is contradictory to the manner in which issues are ideally handled in the Zulu culture (Hechanova & Waeldle, 2017; Gopalkrishnan, 2018). The norm in Zulu culture when problems arise is to speak to a close family member or elder. Elders who are turned to for advice may not recognise MI and therefore reinforce this need to be silent:

> *"Normally the elders they come together and then they said these things should be for the family and must not go out". Thokozile.*

The Zulu individual is inextricably linked to their community; thus, their progress in life means progress for the family or community. If the Zulu individual brings shame through their inability to endure hardship, they can easily be outcasted (Daniels & Isaacs, 2020). The following quote is an example of what the Zulu MHCU may face when admitting to MI:

“…he started like rejecting me because I was suffering from depression and anxiety and he told me that “No you don't have a problem, it's just that you want attention from us and you won’t get it”.” Zandile

To avoid this shame, the Zulu MHCU may endure their hardship in silence and may take measures to display progress that are counterproductive such as getting into debt:

“I am in debt, there are things I cannot afford, I am turning 30 in December and I don’t have a car and I know a car, it doesn’t mean anything but you know it's something which I wish I could have. I don't have a car and I don't have the finest and nicest clothes ever and I’m always making ends meet…” Ntokozo.

Being unfamiliar with mental health services coupled with the norm of not speaking about their hardship can lead the Zulu individual to a very hopeless and isolated situation.

“...some people they even commit suicide you know. Because whatever that they going through, they think they can handle it until they cannot handle it anymore, and then their only solution is to take their life.” Menzi.

Culture is dynamic and will evolve (Kirmayer, 2012). Gender roles have evolved in Zulu culture; previously, the expectation of financial provision and decision-making was left to the men. They were afforded opportunities to work and were required to sustain the family. Female strength was previously measured by her ability to maintain the household and submit to her husband (Langa, 2012). Currently, females have been afforded opportunities to education and careers. Thus, they also seem to get placed in the male role of provision and sustaining the family. Females are still the subordinates, but higher education and a salary render them providers and translates into black tax, where the Zulu individual who has achieved success in their career must provide beyond their own and their immediate family’s needs (Whitelaw & Branson, 2020). Each gender still has particular roles in the traditional Zulu culture.

Spirituality was found to be often intertwined with MI, either described as a cause of MI or the method in which the Zulu MHCU heals (Hechanova & Waeldle, 2017; Gopalkrishnan, 2018). Zulu culture encompassed different views or spiritual beliefs, some believing in God, others in ancestors and some combining the existence of ancestors and God. Rituals and practices linked to these beliefs were deemed important to carry out lest harm befalls not only the Zulu individual but their family and community as well (Kpanake, 2018; Crawford & Lipsedge, 2004; Molot, 2017). The practice of beating the body of a person who has just committed suicide in the Zulu culture is an example of how spiritual beliefs play out and how the community avoids being affected by the same affliction as the suicidal individual.

"Like for example if someone dies in your family by suicide and then they believe that the person, they have to beat that person, the dead body so that there will be no other person in the family does same thing." (Muzi)

Zulu individuals got referred to the psychiatric hospital either through a friend or acquaintance who had been to one, or after experiencing psychosomatic symptoms such as severe bodily pains or respiratory issues which initially led them to physical health practitioners or facilities. This sharing of vulnerability with outsiders of the family is contradictory in Zulu culture. This was supported by the findings of this study where participants described that they were not immediately receptive to seeking help in such a way, and mental health services were regarded as for white individuals only.

When admitted, Zulu MHCUs had the task of accepting their condition, learning what mental health is and then exploring how it applied to them. Only after this were they able to develop skills and resolutions to their issues. This can be a time-consuming process for the Zulu MHCU, and though the hospital afforded an individual a maximum of 21 days of admission, most participants reported that they remained within the facility for 12 to 14 days.

The hospital did, however, play a positive role in validating their experiences and creating a sense of community through which healing began. Group therapies where they shared experiences and perspectives were described as most helpful within the facility. Participants expressed that they felt supported, and it eased their internal conflict when they realised that they were not the only ones experiencing the issues they were afflicted with. Collectivism was their preferred method of support within the facility (Gopalkrishan, 2018), as beyond groups, they valued being able to share informally with each other and create healthy, supportive relationships. This differed from their cultural norms of not sharing personal issues beyond the family.

The isiZulu language was also regarded as necessary in expressing their problems and needs for healing. Being able to share issues that arise within their context and use specific terms that convey meaning was necessary for the Zulu MHCU.

