



**EXPLORING MENTAL HEALTH LITERACY AND AWARENESS OF
HELP-SEEKING BEHAVIOUR INCLUDING BARRIERS THEREOF,
AMONG HINDU STUDENTS' AT UKZN**

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Declaration

I Melissa Moodley declare and acknowledge that all the work presented in this dissertation is my own and where necessary, I have referenced and given credit to external sources.

This dissertation was compiled at the University of KwaZulu-Natal, Howard College, Durban, South Africa under the supervision of **Ntombekhaya Mtwentula** in fulfilment of my Master of Social Science degree.

I fully accept and take responsibility for all work presented in this dissertation.

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Abstract

Background: There exists, in the developing world, a lack of research concerning mental health awareness and help-seeking behaviour, and South Africa is no different. Within the South African context, there is a diverse range of people from different religions. Culture and religion can influence the way people view mental health and help-seeking therefore, further research regarding religious influences in the understanding of mental disorders is urgently required to better accommodate cultural uniqueness. This study investigated mental health literacy and awareness of help-seeking behaviour among Hindu students at the University of KwaZulu-Natal.

Method: A qualitative research approach was used to frame this research. Thirteen (n=13) Hindu participants aged 18 to 25 years old were sampled, consisting of both male and female students. To select the participants, the researcher used both purposive and snowball sampling techniques. Data was collected through a predetermined interview schedule, administered during semi-structured interviews. Data was analysed using thematic analysis.

Findings: The researcher established that there exists a lack of mental health awareness among Hindu students at UKZN which may result in barriers to help-seeking. Stigma linked to mental health awareness was identified as the main barrier to help-seeking. A link between religion (Hinduism) and the way mental health is perceived has been highlighted. Additionally, findings highlighted that prior history/exposure to others with mental health conditions positively influenced mental health awareness and help-seeking behaviour.

Conclusion: It can be concluded that more needs to be done to promote mental health and educate students on campus, however it also highlights, the key to increasing help-seeking and mental health awareness among students may be targeting their communities first. This may lead to decreased stigma and misconceptions and encourage help-seeking behaviour.

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LIST OF ABBREVIATIONS

APA: The American Psychological Association

DSM: Diagnostic and Statistical Manual of Mental Disorders

LMIC: Lower Middle-Income Country

MHL: Mental Health Literacy

SIT: Social Identity Theory

UKZN: University of KwaZulu-Natal

UNICEF: The United Nations International Children's Emergency Fund

WHO: World Health Organization

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Appendix 1: UKZN Ethical Clearance Letter

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CHAPTER 1: INTRODUCTION AND BACKGROUND

1.0 Introduction

According to the World Health Organization (WHO) (2022), a mental health condition can be classified by clinically significant disruptions in a person's perception, emotional regulation, or conduct. It is typically correlated with distress or impairment in crucial areas of functioning. In 2019, approximately nine hundred and seventy (970) million people around the world lived with a mental health condition (one (1) in every eight (8) people), with anxiety and depression being the most frequent. In 2020, preliminary assessments showed a twenty-six percent (26%) and twenty-eight percent (28%) rise respectively for anxiety and major depressive disorders (WHO, 2022).

South African statistics show that one (1) in three (3) South Africans do have or will have a mental health condition at some point in their lifetime, and only one (1) in ten (10) people with a mental illness will access mental health services (SADAG, 2022). The United Nations International Children's Emergency Fund South Africa (UNICEF SA) published a report that examined the state of mental health care and help-seeking among youth up to twenty-four (24) years of age. Approximately sixty-five percent (65%) of young people stated that they had some form of mental health condition but did not seek help. Twenty percent (20%) of participants did not know where to get help and eighteen percent (18%) were afraid of what people would think (UNICEF SA, 2021).

The statistics mentioned above are alarmingly high and as a result, more research needs to be conducted, examining mental health care amongst South African university students. It is important to study the young population because adolescence and young adulthood are crucial developmental periods in a person life (Rickwood *et al.*, 2014). Factors such as social, religious, emotional, physical, and cognitive influences, can evoke major changes that may

modify effects in adulthood, and the influence of mental health conditions at this stage of life, can be reflective (Rickwood *et al.*, 2014). Culture, religion, and the values they bring, all shape the expression, perceptions, and treatment preferences of people. Every religion has its unique view on mental health, therefore examining the link between religious influences and the younger student population could provide great insight and assist in improving mental health care among this population group.

The purpose of the study was to explore mental health literacy, specifically among Hindu students. This study intended on exploring the relevant help-seeking behaviour among Hindu students and unpacked the possible barriers involved. A total of thirteen (13) participants were selected based on purposive sampling and semi-structured interviews were conducted to explore views on mental health literacy and awareness of help-seeking.

1.1 Background to the research problem

Mental health has been a very complex and sensitive topic, not only in South Africa but worldwide (Keyes *et al.*, 2008). There exists, in the developing world, a lack of research concerning mental health awareness and help-seeking behaviour, and South Africa is no different (Keyes *et al.*, 2008). Drawing on studies done in developed countries can be beneficial in providing a foundation to build on. One such study was conducted by Kearns *et al.* (2015), focused on understanding help-seeking behaviour amongst university students. The central issues in this study appeared to be the stigma attached to mental health and help-seeking as well as group identification and the fear of being discriminated against or becoming an outcast (Kearns *et al.*, 2015).

Looking at the South African context, there is a diverse range of people from different religions. Moreira-Almeida *et al.*, (2006) define religion as a systematic set of values, rituals, and emblems created to aid attachment to the sacred or transcendent (God, higher power, or

ultimate truth/reality). A study conducted by Campbell *et al.* (2017), aimed at examining the relationship between the cultural/religious context of a person and the content of delusions due to mental illness. The results of this study showed that many of its participants strongly believed that other people had "bewitched" them, inducing their mental illness because they were jealous of the participant. These findings align well with the common understanding of jealousy-induced witchcraft in Southern African communities and point out the important role culture plays in people's perceptions of mental health (Campbell *et al.*, 2017).

This trend is not only associated with the African religion but other cultures in South Africa as well, in particular, Hinduism. A study conducted by Padayachee and Laher (2014) sought to provide a deeper understanding of the impact that religious beliefs, particularly Hinduism, have on such conceptualisations. According to this study, Hindu psychologists seemed to believe that religion plays a critical role in defining and understanding the causes of, as well as attitudes toward treatment for mental health conditions. This is relevant to the Hindu community due to the importance placed on religious and cultural beliefs and traditions within this community.

As stated by Padayachee and Laher (2014), culture and religion can influence the way people view mental health, as well as their response to help-seeking. In a multicultural society such as South Africa, further research regarding religious differences in the clinical manifestation of mental disorders is urgently required to make the necessary provisions and to better accommodate cultural uniqueness. This is important as students' specific views, ideologies, similarities and differences all related to their culture and religion, and these need to be acknowledged and considered in the therapeutic process. Culture and religion have a significant impact on how certain situations and mannerisms in therapy may be understood. Acknowledging cultural uniqueness may encourage students to seek help as they may feel more

understood, accepted and may further enhance the therapy session, as well as assist in understanding possible resistance to engaging positively with mental health services.

Dating back to archaic times, different religions have different values and approaches to worshipping. All religions, with its belief system, has consequences for mental health and illness (Behere *et al.*, 2013). From a mental health standpoint, religion offers the necessary parameters, which assists individuals formulate a path for their lives. Tensions and pressures of life can be endured more easily by believers. Psychiatry and religion have always been associated. During the middle-ages, psychiatric conditions were usually associated with the 'Devil' and witchcraft. These ideologies were passed down multiple generations and individuals with psychotic symptoms have sought interventions within their religious systems (Ventriglio *et al.*, 2018). For example: "In some settings, supernatural forces are frequently conjectured as a causal explanation of mental illness, and consequently the practices of magic-religious healers are often considered as a first-step treatment of mental disorders" (Ventriglio *et al.*, 2018, p. 1).

India has been linked to high levels of spirituality and religiosity for centuries. It's home to some of the oldest religions of the world like Hinduism, Buddhism, Jainism, Sikhism, Christianity, and Zoroastrianism. Spirituality has become a way of life and a way of being, where people may describe symptoms as "being possessed by Deities" during a trance-like state (Behere *et al.*, 2013). Visiting traditional healers and priests in India account for a large part of mental health intervention. It has been noted that there exist few psychiatric facilities across India and research highlights that individuals are more likely to visit a traditional healer as first line interventions before considering biomedical psychiatric interventions (Dein, 2020).

The Diagnostic and Statistical Manual of Mental Disorders (DSM) plays a significant role in practitioners understanding, classifying and diagnosis mental health conditions. For a practitioner to properly assist a client, understanding every aspect and influence in the client's life is important and this included any religious views. Understanding and including religious perceptions and influences on mental health within the DSM lens is imperative, however it was not always included in the original and earlier versions of the DSM.

The American Psychiatric Association (APA) first published the DSM in 1952, however religious considerations were only included much later, specifically 1994, almost 42 years later (Horwitz, 2021). The 1994 revision of the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) included a new diagnostic category (V62.89) labelled "religious or spiritual problem." In previous versions (e.g., DSM-III-R), the only references to religion were that they were a sign of psychopathology, which included features of cases illustrating cognitive incoherence, catatonia, delusion, magical thinking, hallucinations, or schizotypal disorders (Larson *et al.*, 1993). Once this assumption was broken down and investigated, the new construct was implemented in the DSM-IV, defined broadly as a condition whereby "the focus of clinical attention is a religious or spiritual problem" (American Psychiatric Association, 1994, p. 300).

The acceptance of this new category by the APA on DSM-IV was based on a proposal detailing the exhaustive literature on the frequent occurrence of religious and spiritual issues in clinical practice, the lack of training provided to mental health professionals, and the need for a diagnostic category to support training and research in this area of clinical practice (Lukoff *et al.*, 2010). Most studies concentrate on aspects of well-being such as life satisfaction, congruence, happiness, positive affect, depressed mood. Fewer studies explore religion's impact on psychiatric diagnoses and psychological perceptions (Levin, 2010).

Looking at the Hindu student population, there lies a severe gap in research done on the Hindu student population (Kumar *et al.*, 2019). Much needs to be done in understanding this population group and exploring if culture/religion influences the way they view and understand mental health. Further research must be conducted, to unravel this component of mental health and help-seeking. Although this religious component has been explored briefly, it has not yet been explored in the context of young people and the Hindu religion in particular. Therefore, this study can contribute greatly to unpacking these potential barriers within the South African context.

During the researchers honours research project, after doing a review of research projects on the University of KwaZulu-Natal research space, it was found that there exists research done on mental health and the African culture, as well as Christianity but there exists a gap in extensive research done on the Hindu student population. Research reveals that approximately twenty-five-point seven percent (25.7%) of South Africans suffer with depression, with the highest rates of mental illness being reported in Northern Cape, Eastern Cape, Western Cape, Gauteng, and Mpumalanga (Craig *et al.*, 2022). More than six point five (6.5) million people in South Africa are in dire need of professional mental health services, of which approximately one point three (1.3) million people require intervention for severe psychiatric conditions (Teichmann, 2022). Among the six point five (6.5) million people who suffer from mental health conditions, approximately sixty-five percent (65%) are young people (UNICEF, 2021). In India, among the Hindu population, one (1) out of three (3) individuals suffer from depression. India has also reported the highest rate of depression in the world. Among the 15- to 24-year-old age group in India, one (1) out of seven (7) individuals have reported depressive symptoms (Garg, 2022).

Therefore, doing a study on the Hindu student population is quite beneficial as the Hindu student population is not a very well-researched one. This study would help understand

how Hindu students' view mental health, understand if religion/culture (Hinduism) plays an important role in how students (living in a very modern and advanced world), identify with and engage in certain aspects of life e.g., mental health and help-seeking, and find possible ways to improve mental health literacy and awareness of help-seeking among the Hindu student population. To improve mental health literacy and help-seeking propensity, this study would further assist in understanding the barriers that Hindu students face that may prevent them from engaging in positive help-seeking behaviour.

1.2 Rationale, purpose of the study, research objectives and questions

1.2.1 Rationale

The motivation for this research grew from the researchers experience during Honours research. The researcher explored mental health literacy and awareness of help-seeking behaviour among UKZN students, however no exclusion criteria for example age, gender, race and religion were made. During the process of writing the literature review and doing comprehensive research on many research websites, including the UKZN research space, the researcher uncovered a lack of research studies looking at the Hindu student population in South Africa.

The interest for the topic then grew exponentially through personal observations within the researchers Hindu community in relation to the attitude of young people towards mental health and help-seeking. The researcher then came to a realisation that there could be a lot to learn from by delving into this topic, specifically among the student population to improve and encourage help-seeking at UKZN, Howard College. The researchers' personal experiences and observations were then corroborated by literature displaying the link between certain religious beliefs within Hinduism and how mental health presents itself. Joshi (2006) and Dywer (2003) refer to spiritual possession and witchcraft as understandings for physical and mental symptoms that can be attributed to mental health presentations. Dwyer (2003) and Stanford

(2005) further reference first line interventions for the population to be traditional healers and priests cementing the fact that physical and mental symptoms as mental health presentations are not understood and accepted within the Hindu community. Chapter two (2) details these arguments and provides literature to assist in understanding the need for this study.

1.2.2 Purpose of the study

The overall purpose of the study was to explore mental health literacy and awareness of help-seeking behaviour among the Hindu student population at the University of KwaZulu-Natal, Howard College campus. The study intended on examining Hindu students' beliefs and views towards mental health and to understand how the Hinduism affects these perspectives and decision to engage in help-seeking. Uncovering the possible barriers to mental health help-seeking was also explored in this study.

1.2.3 Research objectives

- 1) To explore Hindu students' beliefs and attitudes towards mental health at UKZN.
- 2) To explore if there are barriers to mental health help-seeking among Hindu students at UKZN.
- 3) To understand the influence of the Hindu culture on the decision on whether to seek help for mental health care among Hindu students at UKZN.

1.2.4 Research questions

- 1) What are Hindu students' beliefs and views towards mental health at UKZN?
- 2) What are the barriers to mental health help-seeking among Hindu students at UKZN?
- 3) How does the Hindu culture influence the decision on whether to seek help for mental health care among Hindu students at UKZN?

1.3 Outline of study

This study was limited to Hindu students currently enrolled for either undergraduate or postgraduate studies at UKZN, Howard College aged 18 to 25 years old. Chapter one (1) introduces the topic of mental health and help-seeking, the rationale, purpose of study and the research objections and questions. This provides the first step in understanding the background to the research topic and motivation for the research.

Chapter two (2) discusses the literature review which highlights four (4) main aspects i.e. mental health literacy, help-seeking, stigma and religion (Hinduism). The first aspect explores mental health and mental health literacy among western and non-western populations. This provides a foundation for understanding mental health among the general population within South Africa. This section further examines mental health literacy among the university population worldwide and within South Africa. The second aspect delves into help-seeking and explains what help-seeking entails, thereafter the focus shifts to help-seeking specifically among the student population. The third aspect of this chapter examines stigma as a concept and its association with mental health and help-seeking. The fourth and final aspect of this chapter looks at religion (Hinduism) and the impact it may or may not have on mental health awareness and help-seeking.

Chapter three (3) lays out the theoretical framework employed for this research. This chapter focuses on introducing social identity theory, explores the building blocks of the theory and relates the theory to the relevance of using it in the current study. This chapter ends by examining the strengths of the theory.

Chapter four (4) presents the research methodology employed in the study. It highlights the research approach, design and paradigm, the selection of participants, recruitment processes and the methods employed for data collection and analysis. This chapter further explores the

procedures and ethical practices used to ensure the study was trustworthy and ethical. This included reliability and validity, credibility, dependability, transferability and abiding to the principals guiding ethical research. Other aspects included were confidentiality and mannerisms during interviews to ensure participants were not harmed during the data collection process.

Chapter five (5) presents the findings highlighted during data collection and analysis. Themes found during data analysis are explained and excerpts from interviews were included to provide a full understanding of the themes that emerged. This chapter further details and provides a discussion of the findings by integrating them to the research objectives in chapter one (1). A discussion linking the findings to research explored in the literature review found in Chapter two (2) is provided.

Chapter six (6) concludes the research by reviewing the purpose and objectives of the study. This chapter includes the researchers' personal reflections and limitations of the study. Recommendations for future research are provided.

1.4 Chapter summary

This chapter introduced the study. It presented a background to the research topic. In addition, this chapter provided a rationale, purpose of the study, research objectives and questions and offered an outline of the chapters still be presented in this research paper. The following chapter provides a literature review examining other research done on mental health literacy and awareness of help-seeking behaviour.

CHAPTER 2: LITERATURE REVIEW

2.0 Introduction

This chapter investigated prior literature and research into mental health literacy and awareness of help-seeking behaviour. Mental health is defined in this chapter and global statistics regarding mental health are stated. This chapter defines the meaning of mental health literacy which is key in understanding mental health awareness. Cultural differences and practices between western and non-western populations globally are collated and contrasted in this chapter. Attitudes and understanding of mental health literacy among university students globally and within the African continent are discussed in this chapter. Helping-seeking behaviour is defined and help-seeking patterns among university students are detailed in this chapter.

Stigma has been highly correlated with mental health and help-seeking and was an important concept to include and unpack in this chapter. Stigma is discussed in the global context and within low-middle income countries (LMIC) specifically in South Africa. Perceived and public stigma are also compared. Lastly, this chapter concludes by analysing the effect religion has, specifically Hinduism on mental health. Culture as a concept is defined and the impact cultural diversity has on help-seeking behaviour was explored. The value system linked to Hinduism was examined and concepts like shame and embarrassment were discussed. Hindu beliefs related to the presentation of mental illness and its symptoms were unpacked.

2.1 Mental health

Mental health can be defined as: "a state of well-being in which every individual realizes his or her potential, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to her or his community" (World Health Organization, 2014). According to the World Health Organisation (2022), mental health is a vital element of health

that strengthens our personal and shared abilities to make decisions, build relationships and influence the world we live in. Mental health is a fundamental human right. It is necessary for personal, community, and socio-economic development. Mental health encompasses more than the lack of mental disorders. It occurs on a complex continuum, which each person experiences differently, with differing levels of complexity and stress and possibly very different social and clinical outcomes (World Health Organization, 2022).

Global statistics reveal that nearly one (1) billion people live with a mental disorder and in low-income countries, more than seventy-five percent (75%) of people with a disorder do not receive the treatment they require. Every year, close to three (3) million people die due to substance abuse. Every forty (40) seconds, a person dies by suicide. About fifty percent (50%) of mental health disorders begin by the age of 14 (Kovacevic, 2021). It is projected that over one hundred and sixty (160) million people need humanitarian aid because of conflicts, natural disasters, and other emergencies. The rates of mental disorders can double during such crises. One (1) in five (5) people affected by conflict is estimated to have a mental health condition (Kovacevic, 2021). Approximately twenty percent (20%) of the world's children and adolescents have a mental health condition, with suicide the second leading cause of death among 15- to 29-year-olds (World Health Organization, 2022).

2.2 Mental health literacy

Mental health literacy (MHL) is a multi-layered model which was first proposed by Jorm *et al.* (1996), which can be defined as: “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm, 2000, p. 2). It highlights enhancing 1) mental health knowledge, 2) help-seeking behaviour, and focusing on 3) mental health stigma, to better mental health (Singh *et al.*, 2022).

The mental health knowledge element of MHL centres on expanding the capability of individuals to accurately identify mental health disorders early on. Furthermore, this element also centres around an individual's knowledge concerning interventions, preventive measures, and mental health first aid (Singh *et al.*, 2022). The help-seeking element of MHL fosters suitable help-seeking behaviour, choosing of appropriate resources for help, and the recognition and removal of barriers to help-seeking behaviour. The stigma element of MHL encompasses a variety of stigma, related to mental health disorders (i.e., stigmatising attitudes, perceived/personal stigma, and social distancing) with the goal of destigmatising mental health disorders. As the elements of MHL are frequently interconnected, they need to be evaluated holistically to enhance MHL overall (Singh *et al.*, 2022).

2.2.1 Western verses non-western populations

A vast majority of the knowledge and utilisation of mental health, encompassing psychiatry and psychology, has been developed from western cultural ideologies and western perceptions of human behaviour (Gopalkrishnan, 2018). According to Singh *et al.* (2022), levels of MHL tend to differ by population; for example, western populations demonstrated higher levels of MHL as well as more developed countries. A study conducted by Kometsi *et al.* (2020) examined perceptions and aetiological ideas about mental illness among seven hundred and eighty-seven (787) African residents of the Sisonke District (KwaZulu-Natal). The findings showed that participants had little knowledge of basic psychological jargon used to describe mental illness, but rather used very general and wide-ranging terms. The results of this study emphasized the value of MHL awareness campaigns in developing low-income communities.

Furnham and Aseel (2014) further reiterate that MHL in non-western, developing countries is poorly understood. Nearly four hundred and fifty (450) million individuals globally, suffer from neuropsychiatric disorders within their lifespan (World Health

Organization, 2001). It was also reported that prevalence rates between western and non-western countries are almost equal (Acharya, 2001). In effect, it can be suggested that the socioeconomic factors of multiple disorders have been acknowledged, therefore, a higher prevalence of mental illness within developing countries in comparison to developed countries would be expected (Furnham & Aseel, 2014). For example, Ganasen *et al.* (2008) “carried out a non-systematic review of published papers between 1990 and 2006 on MHL in the developing world. They noted that there was a large gap in research and that research efforts should be directed to MHL to address some of the disparities in mental health care in non-western countries” (Furnham & Aseel, 2014, p. 85).

A study conducted by Atilola (2014) which examined levels of community MHL in the sub-Saharan African continent yielded similar results. This study posited that respondents were generally unable to identify standard psychiatry syndromes correctly. Supernatural views were popular, and alternative, traditional mental health treatments were preferred. A more comprehensive approach to the evaluation of MHL is required.

2.2.2 Mental health literacy and university students

Research has shown that seventy percent (70%) of mental disorders can be diagnosed before the age of 25 years, yet the diagnosis rate among young people seems to be relatively lower than it could be (Kutcher *et al.*, 2016). The youth tend to be inadequately educated about mental health. The lack of MHL initiatives is particularly prominent during the adolescent and early adulthood stages. It is during this time that health-related behaviours are shaped and when they begin to take responsibility for their wellbeing (Rickwood *et al.*, 2014).

A study examining MHL among undergraduate students at a Saudi university found that most students (ninety-point three percent (90.3%)) have medical mental health literacy. Students demonstrated mixed attitudes towards psychiatric patients, with sixty-eight-point

seven percent (68.7%) stating that they could sustain a friendship with a person who has a psychiatric disorder and that people with mental illness should be awarded the same human rights as everyone else. This study concluded that there was a vital need for MHL programs to modify the attitudes of students (Mahfouz *et al.*, 2016).

A study conducted by Gorczynski *et al.* (2017) aimed at determining levels of MHL among United Kingdom university students and to explore if MHL is linked to better mental health outcomes and the probability to seek professional help. Results demonstrated that MHL levels were lower than previously recorded. Those students who had prior exposure to mental health difficulties (through themselves or others), had a better understanding of the issues. Students also stated that they were more likely to seek help from family and friends or through sources of online support rather than professional assistance (Gorczynski *et al.*, 2017).

Understanding levels of MHL among university students within the African context, is crucial as factors differ globally. Aluh *et al.* (2019), aimed at assessing students' recognition of schizophrenia and help-seeking behaviour among undergraduate students at a Nigerian university. Stigmatising labels such as 'crazy' and 'mad' were used by more than ten percent (10%) of the participants. Overall results showed that MHL among students at the university of Nigeria was low. There is a need for research based on culturally sensitive interventions for the improvement of MHL and help-seeking behaviour.

Kristina *et al.* (2020, p. 2244), state that: "mental health literacy is really important among university students since about one-third of university students suffer from a diagnosable mental disorder, and sixty-four percent (64%) of individuals who dropped out of college did so because of a mental disorder". This study explored MHL amongst university students in Yogyakarta (Indonesia), and to investigate the influence of sociodemographic influences on MHL. Results stated that MHL amongst university students in Yogyakarta

(Indonesia) was comparatively low. Variations in sex, year of study, category of study, and disposition to seek treatment were found.