When discharged, a significant concern of the Zulu MHCU was that they would return to the same environment where they would not be externally validated and may not be able to receive the support they needed. Zulu MHCUs described activities that assisted them in sustaining their state of wellbeing but expressed their need for support outside of the facility. Activities are concrete and can be participated in socially, these improve the mood of the MHCU, but the need to discuss their issues and find solutions or comfort remains.

3.2 Significance

The findings are significant to the South African context, where the Zulu culture is dominant. The Zulu people have not been included enough in OT literature (Mahoney & Kiraly-Alvarez, 2019). Lately, there has been a call for research with indigenous cultures to enhance contextually appropriate healthcare. Culturally formed worldviews guide practice and defined normal versus abnormal; they are deeply connected to occupational performance and meaning-making (Castro, Dahlin-Ivanoff & Martensson, 2014). A collectivist culture will encompass a worldview that differs from individualistic worldviews that guided many models of treatment.

Taking into account these concepts allow therapy to be more client centred and retains the autonomy of the MHCU instead of being dictated to or oppressive to them. This avoids the disconnect between intervention and what realistically occurs within the context. Understanding the interaction or congruency between traditional methods, cultural ideologies, and the mental health system helps us understand what is helpful versus where there is room for improvement of mental health services in the South African context. There are implications for therapy, such as therapists being able to identify the language in which Zulu MHCUs describe their issues, the dynamics between genders, and how MI results from gender-specific issues.

3.3 Limitations

- This research was conducted within an urban area of KZN. Due to acculturation, culture in urban areas differs from those in rural settings.
- Participants' identities and experiences will account for differences in their perceptions and experiences of mental health and OT.
- However carefully the sample has been selected to be representative of the population, it cannot be expected to be generalised to all Black South Africans practising the Zulu culture. The aim of qualitative research is not to be confirmatory but rather to build an understanding of a complex phenomenon or meaning in a specific context that cannot be quantified (Queiros, Faria & Almeida, 2017).
- Certain concepts that may have deep meaning in isiZulu may have been lost in the attempt to translate them to English.
- Interviews were conducted once with each participant; thus, information was limited to what the participant shared during their interview.

3.4 Recommendations

- Mental health awareness and resources need to be disseminated at community level to decrease the doctrine of isolation and helplessness when experiencing MI. This will also enhance perspectives into MI and prove beneficial when admitted to a facility. The Zulu client can empower themselves through comprehension of their situation and taking control of their healing. These can be conducted through de-stigmatization campaigns utilising well-known Zulu community figures or willing MHCUs.
- The family of the Zulu client need to be involved in their intervention. This can be done through family meetings.
- There is a need for accessible support groups beyond the facility created by mental health facilities or organisations.
- Spiritual beliefs, and participation in spiritually related activities, are essential for the occupational therapist to consider in individual intervention with Zulu clients. The beliefs and spiritually related occupations of the Zulu MHCU must be respected or explored, and this choice should be available for them to pursue beyond the facility.
- Understanding spirituality and diversity are essential in occupational therapy education. This ensures holistic care and respect for diversity. Occupational therapists must be equipped to respond to spiritually diverse populations and promote meaningful participation.
- There is scope for further investigation into the difference between perceptions of urban and rural communities.
- There is also scope for further research into language and the terms contributing to MI to guide therapists' understanding of clients and subsequent intervention.
- The isiZulu language is essential to expressing issues experienced, and more professionals working within Zulu communities should be able to understand and respond accordingly. A therapist in KwaZulu Natal should understand at least the basics of the isiZulu language and the popular terms and phenomena. Group therapies in isiZulu may also prove beneficial.

3.5. Dissemination

- On completion of the study, results were made available to the participants who opted to receive an emailed summary of the study's findings.
- A journal article for SAJOT was formulated for publishing so that the information may reach fellow health professionals.
- Details of the site utilised were kept out of the results disseminated for confidentiality purposes.

- The research site was also allowed access to the findings and recommendations from the study for their interest or review of the current programme.