Literature also supports that individuals with inadequate levels of MHL are predisposed to have poorer quality of mental health outcomes and are at higher risk of acquiring mental health disorders. Jorm *et al.* (2012), suggest that these results have been associated with the fact that people with low MHL would be unable to identify mental health disorders early on which would delay any help-seeking or treatment. Additionally, low MHL would also result in higher levels of stigma which would also subsequently deter any help-seeking or treatment. In essence, literature shows that improving MHL is imperative to help-seeking as well as overall improving mental health outcomes (Gulliver *et al.*, 2010).

2.3 Help-seeking behaviour

To explore the reasons students', engage in help-seeking or not, we need to first examine what the term help-seeking entails.

Help-seeking can be defined as: a term that is generally used to refer to the behaviour of actively seeking help from other people. It is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience (Rickwood *et al.*, 2014, p. 5).

Many mental health conditions have an onset linked to mid-adolescence and those in their mid-twenties which has been associated with engaging in further studies and university attendance. Understanding mental health and help-seeking behaviours during this critical period may have a significant impact on ensuring positive health outcomes (Lipson *et al.*, 2022).

2.3.1 Help-seeking and university students

Studying at the tertiary level can be a time of tremendous transition and challenges in young adults' lives. There are probably multiple factors that determine if young people seek help from professional sources for mental health-related conditions. Moving away from home, becoming independent, forming personal and professional relationships, handling finances as well as the added stress of coursework and exams are some of the difficulties that they may face (Laidlaw *et al.*, 2015). The American College Health Association conducted a survey yielding similar results. Findings revealed that forty-five-point one percent (45.1%) of university students described experiencing increased levels of stress, anxiety and depression. Students revealed that academic struggles, finances, personal and family relationships and lack of sleep as the main triggers for their anxiety and depressive symptoms (Hubbard, 2018).

Shahwan *et al.* (2020) state that the hesitancy of young adults to engage in mental health treatment has been ascribed to low levels of MHL, stigma, preference for autonomy, and fears about confidentiality. Gebreegziabher *et al.* (2019) similarly state that low levels of MHL, the stigma associated with mental health conditions, and preference for non-professional support are the most common deterrents to help-seeking.

Shahwan *et al.* (2020) conducted a study examining the probable effect of an anti-stigma intervention that included information about depression and help-seeking and exposure to someone with personal experiences with help-seeking. The study revealed that the short-term anti-stigma intervention was linked to increases in help-seeking attitudes among university students. Favourable outcomes were shown to decline over time however, booster sessions or prospects to partake in mental health-related activities (post-intervention) may be necessary to sustain positive help-seeking attitudes (Shahwan *et al.*, 2020).

Despite the high prevalence rates for mental health conditions and statistics, research shows poor rates of help-seeking among university students (Hubbard, 2018). Data has described a negative preference for professional help-seeking (psychologists, counsellors and other mental health practitioners) and a positive preference for non-professional help-seeking (family and friends) (Zochil *et al.*, 2020).

Bryant *et al.* (2022) conducted a study that sought to investigate the mediators and obstacles to traditional and non-traditional options of help-seeking for mental health related difficulties in students established in the United Kingdom. The outcomes of this study revealed that help-seeking behaviours were associated with accommodation, sexuality, and age. Findings from this study further highlighted the need for successful programmes that promote students to engage in discourse regarding mental health and to promote positive help-seeking outcomes (Bryant *et al.*, 2022). Another similar study conducted by Gebreegziabher *et al.* (2019) aimed at examining the prevalence and factors affecting help-seeking, and sources of help sought by undergraduate university students. The study concluded that more than fifty percent (50%) of students were at high risk of mental health conditions and most students would prefer to seek help informally. Potential studies are required to investigate the barriers of seeking help from formal resources, and the possible impacts of not engaging in formal help-seeking (Gebreegziabher *et al.*, 2019).

2.4 Stigma

As members of a functioning society, stigma, and fear of being labelled as “mentally ill” remain one of the biggest obstacles to help-seeking. Stigma can be defined as “a multi-component phenomenon which includes stereotypes, prejudice, and discrimination against members of a particular group” (Chen, 2013, p. 27). Stigma may be considered as a “mark of shame, disgrace or disapproval which results in an individual being rejected, discriminated against and excluded from participating in several different areas of society” (World Health

Organization, 2001). Mental health stigma is used in very broad terms, but it encompasses different dimensions. “Public stigma is defined as negative stereotypes and prejudice about mental illness (such as “people with mental illness are dangerous and unreliable”) held collectively by people in a society or community” (Eisenberg *et al.*, 2009, p. 2). Personal stigma is associated with an “individual’s stereotypes and prejudices”. When an individual becomes conscious of public stigma (i.e., perceived public stigma), they then begin to form personal attitudes (i.e., personal stigma) (Eisenberg *et al.*, 2009).

Numerous pragmatic studies have investigated how mental health stigma correlates to help-seeking attitudes and behaviour. Research assessing people’s stigmatising attitudes has largely found that elevated personal stigma is related to lower help-seeking among both adults and adolescents. Another study conducted highlighted that participants who stated embarrassment linked with mental health treatment were prone to view help-seeking negatively and were likely to not use these services (Eisenberg *et al.*, 2009).

A study conducted by Eisenberg *et al.* (2009), revealed three (3) main findings: (1) Perceived public stigma was significantly greater than personal stigma; (2) personal stigma was greater among students who fit these criteria (male, younger, Asian, international, higher levels of religiosity , or from a low income/ impoverished family; and (3) personal stigma was substantially and negatively related to help-seeking (the apparent need and utilisation of psychotropic medication, rehabilitation, and theoretical sources of support).

Lally *et al.* (2013), investigated levels of personal and perceived public mental illness stigma in a university student population and the link between the relevant levels of stigma and help-seeking intent. This study found higher average perceived public stigma levels than personal stigma levels. Perceived public stigma was not considered related to future non-help-seeking intentions. However, personal stigma was substantially associated with a diminished

probability of future help-seeking intention. Furthermore, being younger than twenty-five (25), with no preceding history of mental illness, and not having prior exposure to a person with a history of mental illness were all linked to higher levels of personal stigma (Lally *et al.*, 2013).

The need for more psychoeducation within communities to curb stigma has a direct link. Seloilwe and Thupayagale-Tshweneagae (2007), state that in countries like Botswana, stigma not only affects the individual experiencing mental health difficulties but extends to the individuals' family, which may then lead them to avoid seeking help for the fear of themselves or their families being either labelled or ostracised. The lack of understanding and low levels of MHL further increases the cycle of stigma and decreases positive help-seeking behaviour.

According to Egbe *et al.* (2014), stigma and judgement towards people with mental health related difficulties persist as detrimental barriers to help-seeking and treatment for individuals needing mental health services. However, there is insufficient research exploring the impact of psychiatric stigma on mental health service users in LMICs. Their study aimed to investigate the experiences of psychiatric stigma by individuals using these services to update interventions to decrease such stigma and discrimination in one LMIC, namely South Africa. Results from this study showed that relatives, friends, employers, community representatives, and healthcare service providers were the main perpetrators of stigma. Misunderstandings about mental health frequently led to setbacks in help-seeking. Being subjected to psychiatric stigma proved to deteriorate the health of the service user and inhibit their ability to fully recover (Egbe *et al.*, 2014).

Previous studies from Africa have recognised causes of why people do not seek help when they experience mental health difficulties, such as being unable to understand that the illness is treatable and believes that they could recover without formal treatment, not having information about where to seek help or feeling ashamed and views that the mental illness is a

somatic illness. Stigma and misconstructions about the source and seriousness of mental illness are common barriers specifically in areas with inadequate resources, where regional culture has a significant effect on people's lives (Andersson *et al.*, 2013).

Existing research shows high levels of under reporting and under diagnosing of mental health conditions among LMIC's and South Africa is one the countries that this trend has been observed. Depression, anxiety disorders, substance abuse disorders and mood disorders are some of the most frequently reported mental health conditions within South Africa (Matlala, 2018). Individuals dealing with their mental health conditions very often simultaneously must deal with poor access to mental health care within the public healthcare system as well as stigma attached to having a mental health condition. These factors often lead to negative health outcomes, individuals feeling alone and isolated as well as high rates of suicide (Matlala, 2018).

2.5 Effects of religion on mental health: Hinduism

In South Africa, there exists such a diverse range of cultures. Culture can be defined as the individualistic features and information of a specific group of people, characterised by certain facets like dialect, religion, social habits and values including food, music and clothing and art (Zimmermann, 2015). Each culture has a unique set of beliefs and values, that they all live by. It is important to look at the cultural influence on help-seeking because it affects how the person seeks help, what type of help they seek, and the type of symptoms they chose to disclose (US Department of Health and Human Services, 2011).

Gopalkrishnan (2018) reiterates that cultural diversity significantly influences several aspects of mental health, varying from how health and illness are understood, help-seeking behaviour, and perceptions of the service user, practitioners and mental healthcare systems. Hernandez *et. al* (2009, p. 1047) propose that: “culture influences what gets defined as a problem, how the problem is understood, and which solutions to the problem are acceptable.”

There is an ample amount of literature that highlights the fact that well-being and disease are perceived differently throughout cultures (Bhugra *et al.*, 2019; Fernando & Moodley, 2018). Cultural meanings of well-being and disease have actual significance regarding whether people are interested in seeking treatment, the amount of support they receive from their families and communities (mental health practitioner, general health care provider, clergy/traditional healer), and how well they do in treatment (Gopalkrishnan, 2018).

Hinduism is a term that was derived from the word 'Hindu' and 'India' which are Sanskrit words meaning Sindhu (translating to ocean or river). These words were used to name the river now known as the Indus River which flows through the Himalayas in Tibet. The Sanskrit word for place is 'sthana' therefore the area around the Indus River was known as 'Hindusthana'. In modern times India is still known as 'Hindusthan' however the term 'Hindu' now refers to the religious orientation of a population within India and across the world (Rodrigues, 2023).

Hinduism is a polytheistic religion and is one of the largest world religions after Christianity and Islam (Hannabuss, 2005). While it is true that the objects of worship take the form of innumerable deities (Flood, 1996), within this polytheistic framework Hindus do not worship all the Gods in the same way. Each individual worshipper has a chosen deity, also known as the *ista-devata*. However, all the deities are regarded as manifestations of the sacred power (Flood, 1996), or a transcendent God who can manifest in a variety of different ways.

The Veda is a large body of literature written in Sanskrit, the holy language of Hinduism. This language is revered as the revelation (*sruti*) and the source of the Dharma (Flood, 1996). The Veda and the Dharma incorporate the ideas of truth, duty, ethics, laws and even natural laws. The 22 sources of Hindu belief rests within these two texts, amongst others (like the *Bhagavati-Gita*). The Veda contains magical poems that are used for all sorts of magic,

including destructive sorcery (Flood, 2003). Thus, the sacred books of Hinduism incorporate an element of magic and witchcraft, and this is passed on from generation to generation through storytelling, dance and poetry (Flood, 2003). However, as Flood indicates, “one striking feature of Hinduism is that practice takes precedence over belief” (1996, p. 12), thus indicating that what a Hindu does is more important than what a Hindu believes. These acts can be said to form the cultural practices of a group of people. As further stated by Flood (1996), “A Hindu is someone born within an Indian social group, a caste, who adheres to its rules with regard to purity and marriage, and who performs its prescribed rituals which usually focus on one of the many Hindu deities...” (p. 12).

Certain cultures attribute the start of mental illness to possession by spirits,” black magic, or the breaking of taboos, which then leads treatment pathways toward traditional healers, elders, or other significant community members. Khosla *et al.* (2020), share the same sentiments about Hinduism as they state that mental illnesses are often related to witchcraft and spiritual possession. According to Danielou (1991), Sakini or Dakini are the Hindi terms used to describe the equivalent of the English term “witch”. As stated by Joshi *et al.* (2006), accidents, sicknesses, death and other events have been thought to be caused by witches that have magical powers, which they use for evil purposes. In Hinduism, the witch is considered as being inherently malevolent from birth (Dwyer, 2003); i.e., she is born at an inauspicious time (ashubh) or may have consumed impure (ganda) substances during childhood, particularly faeces and urine. In addition to these predisposing influences, it is further believed that she may become wicked due to not bathing, wearing dirty clothes or sitting in filthy places. It is further mentioned by Dwyer (2003) that she may be possessed during childhood by an evil spirit, called a Dakini.

Witchcraft ingredients may include the ash from cremation grounds or graves, chicken or lizard bones, cat faeces, mustard seeds, etc. These objects are mixed with the food of the

victim, who will experience a variety of bewitchment symptoms. This direct method of witchcraft also incorporates a belief in the fact that witches have knowledge of poisonous herbs and substances. The indirect method of witchcraft is believed to be the use of supernatural powers, often invoked by chanting spells. It is also believed that a witch can transform herself into a cat, enter the victims' houses at night and cause severe illness to them (Joshi et al, 2006). The symptoms caused by witchcraft include feeling sluggish and ill (Joshi et al, 2006), suffering severe body pains, headaches and excessive fevers (Dwyer, 2003). Skin disease, infertility, nightmares, and insomnia are also believed to be caused by witches. Psychological symptoms like lethargy, weakness and loss of appetite may also be experienced. Witchcraft is often associated with business misfortune or financial loss (Joshi et al, 2006).

Possession by spirits in the Hindu faith is described by the term bhut (ghost) (Stafford, 2005). In the case of the untimely death of a person, unresolved grievances can result in the lingering spirit. Spirits or ghosts can be said to form an integral part of Hindu ideas about the soul. That is, the condition of the soul rests upon its activities in life, also known as the person's karma (Spiro, 2005). Possession experiences are believed to result from the supernatural, particularly when a spirit attacks a person. When this occurs, the assistance of an exorcist is needed to 'expel' the spirit from the afflicted. Among the symptoms of bhut (ghost) possession are trance-like states, moans or shaking, strange speech and physique, and even exhibitions of supernatural power (Stafford, 2005). Other symptoms include fainting, hallucinations and epilepsy (Dwyer, 2003). These spirits or bhuts may take rest in the victims' body or even leave the victim for short periods of time. The subsequent unpleasant physical sensations and psychological turmoil that the victim experiences during the exorcism is believed to be caused by either the spirit presenting itself, or the expression of emotion from the victim who takes the form of a particular deity.

In India, Ayurveda is the main traditional healing system, and mental health may be understood as a product of karma or one's actions, Vayu (air), and Swabhava (one's nature) (Biswas *et al.*, 2016). Religion and spirituality play a crucial part in these experiences by contrasting adversity with a higher order God and the explanations are consequently pursued within the view of these structures. Some examples would be the temples in India or other religious pilgrimage sites worldwide, which thousands of people experiencing mental health conditions frequent daily (Hechanova & Waelde, 2017). Biswas *et al.* (2016), maintain that help-seeking from conventional healthcare systems in India tended to present with mainly physical (somatic) symptoms compared to those in the United States that presented with more psychological (mental-based) symptoms.

When a Hindu individual displays symptoms resembling schizophrenia or psychosis, he or she is brought to a traditional healer for treatment (Dwyer, 2006; Stafford, 2005). According to Spiro (2005), the exorcising of ghosts requires positive energy in the form of 'vidhya' (knowledge). This energy is derived from performing many mantras (prayers) (Spiro, 2005). The traditional healer (Baba, Guruji or Pandit) begins an exorcism by waving a tray of lights (arati) in front of the afflicted. Once this occurs, the body of the person is totally possessed by the 'bhut' (ghost). After the completion of the exorcism, the victim does not remember anything about the process (Stafford, 2005).

The healer is also believed to have the capacity to become possessed by Sanskrit deities, particularly Hanuman, Bhairava and Kali. It is also believed that Hindu healers could either be born with the supernatural ability to heal those affected by supernatural entities, or develop this capacity later in life (Dwyer, 2006). Various mantras are used to increase the healer's ability to heal, including sacred phrases or sentences, such as 'Om'. From the descriptions above, many of the symptoms described as being caused by bewitchment or

possession seem to correlate with the symptoms of psychological disturbances. These beliefs may impact on how psychological disturbance is conceptualised, understood and treated.

Shame and embarrassment may be a big contributing factor to low levels of help-seeking among the Indian population Gopalkrishnan (2018). Shame-related reasons for poor access to mental healthcare could have many explanations. Firstly, the need to shield the reputation and dignity of their family. Secondly, the possibility that the mental health practitioner would view them as “crazy”, and lastly that the person may be hesitant to open up to strangers, due to factors such as a fear of “loss of face”, low levels of trust, or the fear of reliving traumatic events from their past (Hechanova & Waelde, 2017).

On the contrary, a study conducted by Francis *et al.* (2008) aimed at exploring the relationship between mental health and attitudes toward religious traditions in young people. Results from this study revealed that higher degrees of religiosity correlated to higher levels of positive attitudes towards mental health. Those who have positive ideologies of Hinduism, thus in turn were more aware, receptive, and sympathetic towards mental health. Nandika and Nagalakshmi (2022) yielded similar findings in their study which concluded that increased religiosity significantly predicts better psychological, social, and environmental health perceptions. People who are more religious by nature, have been linked to better mental health outcomes. It has been observed that engaging in religious and spiritual activities has multiple benefits which include markedly improved social and interpersonal relationships, better coping skills, increased confidence, diminished fear, and promoted better mental health behaviours (Kurhade *et al.*, 2022).

2.6 Chapter summary

After a review of existing, relevant literature, several salient points have been highlighted. Low levels of MHL have been found in non-western populations, although there

are high prevalence rates due to certain socio-economic disparities. University students are poorly informed about mental health despite the onset of many mental health conditions during this age. Low levels of help-seeking among university students have also been reported. Research has also shown that there are many reasons for low levels of help-seeking e.g., stigma (both personal and public), and fears about confidentiality among others.

Literature has also revealed that culture and religion do play an important role in mental health attitudes and help-seeking behaviour. Certain cultures, including Hinduism, attribute psychological symptoms to religious ideologies e.g., witchcraft, and spiritual possession. Shame and embarrassment are major contributing factors to avoiding help-seeking among the Indian population. Conversely, some research shows positive correlations between Hinduism and positive mental health outcomes and help-seeking.

Most of the aforementioned studies were done abroad, hence the need for more research within the unique South African context. Although similarities exist between the Hindu population worldwide, some contextual differences may exist. This highlighted the need for this study among the Hindu population in South Africa. The following chapter details the theoretical framework employed in this study. Social Identity Theory (SIT) is discussed and its relevance to the study is highlighted.

CHAPTER 3: THEORETICAL FRAMEWORK

3.0 Introduction

This chapter provides an overview of the theoretical framework guiding the research. Social identity theory by Hemri Tajfel (1979) was used. This theory assists in understanding and exploring any link between identification as a Hindu and its possible influence on mental health literacy and awareness of help-seeking behaviour. The development and origin of the theory is presented through detailing the founding research conducted on students. This provides a foundation for understanding the birth of the theory, thereafter the building blocks of the theory are discussed. This chapter provides an example of how the theory can relate to real life situations. Understanding how social identity theory is relevant and fits in to the current research is explored and to conclude the chapter, the strengths of the theory are presented.

3.1 Development of Social Identity Theory

Social identity theory (SIT) was first developed by a cognitive psychologist at the University of Bristol, England, Hemri Tajfel in 1979, who would later become the founding father of SIT. Social identity theory was developed through research conducted on students who participated in the study by being allocated to one (1) of two (2) groups based on their preference for either Klee or Klandinsky who were famous painters at the time. The only information participants were given was that there were two (2) groups and they belonged to one of these groups. No contact was made between or within these groups. Once assigned to a group, participants had to allocate money to unknown members of the two (2) groups. Results showed that participants preferred members of their own group compared to those from the opposing group (Scheepers & Ellemers, 2019).

3.2 Building blocks of Social Identity Theory

Social identity theory contains two (2) general parts. Firstly, one part maintains a basic psychological component which explores the cognitive processes underlying social identity and the notion that people innately need to have a positive social identity. The second part details the socio-structural component which designates the way people manage having a negative social identity. Social identity theory begins with the view within social categorization, you always belong to one of the two (2) social categories or a third (e.g., outsider) category (Scheepers & Ellemers, 2019).

An example would be a sporting event with two (2) specific sporting teams. Your identification with one of these teams may make your identification known or with a third category of people supporting neither or both teams. With each potential, the fundamental cognitive social categorization process indicates an aspect of your identity. A combination of this self-categorisation and need for positive social identity prompts social difference with applicable out-groups targeted at positively differentiating the in-group from these out-groups (Scheepers & Ellemers, 2019). This differentiation fosters a positive sense of self and in turn provides the fundamental human need for confidence and need for self-esteem. Ultimately, by defining an individual's position in their social world, forming positive group identity also aids the ongoing search for meaning about where we belong in our social world, who we are and how this identify allows us to behave (Scheepers & Ellemers, 2019).

Social identity theory further explores the link between groups and individuals (Greenfield & Marks, 2007). The theory hypothesises that individuals exist in a society encompassed of various social groups or categories that exist comparatively to each other in relation to power and status. Although these social groups/categories might differ, they have the potential to influence and mould a person's sense of self and the way they behave (Tajfel,

1972). Social identity theory proposes that group membership and psychological wellness are correlated to the social identity applicable to that social group.

3.3 Relevance of the Social Identity Theory to the current study

Social identity theory, a well-established social psychological model which investigates the line between groups and individuals - has not been explored and applied to research on religion and mental health (Greenfield & Marks, 2007). The current research study drew on SIT to explore any link between identification as a Hindu and its possible influence on mental health literacy and awareness of help-seeking behaviour.

Social identity theory, thus, provides a good theoretical foundation for exploring the impact religion can have on perceptions around mental health. Closely identifying with this specific social group may impact perceptions surrounding mental health, for example, if this group views mental health and help-seeking as positive then the possibility of the individual engaging in help-seeking increases. However, if mental health and help-seeking is viewed negatively then the possibility of an individual seeking help decreases.

Social identity theory proposes that regular religious involvement and participation could be correlated to a deeper group membership of an individual's specific religious group which would result in higher levels of psychological well-being (Greenfield & Marks, 2007).

3.4) Strengths of Social Identity Theory

Social identity theory is supported by many empirical studies, it highlights the difference between personal identity and social identity and explores how the basic need to fit in affects social interaction. Social identity theory assists in understanding human behaviour, for example, ethnocentrism, favouritism, conformity, and stereotyping (Hogg *et al.*, 2012; Hornsey, 2008).

According to Hornsey (2008) social identity theory states that individuals identify with similar groups to increase positive uniqueness. This assists in explaining humanitarian acts carried out by social groups like food drives and other charitable acts. Subsequently, the key driver behind associating with a group's positive distinctiveness, demonstrates that individuals would want their group to be perceived more positively than other groups.

Social identity theory aids in understanding the formation of in-groups and out-groups, and the prejudices that accompany them. An in-group is a social group that an individual can identify with, and an out-group is those who don't form part of the in-group (Hornsey, 2008). In-group bias is the expected inclination of humans to favour those in the same in-group. For example, members of an exclusive school, or private club may favour those belonging to their in-group when networking for business or hiring for jobs (Hornsey, 2008).

3.5) Critiques of Social Identity Theory

Social identity theory has been criticized for failing to account for environmental influences on identity formation, for example, cultural expectations, rewards, and social constraints (poverty). Huddy (2011) has contended that identity development is not simply a by-product of group designation; but rather, relies on a blend of subjective factors. This may add some contention to the applicability of SIT to the South African context where culture plays a significant role in identity formation and where the collectivist approach may be more dominant than individualism.

Demirden (2021) proposes that SIT bypasses the potential cross-cultural differences, for example, any differences between individualistic versus collectivist cultures with regards to social identity development and preservation. Societies and groups worldwide show cultural differences. One main designation of societies is the classification of individualistic versus collectivist societies. Naturally, social relationships within groups may vary based on

individualistic and collectivist characteristics. These differences can be viewed as either; what an individual can obtain from being a member of a social group and what that specific social group expects back from its members may differ significantly in individualistic versus collectivist social groups. Individuals who are members of a social group within individualistic classification may be permitted to be more flexible in the construction, preservation, or relinquishing of social identity whilst the same amount of clemency may not be afforded to the members of a collectivist social group.