3.6 Conclusion

Zulu people construct their sense of self interconnectedly and thus cannot be regarded in isolation. A cognitive dissonance occurs when faced with the choice between traditional and westernised systems of healthcare and understanding. Their participation is linked to their family or greater community in terms of the pride or shame it may bring. Zulu culture maintains an ideology that life inevitably consists of hardship and thus the Zulu individual must be prepared to face adversity and endure it. Mental health was described as a western issue, which many Zulu MHCUs admit to perceiving it as. Thus, they were not easily open to receiving treatment. When finally receiving treatment, it was a significant process of learning, understanding and planning for change which is not easy when returning to an environment that may not always understand their predicament. Mental health affects all cultures, the constructions of it and the perceived healing methods will differ for MHCUs from the collectivist Zulu culture. The Zulu MHCU often found that both traditional forms of healing and the westernised medical intervention were beneficial. Therapists working with Zulu patients should understand the factors contributing to the mental wellbeing of the Zulu individual as well as explore their personal perspectives around healing when designing interventions.

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APPENDICES

Appendix A: Gatekeeper permission request

Request for permission to conduct research

Dear Sir/Mam

My name is Ashira Singh, an Occupational Therapist and master's student at the University of KwaZulu Natal. The research I am undertaking towards my post-graduate degree involves studying the cultural-based mental health perspectives and experiences of Zulu males and females, over the age of 18, who have previously been admitted to a psychiatric facility for therapy. This will be a qualitative study, generating meaning and seeking to understand ways of being and doing that were previously inadequately reflected in literature guiding practice.

I am seeking your assistance and consent to allow me to contact the clients previously admitted to Akeso Clinic Umhlanga and request their participation in this study. This means that I would require demographic information, admission and contact details of suitable clients in order to contact and invite them to participate in telephonic or virtual interviews where they will share their cultural-based perspectives and experiences of mental health. A total of 10 participants will make up the final sample that participates in the study, five being male and five being female.

This data collection phase of this study is scheduled to run from July 2021 until August 2021 and its completion (a formulated report), by November 2021. A copy of the proposal and summary of the findings will be made available to you should you require it.

I, as an employee of the same clinic, understand that there are risks involved and therefore will make every effort to ensure that these are minimised or eliminated. The name of the clinic, the therapists involved and any other identifying details will be avoided in the reporting of the results. Participant experiences or descriptions that may identify the specific facility will

also not be included in the final report. Participants will also be blind to each other and the risk of fellow participants listening to each other's perspectives/experiences and breaking confidentiality is non-existent.

I will ensure that the facility will not be identified or defamed in the reporting of the results and that the Akeso is treated with utmost sensitivity and respect during this research. The study will also pose no disruption to the current services provided by Akeso Umhlanga as it will be conducted outside of working hours, with ex-clients and at no cost to the facility.

I have attached the research proposal, ethical clearance has been gained from UKZN BREC, and the reference number is BREC/00002882/2021. You are invited to contact the BREC should you have any concerns regarding this research:

Email: brec@ukzn.ac.za

This research will benefit the practice of occupational therapy in mental health, enhancing it for the specific population served and will be especially relevant to Akeso Umhlanga. I urge you to consider this request to allow clients to contribute to Afrocentric perspectives emerging in literature and enhance their therapy experiences.

Please do not hesitate to contact the research supervisors with any other queries or concerns:
T. Lingah: (Lingaht@ukzn.ac.za)
T. Gurayah: (Gurayaht@ukzn.ac.za)

Or the researcher:
Ashira Singh
ashira274@gmail.com
072 716 7543

Thank you for your time and consideration.
Kind regards
Ashira Singh
Occupational Therapist and Masters Student

Appendix B: Interview Schedule

Interview Schedule

Project: IsiZulu cultural perspectives and experiences of mental health and mental health occupational therapy in South Africa.
Researcher: Ashira Singh
Interviewer:

- Create a comfortable atmosphere, enquiring into the wellbeing of the participant and getting to know them through questioning.
- Introduce yourself to familiarise the participant.
- Inform the participant that they are not obligated to answer questions that cause them discomfort and that they are not forced to recollect negative experiences.
- Reiterate that the interview will take roughly an hour and will be recorded for analysis purposes.

Questions:
The conversation will loosely follow these questions, with opportunities to deviate and pursue a new or interesting concept shared by the participant.

1. What do you understand about mental health?
2. How do you believe mental illness should be treated?
    - Are there traditional methods or activities to treat mental illness?
3. Are there any specific names for mental illness or cultural understandings of things usually called mental illness in society?
4. Does this differ from how you understand mental health now? How do you understand mental health now?
5. Where did you learn this new understanding from?
    - Where did you learn the old understanding from, if it differs?
6. What forms of traditional healing do you believe helps with mental ill health?
7. Where did you seek help first when it came to mental illness or when your wellbeing was affected?
8. Tell me a bit about your mental health experience.
    - Was it an overall good or poor experience?
    - How did you experience being in a mental health facility?
    - Did it help address the problems you were dealing with? How?