SIT does not account for or attempt to explore these possible cultural differences. Cultural differences may also be imperative in understanding "unsatisfactory" social identity and how a member may react to these demands and what a social group sees as an adequate method for its members to deal with "unsatisfactory" social identity. By investigating above potential cultural differences between social groups, SIT may increase its applicability to practical and real-life issues (Demirden, 2021).

The use of SIT, in examining the link between individual behaviour and group behaviour has been put through a lot of criticism and there are some limitations to using this theory.

Social identity theory has been critiqued for having very low ecological validity. The theory is said to be more descriptive than a predictive model, meaning that although it can be very useful in explaining existing phenomena, it is not always truly precise in predicting future behaviour (Brown, 2000).

Social identity theory states that when groups have inflexible boundaries and an alike social status, there is a high probability that they would engage in conflict and competition. However, this may not always be the case. In various instances, groups that are situated similarly in terms of social status, and which have inflexible boundaries, can engage in

collaboration. For example, in many multi-ethnic, multi-racial societies, peaceful coexistence has been shown to exist, rather than ethnic conflict (Brown, 2000).

3.6) Chapter summary

This chapter introduced SIT and provided an overview of what the theory entails. It further detailed the research conducted by Henri Tajfel which prompted the birth of the theory. Understanding the building blocks and the scaffolding of a theory is essential in understanding its applicability to research. These building blocks were presented and an example of its practicality to everyday life was provided. Once the foundation of SIT was unpacked, the relevance to the current study was explored. Although SIT may not be widely applied to research involving religion and mental health, it did provide a good theoretical grounding for exploring the possible influence religion may have on mental health. The chapter concluded by presenting some strengths of the theory, which further assisted in understanding why SIT was chosen for this study. The following chapter presents the methodology employed for the study. Details regarding selection of participants, data collection methods and analysis are discussed in further detail.

CHAPTER 4: METHODOLOGY

4.0 Introduction

This chapter presents all methods and processes employed to conduct this research. The research approach, which is qualitative research is defined and specific characteristics of this approach is discussed. The type of research approach, design and paradigm are explored and relevance to the current study is discussed. This chapter also highlights how participants were selected and details about the number of participants and inclusion-exclusion criteria were included. Sampling techniques used, which were purposive and snowball sampling are explained and reasons for its inclusion are provided. The method of data collection using semi-structured interviews is detailed in this chapter and key points on the practicality of this data collection method is discussed. This chapter further details the data analysis process which was thematic analysis by Braun and Clark (2006) and the six (6) phases of this data analysis process are explained. This chapter concludes by comprehensively discussing the trustworthiness of the study which includes reliability and validity, credibility, dependability and transferability. Methods used to ensure that the study was ethically conducted and that research participants were treated fairly and ethically are discussed.

4.1 Research approach

The research approach followed in this study was the Qualitative research approach. The qualitative research approach is characterised by seeking an in-depth understanding, exploring and discovering why, how, and under what circumstances events and situations occur (Terre Blanche *et al.*, 2006). It is a holistic approach that seeks to understand the human experience. Qualitative research focuses on describing and deeply understanding phenomena in the social world (Rahman, 2020). Qualitative research is emergent (inductive) and an

iterative process (Terre Blanche *et al.*, 2006). This approach assists in providing a detailed and rich description of participants feelings, thoughts and experiences (Rahman, 2020).

The qualitative research approach was chosen because it sought to understand, explore and uncover and was most suited to the goals of this study. Choosing this approach was motivated by the researcher wanting to explore and obtain rich and insightful information. It assisted the researcher to gain deeper insights into participants experiences related to mental health and help seeking. This approach allowed the researcher flexibility in its structure as qualitative research can be created and reassembled to a greater degree (Rahman, 2020). Qualitative research allowed the researcher to engage in rigorous and rich data collection to ensure that the participants feelings and experiences were captured. In this study, qualitative research questioning (how interview questions are framed and structured), helped participants detail their understanding of mental health, help seeking and how Hinduism influences these two concepts. This approach was appropriately in keeping with the study objections and intended outcomes.

4.2 Research design

An exploratory research design was employed in this study. Exploratory research can be defined as: “research whose primary focus is to examine a little understood issue or phenomenon and to develop preliminary ideas about it and moves forward to refined research questions” (Neuman, 2011, p. 38). Exploratory research is interested in research that is in the introductory or infant stages. It promotes discovery and ingenuity (Casula *et al.*, 2020). Researchers that use the exploratory approach need to ensure they are flexible, creative, open-minded, and employ an investigative stance (Neuman, 2011).

According to Casula *et al.* (2020), exploratory research is synonymous and works well with the qualitative approach further enhancing the researcher’s choice for this research design.

This study sought to understand and explore, and the exploratory research design was well aligned with this goal. The motive for using this research design was that the exploratory design is employed when the research topic is little understood, and for the current study the Hindu student population at UKZN, their levels of MHL and help-seeking behaviour is something that is not well understood.

4.3 Research paradigm

The interpretivist paradigm was used in this study. The interpretivist paradigm can be defined as “emphasizing meaningful social action, socially constructed meaning, and value relativism” (Neuman, 2011, p. 101). Interpretivism focuses on detailed research variables and influences and believes that human beings cannot be explored and studied in the same manner as physical phenomena. This research paradigm highlights differences related to culture, religion and contextual differences (Alharahsheh & Pius, 2020). Through an interpretivist paradigm lens, information is observed as being subjective, sensitive and flexible as the researcher has access to engaging with research participants directly (Ataro, 2020). By employing the interpretivism paradigm, the researcher would ensure high levels of validity due to the personal contributions of participants as this paradigm considers the different variables (Alharahsheh & Pius, 2020).

This paradigm was chosen for this study due to the researcher’s propensity to produce detail rich, meaningful and context specific information. The interpretivist paradigm works well with the qualitative research approach as both aims to explore subjective experiences of people. This paradigm allowed the researcher flexibility when creating research questions and problem identification because it highlights that these should be derived from the researchers’ focus and interests. The research approach (qualitative), design (exploratory) and paradigm (interpretivist) all have similarities in its key characteristics and features which assisted the researcher in ensuring that the study provided the in-depth exploration it intended to.

4.4 Location of study

The location of the study was the University of KwaZulu-Natal, Howard College campus in Durban, KwaZulu-Natal, South Africa. Student demographic numbers at UKZN showed that there were 46 925 students in 2020 and 44 068 students in 2021. The proportion of African students was 81% in 2020 and 2021 and White, Indian and Coloured students made up the remaining 19% (UKZN annual report; 2021).

Students come from different socio-economic and socio-religious backgrounds, comprising of majority middle to low-income households. The researcher was unable to obtain specific demographic information regarding UKZN student religious affiliations. According to the South African Embassy in Netherlands (2021), it may be important to note that in South Africa, approximately 1.2% of South Africans follow the Hindu faith.

These statistics provide a foundation for understanding the researcher's decision for choosing the student Hindu population group. Although a minority group within the South African context, through the researchers experience of reviewing literature about Hindu students, and personal observations within the Hindu community, it was highlighted as a under researched population group. Literature highlighted in Chapter 2 (literature review), further displays the need to understand Hinduism and mental health among the student population. As stated by Flood (1996; 2003); Danielou (1991 and Joshi et. al (2006), strong associations have been made between understanding mental health presentations through the lens of cultural and religious beliefs within Hinduism.

4.5 Entry into the research site

Firstly, permission was granted from the tertiary institutions' gatekeeper (the registrar from UKZN Howard College Campus). Ethical clearance was granted by the Humanities and Social Science Research Ethics Committee at the University of KwaZulu-Natal (please see

Appendix 1). Due to the current COVID-19 Alert Level 3 restrictions, the previous recruitment process through engaging with students in lectures was no longer possible.

The new recruitment process was as follows; the administrator of the School of Applied Human Sciences was contacted, who provided details of the respective module administrators. Once the details were provided, the module administrators were contacted and provided the details of the respective lecturers who teach the student sample required. Lecturers from the College of Humanities, specifically the Psychology, Criminology, and Social Work departments were contacted through the process detailed above. An email/advert was sent to students via the respective lecturers and the study was explained.

Contact details of the researcher were provided for students to contact if they were interested in participating. Students could choose to respond via private email or text message. Once students made contact, individual times were set up to discuss with students the necessary details of the research study, providing elaboration on the ethics of the study, how the interviews will be conducted, and creating a platform for questions to be asked.

The Covid alert level at the time did not allow face-to-face interviews as initially planned. It was decided that telephone calls at the expense of the researcher and not the participant was the best option. Avoiding airtime and data costs for the participant was the driving reason for telephonic interviews.

4.6 Selection of participants

The study sample was thirteen (13) participants. Guest *et al.* (2020) propose that saturation often occurs around twelve (12) participants in homogeneous groups. To guarantee that you have reached saturation you have to go beyond the point of saturation to make sure no new major concepts emerge in the next few interviews or observations. Fifteen (15) as a minimum for most qualitative interview studies works very well when the participants are

homogeneous. For a particular group, saturation often occurs between twelve (12) and fifteen (15). Participants were selected based on certain inclusion and exclusion criteria.

Participants had to have been actively enrolled at UKZN and belong to the Hindu faith. Participants ranged from eighteen (18) to twenty-five (25) years old and consisted of both male and female students enrolled for undergraduate and postgraduate studies in the College of Humanities. The College of Humanities was chosen because of the courses offered in this college. Students enrolled had a background in psychology and other social science subjects which gave them a unique perspective into mental health and help-seeking. The researcher was interested in exploring this aspect along with the influence the student's religion would have on their attitude towards mental health and help-seeking.

The final 13 participants that were included in the study fit all in the inclusion criteria. There was a total of nine (9) girls and four (4) boys included in this study all registered at UKZN. All participants were of Hindu descent (practicing Hindus') and were Indian. The selected participants ranged from 19 to 25 years old. Two participants were 19, two were 20, three (3) were 22, three (3) were 23 and three (3) were 25 years old. Two (2) of the participants were enrolled as Sociology majors, four (4) were Criminology majors and the remaining seven (7) were Psychology majors. Three (3) participants were postgraduate students and ten (10) were undergraduate students.

Table1: Research participant details

Participant	Gender (Male/Female/ Other)	Age	University Major (course registration)	Undergraduate or Postgraduate
1	Female	19	Psychology	Postgraduate
2	Female	19	Criminology	Undergraduate
3	Female	23	Sociology	Undergraduate
4	Female	22	Psychology	Undergraduate
5	Male	23	Psychology	Postgraduate
6	Female	22	Psychology	Undergraduate
7	Female	25	Psychology	Undergraduate
8	Female	25	Sociology	Undergraduate
9	Female	20	Psychology	Undergraduate
10	Male	25	Criminology	Undergraduate
11	Female	20	Psychology	Postgraduate
12	Male	23	Criminology	Undergraduate
13	Male	22	Criminology	Undergraduate

There were two (2) sampling techniques used in this study. The first technique employed is purposive sampling which can be defined as: "a non-random sample in which the researcher uses a wide range of methods to locate all possible cases of a highly specific and difficult to reach population" (Neuman, 2011, p. 267). Some advantages of using purposive sampling are that this technique focuses only on the population of interest to the study and it reduces variance between the sample increasing statistical significance (Andrade, 2021). It is usually used to examine a difficult-to-reach population that meets certain inclusion and

exclusion criteria (Neuman, 2011). This technique is appropriate for this current study because there are specific criteria that need to be met to qualify to be a research participant.

An additional technique that was used is snowball sampling (also known as network or chain referral sampling), which is: "a non-random sample in which the researcher begins with one case and then, based on information about interrelationships from that case, identifies other cases and repeats the process again and again" (Neuman, 2011, p. 269). This technique is appropriate in a university setting, as one student may be able to recommend others who meet the inclusion criteria. This study focused on a specific population group which was Hindu students, therefore snowball sampling assisted the researcher to recruit participants through recommendation within this population group.