9. Did you feel that the treatment in the facility matched up with your beliefs about how mental health should be treated? Why/Why not?
10. Does your community hold any beliefs around being admitted to a mental health institution?
11. What skills and activities that you learned from your therapy at the facility, do you use in your daily life now?
12. Were the skills always applicable to your situation? If not all at least some? Why or why not? Could you provide examples?
13. Do you find it easy to apply the skills, if you have? Why or why not.
14. Was there a good variety of activities to choose from at the facility or would you have preferred something different and more familiar?
15. What do you find helps the most in coping with your mental illness?
16. What contributes to your overall well-being?
    - How do you engage in self-care and leisure activities?
    - What other coping mechanisms have you found works for you?
17. Is there anything you would suggest is added to the treatment programme?

Appendix C: Participant information sheet

Participant Information Sheet

Project title: IsiZulu cultural perspectives and experiences of mental health and mental health occupational therapy in South Africa.

Introduction

This study is looking to connect with Black South African, isiZulu speaking women and men above the age of 18, who are willing to share their ideas about mental health and mental health intervention as well as their experiences of being admitted to a mental health facility. If you match the above description and are willing to share your thoughts and experiences, you are invited to participate in this study (toward the researcher's master's degree).

Purpose of Study

The study is looking to understand how people of the Zulu culture view mental health and what they consider appropriate interventions as well as how they have experienced formalised mental health intervention in Durban, South Africa.

If you participate, what will this involve?

If you decide to participate in this study, I require you to engage in a 1-hour interview with an interviewer. This interview can be done telephonically or through a video call, this will be your choice. You will incur no cost if you choose to be contacted telephonically, however you will have to have your own mobile data or a suitable internet connection should you choose to be video-called.

Risks

This study has very little to no risk. I will be asking you about personal views and experiences and you might risk being triggered by remembering your personal experiences. You will not be forced to share anything that causes you extreme discomfort. The researcher is a trained mental health professional who should be able to help you should you experience any psychological discomfort.

Benefits

Studies such as this one valuably contributes to practice and how clients are understood. For many years practice has been guided using literature from western countries and thus this research seeks Afrocentric (African) perspectives relevant for South African use.

Voluntary Participation

Your participation is entirely your choice and you will not be forced to participate. If you choose to participate you may also choose to remove yourself from the study at any point before the results are shared with others. No explanation will be needed should you ask to remove yourself from the study and you will not face any negative consequences. You may also choose to remove certain things that you have said from the results.

Privacy/Confidentiality

Measures will be taken by the researcher to ensure your identity is kept private. You will not be mentioned by your name in any publication. The interviews will be in a private place, where only the researcher will hear your responses. The recordings and notes from the interview will be kept on a password protected computer. No other participants will have any information of who their fellow participants are or what you have shared.

Costs to participant

As previously mentioned, if you choose to be contacted telephonically it will cost you nothing. I merely ask for an hour of your time.
If you choose to be contacted through a video-call, you will have to make sure you have enough mobile data or some kind of internet connection.
There are no other costs involved.

Contact details

Any concerns regarding this research should be reported to the research supervisors. The research will be supervised by:

T. Lingah: (Lingaht@ukzn.ac.za)
T. Gurayah: (Gurayaht@ukzn.ac.za)

If you have any complaint or question regarding your rights or wellbeing, you may contact:

UKZN BREC at: brec@ukzn.ac.za

If you have further questions or concerns you may contact the researcher:

Ashira Singh
ashira274@gmail.com
072 716 7543

This research has been approved by UKZN BREC and its reference number is BREC/00002882/2021

Appendix D: Consent Form

Consent Form

I, ________________________, have read the information sheet provided to me and am satisfied with my understanding of the aim, process, risks, benefits and costs of this study.

- I agree to participate in the study which requires a one-hour interview with me.
- I agree to have the interview audio-recorded and understand that it will be kept confidential, on a password protected computer with any other notes made during the interview and destroyed after the completion of the research.
- I understand that I may withdraw my participation any time before results is disseminated/shared, with no negative consequences to me.
- I understand that there are no financial costs to me should I choose a telephonic interview, but I would need to provide my own data/internet should I choose a video-call interview.

I choose to have the interview through:

- Video-Call
- Telephone

_________________________________ _________________________________

Signature of Participant Date

Appendix E: Gatekeepers' Approval Letter

RESEARCH OPERATIONS COMMITTEE FINAL APPROVAL OF RESEARCH

Approval number: UNIV-2021-0036

Ms Ashira Singh

E mail: ashira.s@kenilworthinc.co.za

Dear Ms Singh

RE: ISIZULU CULTURAL PERSPECTIVES AND EXPERIENCES OF MENTAL HEALTH AND MENTAL HEALTH OCCUPATIONAL THERAPY IN KWA-ZULU NATAL, SOUTH AFRICA

The above-mentioned research was reviewed by the Research Operations Committee's delegated members and it is with pleasure that we inform you that your application to conduct this research at private Hospital, has been approved, subject to the following:

i) Research may now commence with this FINAL APPROVAL from the Committee.

ii) All information regarding the Company will be treated as legally privileged and confidential.

iii) The Company's name will not be mentioned without written consent from the Committee.

iv) All legal requirements regarding patient / participant's rights and confidentiality will be complied with.

v) All data extracted may only be used in an anonymised, aggregated format and for the purposes of this specific study as specified in the proposal. The data may under no circumstances be used for any other purpose whatsoever.

vi) The research will be conducted in compliance with the GUIDELINES FOR GOOD CLINICAL PRACTICE IN HUMAN PARTICIPANTS IN SOUTH AFRICA (2016).

vii) The Company must be furnished with a STATUS REPORT on the progress of the study at least annually on 30th September irrespective of the date of approval from the Committee as well as a FINAL REPORT with reference to intention to publish and probable journals for publication, on completion of the study.

viii) A copy of the research report will be provided to the Committee once it is finally approved by the relevant primary party or tertiary institution, or once complete or if discontinued for any reason whatsoever prior to the expected completion date.

ix) The Company has the right to implement any recommendations from the research.

x) The Company reserves the right to withdraw the approval for research at any time during the process, should the research prove to be detrimental to the subjects/ Company or should the researcher not comply with the conditions of approval.

xi) APPROVAL IS VALID FOR A PERIOD OF 36 MONTHS FROM DATE OF THIS LETTER OR COMPLETION OR DISCONTINUATION OF THE TRIAL, WHICHEVER IS THE FIRST.

We wish you success in your research.

Yours faith[redacted]

Prof Dion du Plessis
Full member: Research Operations Committee & Medical Practitioner evaluating research applications as per Management and Governance Policy

Dr Shannon Nell
Chairperson: Research Operations Committee
Date: 22/9/2021

This letter has been anonymised to ensure confidentiality in the research report. The original letter is available with author of research

Appendix F: University ethics approval

07 October 2021

Miss Ashira Singh (214515798)
School of Health Sciences
Westville

Dear Miss Singh,

Protocol reference number: BREC/00002882/2021
Project title: IsiZulu cultural perspectives and experiences of mental health and mental health Occupational Therapy in Kwa-Zulu Natal, South Africa.
Degree: Masters

EXPEDITED APPLICATION: APPROVAL LETTER

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application.

The conditions have been met and the study is given full ethics approval and may begin as from 07 October 2021. Please ensure that outstanding site permissions are obtained and forwarded to BREC for approval before commencing research at a site.

This approval is subject to national and UKZN lockdown regulations, see (http://research.ukzn.ac.za/Libraries/BREC/BREC_Amended_Lockdown_Level_1_Guidelines.sflb.ashx). Based on feedback from some sites, we urge PIs to show sensitivity and exercise appropriate consideration at sites where personnel and service users appear stressed or overloaded.

This approval is valid for one year from 07 October 2021. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2020) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be noted by a full Committee at its next meeting taking place on 09 November 2021.

Yours sincerely,

Prof D Wassenaar
Chair: Biomedical Research Ethics Committee

Biomedical Research Ethics Committee
Chair: Professor D R Wassenaar
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS

Appendix G: Researcher TRREE Certificate

TRREE

Zertifikat

Certificat

Certificado

Certificate

Promouvoir les plus hauts standards éthiques dans la protection des participants à la recherche biomédicale
Promoting the highest ethical standards in the protection of biomedical research participants

Clinical Trials Centre
The University of Hong Kong

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

Ashira Singh

a complété avec succès - has successfully completed

Introduction to Research Ethics

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

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