4.7 Data collection

The method of data collection used in this study were interviews, through use of semi-structured individual interviews. Semi-structured individual interviews involve one on one conversations between the researcher and participant (Terre Blanche *et al.*, 2006). The researcher asks participants a list of predetermined questions and note down important points to expand on further (probing) (Terre Blanche *et al.*, 2006). An interview allows the researcher to interact with the participant on a more intimate and personal level so the researcher can understand how the participant thinks and feels (Terre Blanche *et al.*, 2006).

This study comprised of thirteen (13) semi-structured interviews. The interview process took approximately forty to fifty (40-50) minutes allowing time for possible probing to gain a deeper understanding of the participants responses. A pre-determined interview schedule with guiding questions was used, however participants were probed based on certain responses they have provided (Appendix 3).

Once participants were recruited through the process detailed above, they were informed of their rights in the study such as voluntary participation, anonymity, confidentiality, and privacy. At the end of this interaction, consent forms (Appendix 2) were sent via email to the students' private email, and interview times were set up. With permission from the participants, interviews were conducted via telephone. This did not add any cost to the student and the audio was recorded and later transcribed verbatim. This process was done using a recorder (i.e., the telephone call was put on speaker and recorded using a voice recorder).

4.8 Data analysis

Data was analysed using Thematic Analysis. Thematic analysis can be defined as: "a method for identifying, analysing and reporting patterns within data" (Braun & Clarke, 2006, p. 79). It categorises and describes the data but can also help with interpreting and establishing patterns (Braun & Clarke, 2006). Once all the interviews had been transcribed from audio, the next step was to begin the thematic analysis. It began by searching for patterns and themes, as well as aspects of potential interest. It is an iterative process and requires constant refining (Braun & Clarke, 2006). Braun and Clarke (2006), have established six (6) phases of thematic analysis:

Phase One (1): is to familiarise yourself with the data. This requires the researcher to immerse themselves in the data and requires repeated readings and recording of emerging themes and patterns. After each interview, the researcher made short notes on first impressions of the interviews, notes on things like the pace of the interview, tone and anything else that stood out during the interview process. These notes assisted the researcher to contextualize and fully understand participants responses during the interviews. The researcher then transcribed the recorded interviews and added the field notes for each participant which helped the researcher familiarize themselves with each participant's responses. Re-reading interviews and

field notes was a vital part of phase one (1) of the data analysis process. *Phase Two (2)*: is generating initial codes. A code is "a most basic segment or element of raw data which can differ from a theme which can be broader" (Braun & Clarke, 2006, p. 88-89). Coding can be done manually or using the software e.g. NVivo, (Terre Blanche *et al.*, 2006). Manual coding was used in this study. The researcher began by rigorously going through each interview in detail and highlighting responses into potential codes.

Phase Three (3): is characterised by searching for themes. Once all the raw data has been coded, the next step would be to find broader themes and similarities in the data. Once all the interviews were coded, the researcher then began comparing and categorizing codes across interviews which was then combined and narrowed down to find similarities and differences which created themes across interviews. By the end of this process, all codes were filtered to form overarching themes.

Phase Four (4): is the reviewing and refining of the themes. Further analysis of themes is required and if possible, certain themes could be combined with others (Braun & Clarke, 2006). The emerging differences now become apparent, if not, then it is essential to re-do phases two (2) and three (3). During this phase, the researcher began critically examining the general themes established in phase two (2), to look for commonalities and differences once again. This process assists in refining and reviewing the themes that emerged. The researcher did find themes that could be combined to streamline the data. The researcher decided to refer back to the codes and transcribed interviews to ensure that no data was missed and to ensure that themes did not overlap. Some themes were combined, some were separated into different categories.

Phase Five (5): is the defining and naming of the themes. At this stage, it should be easy to give each theme a concise title and a short description. If themes become too complex, sub-themes can be used (Braun & Clarke, 2006). The researcher proceeded to name the themes

with concise, effective titles which immediately gave the reader a sense of what the theme is about. Some themes became too complex and long to adequately explore under the same heading, therefore the researcher began breaking down certain themes into sub-themes so all data could be addressed efficiently. Titles were also given to sub-themes to ensure fluidity and easy reference between themes and sub-themes. A table was then created which displayed the flow from main themes to into sub-themes (thematic map) which is included in the results chapter (Table 1).

Phase Six (6): The last phase is the reporting of the data. The report must be able to adequately explain all the data as well as the outcomes. Not all the themes may be used in the thesis, only those that can explicitly explain the data will be used and an abstract from the interview should be presented (Braun & Clarke, 2006). The themes must be able to answer the research questions and not just describe the data collected. The researcher then began the report writing phase in the form of the results chapter. Themes and sub-themes were explored in the context of literature reviewed in chapter two (2) as well as research questions addressed in chapter one (1). Abstracts to adequately describe and explore each theme and sub-theme was included.

4.9 Trustworthiness of the study

This study was qualitative in nature, therefore the researcher had to ensure that measures were in place to guarantee that the study was trustworthy. To ensure the trustworthiness of the study, interviews with participants were recorded using a voice recorder and transcribed accurately. When selecting the number of participants for the study, research on the point of data saturation was taken into consideration and thirteen (13) students were used.

Reliability and validity are imperative because the constructs measured in research are usually obscure and unobservable. These two (2) constructs help establish the truthfulness and credibility of the results of a study (Neuman, 2011). Reliability can be defined as "dependability or consistency" (Neuman, 2011, p. 208). It assumes that outcomes will be the same over a period and under similar conditions (Neuman, 2011). Validity "suggests truthfulness and it refers to how well an idea can translate to the real world" (Neuman, 2011, p. 208). To maintain validity in a qualitative study, researchers need to ensure that no false, distorted, over-reported, or under-reported accounts of the data or outcomes are put forward and it is important to try and build a link between ideas and reality (Neuman, 2011).

This section presents the measures the researcher implemented to ensure that the data collection process and the findings presented in this study are trustworthy and ethical. This section details concepts associated with reliability and validity which are credibility, dependability and transferability. Philosophical principals guiding ethical research are also discussed, confidentiality and mannerisms during the interview process are also described.

4.9.1 Credibility

Credibility refers to the validity of the study which focuses on the accuracy of the findings (Ulin *et al.*, 2002). Two (2) main concepts should be considered, 1) are the findings logical and consistent, and 2) are the findings grounded and substantiated by the data (Ulin *et al.*, 2002). To maintain credibility in a qualitative study, researchers need to ensure that no false, distorted over-reported, or under-reported accounts of the data or outcomes are put forward and it is important to try and build a link between ideas and reality (Neuman, 2011).

To ensure validity in this study, semi-structured interviews were conducted to ensure some consistency and thematic analysis was utilized to ensure accuracy and consistency through the coding and identifying themes process. To further ensure a high degree of

credibility, the researcher compared the data from the current study with the relevant literature. This comparison between the data and the literature enabled the researcher to demonstrate whether participants reflected trends and patterns found in other studies. The researcher also compared the commencing assumptions held (that certain participants would discern and acknowledge in a specific way) with what materialized. This process ensured that the meaning associated to the data was specific to the understanding provided by the participants. This process also ensured that interpretive bias did not prejudice participants' reported perceptions.

4.9.2 Dependability

Dependability refers to the reliability of the study, that is, the consistency of getting the same results if the study must be replicated (Ulin *et al.*, 2002). It assumes that outcomes will be the same over a period of time and under similar conditions (Neuman, 2011). A wide variety of techniques can be used to record observations and ensure consistency e.g. interviews, photographs, etc.

To achieve reliability in this study, the researcher ensured that transcribed material was by read and re-read numerous times. This enabled the researcher to ensure that the initial interpretation attached to the data was as consistent and accurate as possible. Research questions were made as clear and logical as possible. Other aspects concerning methodology were distinct and consistent to ensure that results were reliable and dependable.

4.9.3 Transferability

Transferability refers to whether findings in a particular study can be adapted and related to another study done in a different context, that is, the generalisability of the study (Ulin *et al.*, 2002). Due to the nature of the study, a purposive sample was used in this study. The target population was Hindu students at UKZN. The relatability of the questions and structure of study can easily be adapted to another Hindu population in a different context, for

example in schools, places of work, or communities. In order to demonstrate transferability in this study, the researcher provided a ‘thick description’ which means providing clear and adequate details on the study site, specifics on the participants and other methods or procedures used to collect data.

4.10 Ethical considerations

When conducting research, there are various ethical matters to consider ensuring that both the participant and researcher are protected. There are many ways to ensure that ethical guidelines are followed:

4.10.1 Philosophical principals guiding ethical research

1) *Autonomy and respect for the dignity of persons*: It is important to ensure that participants can make their own decisions and for participants fully understand their role in the study and what is required from them (Terre Blanche *et al.*, 2006). One way of doing this is through informed consent, defined as: “a statement usually written that explains aspects of a study to participants and asks for their voluntary agreement to participate before the study begins” (Neuman, 2011, p. 149). Each participant in the study received an informed consent form before the interview, disclosing the nature and purpose of the study, as well as what role they play in the study. The researcher ensured that before participants engaged in the study, they were fully aware of what was required of them and were in no way coerced or forced to participate. They were made aware that they will be participating within their own free will.

2) *Non-maleficence (Do no harm)*: No harm should befall any participant of the study, directly or indirectly. The researcher needs to be cautious and proceed with caution ensuring that the participant is put in no danger (physical or emotional) (Terre Blanche *et al.*, 2006). Participants were placed in no physical or emotional harm to conduct this study. At the end of

the interviews, a short debrief was offered to participants to ensure they terminated the interview with no unresolved questions or concerns.

3) *Beneficence (Benefits)*: Research should be beneficial not only to the researcher but to the participants and population being studied. This can be provided by possible solutions to the problem being studied (Terre Blanche *et al.*, 2006). Recommendations were offered at the end of the study which could be used to fill in the gaps and shortfalls that students identified. These recommendations were made in the hope that these considerations could help the university better accommodate the mental health needs of future Hindu students.

4) *Justice*: It is important to ensure that participants are treated fairly and with respect and includes the responsibility to provide care and solutions that they may need (Terre Blanche *et al.*, 2006). All participants in the study were treated with the highest level of respect and care. Efforts were made to ensure that participants were addressed and spoken to in a professional and respectful manner. Any questions or concerns participants made were attended to as adequately as possible by the researcher. Recruitment and selection of participants were made in a fair and equal manner according to the criteria of the study. The researcher ensured a fair and equal distribution of the benefits and risks of participation in the study was made available and clear to all participants.

4.11 Confidentiality

Confidentiality can be defined as “the ethical protection for those who are studied by holding research data in confidence or keeping them secret from the public, not releasing information in a way that permits linking specific individuals to specific responses” (Neuman, 2011, p. 153). The names and personal information of all participants in this study remained anonymous to protect the privacy of the participant and protect them from encountering any stereotyping or discrimination based on their responses in the interview. This personal

information was not reported in the outcome of the study. Random names were assigned to participants and these names were disseminated in the study. Great care was made to ensure that these names and responses were not assigned to participants real identities. Transcripts and consent forms were also kept in password protected files that only the researcher had access to.

4.12 Reflexivity and mannerisms during interview

Reflexivity is: “the practice of reflecting upon the research process and providing an account of the researcher’s role in it” (Terre Blanche *et al.*, 2006, p. 60). The researcher acknowledged their role in the study as well as how they impacted the study. The reason a researcher needs to practice reflexivity is to account for the subjective factors brought by the researcher (Terre Blanche *et al.*, 2006). Reflexivity is a learning process throughout the whole research process.

The researcher needs to be aware of mannerisms during an interview. Researchers need to be cautious of ways of speaking and tone of voice, body language, and posture, as well as facial expressions (Terre Blanche *et al.*, 2006). The researcher should not engage in any behaviour that could negatively impact the interview or the participant. The researcher should always speak clearly and should always uphold a professional and alert posture that shows the participant that you are attentively listening and interested in what he/she is saying (Terre Blanche *et al.*, 2006). In this study, the researchers engaged in telephonic interviews and made specific efforts to pay attention to tone of voice, pace of speech, choice of words and phrases, pauses during speech and volume of speech. Great detailed was taken to ensure participants felt comfortable during the interview and felt like the interview was done professionally and ethically.

4.13 Chapter Summary

This chapter provided a detailed discussion of the methodology employed for this study. Specific details regarding the design, data collection and analysis were provided. This chapter

began discussing the research approach, design and paradigm used. A qualitative, exploratory and interpretivist view was chosen and details discussing the benefits were included. The location of the study was described and details regarding entry into the research site are discussed, including recruitment changes made due to the COVID-19 pandemic. Inclusion criteria for the selection of participants are provided. Thirteen (13) Hindu students currently enrolled at UKZN Howard collection for undergraduate or postgraduate studies aged between eighteen (18) and twenty-five (25) years old were recruited. Sampling techniques employed in the study are presented. Data collection methods using semi-structured interviews are detailed in this chapter. Thematic analysis for the data analysis process was used and the six (6) phases of this process are discussed. This chapter concluded by discussing the measures implemented to ensure the study is trustworthy and ethical. These measures included ensuring credibility and dependability and abiding by the principal guidelines to ethical research which are presented in this chapter.

CHAPTER 5: PRESENTATION OF FINDINGS AND DISCUSSION

5.0 Introduction

This chapter presents the findings of this study, according to five (5) umbrella themes that emerged during data analysis. These five (5) umbrella themes were broken down to form nine (9) sub-themes which are discussed in detail in this chapter. This chapter includes a table presenting the themes and sub-themes for easy reference. Each theme and sub-theme are then presented in detail, and the number of participants whose responses elicited that particular theme or sub-theme are presented.

Excerpts from transcribed interviews were included to enhance understanding of these themes and sub-themes and to integrate the findings. Random pseudonyms are used to label the interview excerpts, as the participants identities remain anonymous. These interview excerpts provide the reader the opportunity to explore the true responses of the participants in their own words.

The latter section of this chapter provides a further discussion of the findings within context of the research outcomes outlined in Chapter one (1). Findings were explored and compared to studies and findings in the literature which was outlined in Chapter two (2).

Findings: Introduction of themes

After an in-depth analysis of the interviews many similarities in responses were noted. These similarities were then categorised into broad themes. The five (5) broad themes are mental health awareness, Hinduism: dichotomy of perceptions, stigma, help-seeking behaviour and recommendations to improve mental health awareness and help-seeking on campus. For the purpose of attaining a critical analysis, these five (5) broad themes were broken into sub-themes

to ensure that all the participants' insights were included and analysed. These themes and sub-themes are tabulated below and then discussed in further detail.

Table 1: Presentation of themes

List of Themes
<p>5.1 Mental health awareness</p> <p>5.1.1 Degree of mental health awareness;</p> <p>5.1.2 Definitions: common concepts.</p>
<p>5.2 Hinduism: dichotomy of perceptions</p> <p>5.2.1 Influence of religion on behaviour and thoughts;</p> <p>5.2.2 Influence of religion on perceptions towards mental health.</p>
<p>5.3 Stigma</p>
<p>5.4 Help-seeking behaviour</p> <p>5.4.1 Barriers to help-seeking;</p> <p>5.4.2 Factors that influence help-seeking;</p> <p>5.4.3 Students tendency to use help-seeking services on campus;</p> <p>5.4.4 Awareness of services;</p> <p>5.4.5 First line interventions.</p>
<p>5.5 Recommendations to improve help-seeking on campus</p>

5.1 Mental health awareness

5.1.1 Degree of mental health awareness

Participants were asked if they believed they were knowledgeable enough about mental health care. From the responses received, one (1) out of thirteen (13) participants stated that they felt they had enough information about mental health, and eight (8) out of thirteen (13)

participants felt that while they did have some information, it would never be enough because it is such a vast topic and there is always a lot more to learn and educate yourself on. However, they did feel like they knew enough to know at what point they would seek help or were able to recognize when a friend or family member needed to seek help. Some participants said:

“I feel like mental health care is such a vast and continuously improving aspect and I always feel like I am learning more every day but yes I do feel like I know enough to know when to seek help or tell a loved one to seek help” (Ishan).

“I do understand the basics of it; however, I wouldn't say that I am in complete understanding of how the human mind works. But I think I know enough to understand when a person's mental health needs to be taken care of and when to take care of mine” (Kiara).

Contrastingly four (4) out of thirteen (13) participants explained that they did not have adequate knowledge about general mental health.

“No, I do not, I feel like there is a range of health care out there and what we are exposed to is selective and mainstream. I feel like I don't know enough” (Mia).

“No. not really, would be nice if there were like free trial sessions or workshops where we could learn more” (Bianca).

“To be honest I'm not . . . most of my knowledge has come from social media. College and workplace and family never placed any emphasis on this topic” (May).

The excerpts provided above assists in understanding that levels of mental health awareness vary based on different types of exposure. Participants mentioned that the topic of mental health is a very broad topic and could be overwhelming when trying to learn and educate oneself. Not knowing where to go to get adequate information was discussed as a difficulty.

5.1.2 Definitions: Common concepts

Participants were asked questions about their knowledge and awareness of basic mental health concepts specifically ‘mental health and ‘mental illness. All thirteen (13) participants were able to describe to some degree what these concepts meant or what they believed they meant. Four (4) main themes emerged from participants' understanding of mental health which were a) ability to handle stressful situations (five (5) participants), b) mental well-being (eight (8) participants), c) state of mind (three (3) participants) and self-care (one (1) participant). For example:

“Our state of mind and the way it's affected by other factors” (Mia).

“It deals with the mental state of your wellbeing, which includes dealing with your emotions. More so around how you think, act and feel and having a healthy balance in that area, as well as how we handle different situations” (May).

Common terms from participant understanding of mental illness included ‘disease’, ‘condition’, ‘disorder’, and ‘chemical imbalance’.

“Mental illness is a disorder that affects one's thought processes, emotions and behaviour. It affects how we feel and respond to our surroundings and situations we may find ourselves in” (Megan).

“It is a disease or condition or chemical imbalance in the brain that affects the way an individual thinks and acts and also affects their mood” (Kaylen).

Participants demonstrated a general understanding of mental health and mental illness through expressing what they thought were key words, expressions and mental health conditions to form a complete definition. Some participants solely mentioned one or two key words e.g. mental state or well-being and some participants were able to provide a broad definition.

5.2 Hinduism: Dichotomy of perceptions

5.2.1 Influence of religion on behaviour and thoughts

Some participants believed that their religious backgrounds (being Hindu) did not influence the way they think or behave. When probed about whether they thought religion influenced other young adults' thoughts and behaviour, all thirteen (13) participants seemed to agree that it does. Participants shared that it was their personal experiences that led them to believe that Hinduism does not influence their thoughts and behaviours, but they strongly believed that this would not be the case with other young Hindu adults.

“Yes it does, because the spiritual guides/masters we have, tend to direct or guide based on the lack of education on certain topics like mental health. They often express their dated and subjected views as supposed to being objective and trying to raise awareness. Unless you have your personal experience, this is what we are exposed to” (May).

Some participants stated that while Hinduism does influence their thoughts and behaviour to an extent, they were able to separate what they thought was right and wrong and make decisions based on specific situations and circumstances.

“To a certain extent yes it does. I grew up in a religious home where prayer and faith in God were a crucial part of my upbringing. We were expected to attend services at the temple, part take in prayer meets, and live our lives per our scriptures. While there are certain aspects of my religion I fully believe in, there are things that I do and have developed my views and perspectives on” (Megan).

The remaining seven (7) out of thirteen (13) participants all believed that religion (Hinduism), has a significant impact on the way they think and behave. Many stated that it has been intertwined with how they were raised and was enmeshed in their value system.

“I think my religion influences my behaviour in almost every aspect because I believe I'm quite a religious person and I try to govern my life according to how God has ordained us. I think also, from the time we're young, we are taught basic religious principles regarding what's right and what is wrong, and this is what I believe and follow” (Keenan)

“Most definitely, we are for the most part how we were raised to be. Although Hinduism does influence certain negative aspects, it, however, teaches us about a sense of family and being there for each other. It is not all bad to have that influence because like with anything, it does have bad and good influences” (Mia).

The interview samples provided above demonstrated that although majority of the participants felt like their religion strongly impacts the way they think and behave, there were participants who had slightly different beliefs. Some participants believed that their religion may influence their thoughts and behaviour, but they were able to use the value system they were taught (which differ from religious values) to differentiate between what was right and was wrong. These participants said that if their religious values stated that a certain topic was wrong or against these religious beliefs, however if they still believed that this topic was right that they would choose to go with their own beliefs over their religious beliefs. However, participants mentioned that they do use religious values as a guiding system, but it was not rigid.

5.2.2 Influence of religion on perceptions toward mental health

Participants were also asked about what influences the way they perceive and view mental health. Three (3) main influences arose: 1) family/friends, 2) personal experience/exposure to others; and 3) religion (Hinduism).

Among the participants, seven (7) out of thirteen (13) participants stated that their family and friends were the biggest influence on how they view and understand mental health. Many participants said that they had accepting and understanding family and friends and they don't feel judged by them. Therefore, they feel more comfortable speaking about mental health, whether it's their own or someone else's because they know they have a safe space within their family and friend circle. They also highlighted that their family and friends had a lot of empathy for people who have mental health difficulties, and they ensure that they are well informed about the topic.

“If I could pinpoint one aspect that really influenced how I feel about mental health and why I'm so positive and open about it, I think it's my parents. They were very open about going to a therapist and speaking about your problems. Getting help for your mind was always okay and there was never any judgement, so it made me feel comfortable about the topic” (Keenan).

When probed three (3) out of thirteen (13) participants shared that their own experiences with mental health and/or exposure to others with mental health conditions were the main influence on how they perceive mental health. Many stated that going through depression, anxiety, etc. made them understand the topic on a much deeper level and increased their personal empathy.

“I have dealt with my anxiety issues in the past, and it has definitely changed the way I view mental health now. It was something that I judged because I was poorly informed. My personal experience has shown me that you shouldn't be in denial or ashamed of how you cope with your feelings” (Kiara).

Other participants stated that watching their family/friends struggle with mental health difficulties has made them more empathic and has made them educate themselves on the topic.

“Mostly my dad and mum. My dad has been dealing with mental illness for a long time and my mum who is a nurse has always placed importance on this as something that always needs to be treated through proper methods like psychology and psychiatry. Watching my dad go through difficulties, made me much prepared and well informed when my anxiety issues began” (Ishan).

When asked, three (3) out of thirteen (13) participants mentioned that being Hindu influenced the way they think about mental health. All three (3) participants said that they would turn to their faith in God first and it was their God that got them through difficult phases of their lives. Participants also mentioned that mental health as a topic was not something of significance in their families, however, faith and religion were.

“Religion influences my perceptions on mental health because in a stressful situation I turn to God, not to a psychologist/psychiatrist or medication. My religion teaches me to be strong and God will help me through my difficult times” (Adam).

“I have experienced pits in life where my mental health had taken a dip and just felt like everything was crashing and burning around me. I felt that there was no way out of it. However, my faith in God and religious scriptures had helped me overcome these situations” (Megan).

Additional Information: It was important to note that there were five (5) out of thirteen (13) participants highlighted that to a certain extent, they believed a significant amount of stigma and shame about mental health stemmed from the Indian community/society and not particularly Hinduism. Participants mentioned that as a Hindu, our scriptures teach us to be understanding, non-judgmental, and accepting however not everyone follows these teachings. They believed that Indian communities breed these judgemental ideologies and this stems from

the need to be perceived as ‘perfect’. When families go through difficulties for example mental illness, it is highly judged and ‘looked down upon’.

“It stems from society, certainly not religion. I feel that the in the Indian society it is highly stigmatized, and people don’t like how it would make their families look’. Hinduism teaches us acceptance and understanding, but this is not always followed in our communities. Society only accepts it when they see people of their own go through it or they personally go through it” (Adam).

5.3 Stigma

Stigma is a common theme that arose from multiple questions during interviews. Although many participants thought that stigma related to religion and culture, had a significant impact on mental health awareness and help-seeking, it was important to note that three (3) out of thirteen (13) participants stated that they thought there was no stigma or shame associated with mental illness or help-seeking.

“I don't think that Hinduism presents any barriers at all. Hinduism is about acceptance and non-judgement so there should be no stigma related to it” (Kiara).

“I personally don't think there would be any shame or stigma that would arise within the Hindu community if a person had to see a mental health professional” (Bianca).

“In the past yes, seeking mental health had a stigma attached to it. But nowadays it’s okay and sometimes good to seek help if you need to” (Adam).

The excerpts above demonstrate that some participants felt that the Hindu community would be accepting and understanding of people with mental health conditions and those who see a mental health professional. These beliefs stem from what participants called ‘core Hindu

values. These values preach acceptance and unconditional love; therefore, participants had no doubt that there would be no stigma associated with mental health.

The concept of public and personal stigma emerged during interviews. Among the thirteen (13) interviews conducted, two (2) participants highlighted that a contributing factor to Hindu students not seeking help would be their personal biases and stigma.

“Maybe the student knows he/she needs to seek mental help, but they cannot find within themselves to ask for help because that’s not the type of person they are. Maybe they think that getting help means you are weak. It becomes a personal conflict” (Adam).

“I feel like more so now, many people's mental health is deteriorating. Stigmas around mental illnesses and their validity of it interfere with the need to deal with and resolve mental health conditions. The feeling of being less than, disabled, or not being able to receive the same respect or be valued as a human, are genuine issues many people who have poor mental health must deal with which amplifies why they may not want to seek help” (Priya).

These two participants strongly believed that the only factor that would prevent someone from seeking help would be personal stigma. Participants discussed that a person’s own negative thoughts and perceptions would influence their decision to seek help, regardless of their community and family being supportive.

The issue of public stigma was shared by eight (8) out of thirteen (13) participants. They believed that the main contributing factor to a Hindu student not seeking help would be the external stigma attached to it, from their families, friends, and their respective communities.

“Stigma around mental health and mental illness among Hindus, or generally with people of colour, makes it uncomfortable to have an open conversation. If you had

to tell someone you are mentally ill, they would assume you are retarded or crazy. Many young Hindus tend to feel suffocated with not being able to vocalize their stressors influenced by the stigma, many still hold onto this, in turn, deteriorates their mental health which makes them more prone to mental illnesses” (Jay).

Other participants shared very similar beliefs about the Hindu community, whereby a major concern would be the shame brought on their families if they were to seek help or be diagnosed with a mental health condition. How would their families be portrayed if someone in their family had mental health conditions.

“Hindu community is a big contributing factor, ‘because what would the neighbours say?’. What would family and friends say if they knew. They would mock and laugh at us and know that our family is having problems” (Priya).

Many mentioned that older family members perpetuated these thoughts and would not understand the importance of maintaining good mental health.

“I grew up watching the older family members believe that mental health had more to do with prayer and God than it did with medical science, and I now definitely see the need for more education on this and I hope to see more people who are open to talking about this issue publicly and educating the younger generation” (Ishan).

“The older generation don't seem to understand the concept of mental health, and that it's an actual issue in society. They are constantly in denial of it. They view psychiatrists etc as people who deal with "crazy" or “mad” people. So, they don't believe that their kids should be evaluated if necessary and labelled as such” (Kiara).

5.4 Help-seeking behaviour

5.4.1 Barriers to help-seeking

When participants were asked about what they believed the main barriers to help-seeking were among Hindu students, two (2) out of thirteen (13) participants said there were no barriers that would prevent Hindu students from seeking help. Conversely, two (2) out of thirteen (13) participants mentioned that religion would be a contributing factor to students seeking help. When probed, five (5) out of thirteen (13) participants stated that they believed a lack of understanding and lack of mental health awareness among their family, friends, and community would make students hesitant to help-see.

“Because of our background and past, parents and grandparents may feel that their ancestors never had these problems before so why we are coming forward with this, saying we’re mentally ill and they sincerely believe it to be a phase in your life that you’re just going through. They do not have the information or knowledge about mental health; therefore, they lack understanding and empathy for those going through it” (Lee).

“I think that possible barriers would be the misconceptions; ‘mental illness isn’t really an illness’ or ‘pray to God and you’ll be fine’ are the most common that I’ve always heard others say. I think that most Hindus rely too much on a ‘trance’ to treat these problems instead of actual trained professionals. They are so poorly informed, which leads to low levels of understanding and empathy” (Ishan).

The interview samples above demonstrate that these participants felt like a lack of mental health awareness amongst the Hindu community would be a contributing factor to not seeking help. Participants mentioned that people have misconceptions because they do not have enough information or understanding about what mental health is and more importantly, the

repercussions of not seeking help. These participants stated that they believed if people understood mental health more, then this would promote more acceptance and negate any stigma attached to it.

Among the thirteen (13) participants interviewed, nine (9) participants said they felt stigma would be the main factor in students choosing to not seek help.

“I think it could be a lot of things but specifically what people will think of them, especially those in their community because mental health and getting help for it is still taboo. People also don't take mental health and speaking about your problems seriously, they'd prefer keeping quiet about it and it's also got to do with our society, we worry a great deal about what people think and we want to be perceived as perfect” (Keenan).

Participants discussed that they believed public perception of a person played a big role in perpetuating stigma. According to these participants, families within the Hindu/Indian community promote having the ‘perfect’ public image. Being the best student (always getting all A’s with nothing less than 90%), never getting into any trouble and always behaving according to what the community promotes as ideal (which includes being perfect physically, emotionally and mentally) is how a person should live. Participants shared that they believed there was no room for error, making mistakes or being anything less than perfect.

“When parents hear you say you went to see someone or seek help, immediately they think you're mad. Without even asking or finding out what the actual problem is. I also feel like they're so worried about what other people will say it's insane. There is a lot of embarrassment related to mental illness. That's one of their biggest reasons. Also, they feel like it's just a phase and it'll pass. And what more stressors can a young twenty-

three (23) year old have, they live well, have a job, and have their family what else do they need. They do not understand that mental illness can affect anyone” (Leo).

5.4.2 Factors that influence help-seeking behaviour

Participants were asked questions about help-seeking behaviour, particularly about what influenced their decision to either seek help or not. Five (5) main categories emerged: 1) family/Friends, 2) personal values, 3) personal history/exposure to others, 4) religion; and 5) social media (certain participants may have mentioned more than one category in their response). Among the responses received, eight (8) out of thirteen (13) students believed that their family and friends had the most influence on whether they would seek help or not. Participants said that their decision would be based on their families'/friend's perception of help-seeking (whether their family accepts it or not). Participants also mentioned that they would speak to their family/friends first and get advice on what the next step would be.

“I think I am fortunate enough to have a good support system (family/friend) around me. I think I will first turn to them for advice on what to do” (Megan).

“The main influences on whether to seek help would be my family and friends. I would assess what they would think about seeing a professional and base my decision on this” (Kaylen).

Ten (10) out of thirteen (13) participants mentioned that to some extent, they would base their decision on their value system, and they would need to assess the situation for themselves and then decide.

“I would seek help If I'm I am in a position whereby, I am unable to perform the way I ordinarily would. This would be a decision I would make by and for myself” (Lee).

“I would seek help if need were, I would do it for me not exactly because someone else influences me to do so. I would use my value system to assess the situation first and they decide” (May)

Analysing the excerpts above, majority of the participants believed that the decision to seek help or not would be something they decide for themselves. Relying on their personal value system, religious value system and assessing the situation personally would be some of the factors they would use. Participants believed that every individual’s circumstances are different, therefore they would use their discretion with regards to how they feel and the severity of how they feel to decide if they would seek help or not.

When asked if their personal history with mental health and/or exposure to others with mental health difficulties would influence their decision to seek help or not, seven (7) out of thirteen (13) participants believed it would influence their decision. Participants mentioned that going through mental health difficulties like depression and anxiety has forced themselves and their families to become more well-informed and receptive to help-seeking. It was also mentioned that having friends and family members struggle with mental illness influenced the way they view help-seeking.

“Someone close to me suffered with anxiety and it was so bad, and the parents of this person were in denial about this person's condition, and it was severe. Nevertheless, this person decided to seek help and was on anti-depressants and I supposed it helped. So based on this person's experience, I know if I'm really in a difficult place mentally, I would seek help knowing it's for my benefit” (Lee).

Being exposed to someone who has mental health difficulties appeared to positively influence participants. The interview sample above demonstrates that the participant’s

experience watching a friend struggle would motivate and encourage them to seek help because they saw first-hand how beneficial it can be.

Among the interviews conducted, three (3) out of thirteen (13) participants believed that religion influenced their decision to seek help or not.

“My religion would influence my decision to see a professional or not. Hinduism helps me spiritually connect with someone Higher than us all and I feel like that's so important to stay grounded. My values and morals align with my religion to also help me see wrong from right. It's always such a content feeling knowing that there's someone out there or up there who can protect you, therefore I would rely on scriptures to guide me whether to seek help or not” (Leo).

“Religion would be the influence, as it provides a way to cope in that it allows us to view our issues in a way that can be resolved by a higher being. God would guide me to whether I can cope alone or if I need professional help” (Mia).

The interview samples provided above demonstrate that some participants do rely on their religion (in this case it would be Hinduism) to guide any decisions they make, including whether to seek help or not. These participants believe that their religion provides a foundation and guiding system and during difficult times, they would turn to religious scriptures or God to assist them in deciding to seek help or not.

The impact of social media and how the information they receive via social media influences what they think about help-seeking was discussed by four (4) out of thirteen (13) participants.

“Reading stories of people on social media who were going through the same things as myself, made me feel validated for the way I felt. It wasn't just something made up in my head. I think seeing the growing community with regards to mental

health and all the info available on social media, influences me to do better, educate and be brave enough to seek help” (Megan).

“Social media has had the greatest impact on my view of seeking help. Reading posts about how one should care for their mental health, and being able to relate to others makes a difference. It has shown me that you shouldn't be in denial or ashamed of how you cope with your feelings and that seeking professional help is a positive and courageous thing” (Kiara).

The impact social media has on mental health awareness was discussed by some participants. Participants shared that social media has had a positive influence on how they view mental health and help-seeking. Some thoughts discussed were that social media allowed them to feel heard and connected to others who were experiencing the same difficulties as them. It creates a safe platform for people to share their stories and help motivate others to take better care of their mental health. Participants said that social media helps promote mental health, breaking any related stigma and allows for easy access to information and resources.

5.4.3 Students tendency to use help-seeking services on campus

Various influences on help-seeking were discussed above. These influences have had an impact on participants' help-seeking behaviour in the past and will have an impact on future help-seeking. Participants were asked if they have used the free on-campus services in the past, and five (5) out of thirteen (13) participants stated that they have made use of these services, conversely eight (8) out of thirteen (13) participants stated that they have not used the free on-campus services in the past. When asked about future help-seeking behaviour, ten (10) out of thirteen (13) participants said that would most likely use the free on-campus services if they needed to and three (3) out of thirteen (13) participants said they would not use the services.

5.4.4 Awareness of services

When asked if participants knew of existing free services on campus, eight (8) out of thirteen (13) participants said that they were aware of the free counselling services. Among the thirteen (13) participants interviewed, five (5) participants said they did not know that the campus offers free counselling services to students. This data shows that although eight (8) participants knew that the campus provided these services, only five (5) participants (mentioned above), made use of it, which tells us that although students may know that these free services exist, they may not be making use of them.

5.4.5 First line interventions

When probing participants about what their first line intervention would be, three (3) main categories arose. The first was family/friends which seven (7) out of thirteen (13) participants mentioned. These participants felt like they would approach their family and friends first and speak about their problems. Referring to religious scriptures and utilizing prayer first were mentioned by four (4) out of thirteen (13) participants. The remaining two (2) participants said that they would seek psychotherapy immediately if they were experiencing any difficulties.

5.5 Suggestions to improve mental health awareness and help-seeking

Various options were mentioned to improve both help-seeking and mental health awareness among Hindu students on campus. The most popular suggestion was for more campaigns/workshops recommended by nine (9) out of thirteen (13) students. Participants stated that even if there are currently workshops being held, these are not well advertised. Having more fun and interactive workshops was highly recommended.

“For Hindu students and students in general, I feel like maybe having. How do I say it. Like sort of informal meetings or just fun ways how to tell them about mental

health? Maybe, calling them during their break one of the days on campus, setting up a little tent, and making them do fun activities, like a fun thirty (30) seconds or five (5) second rule game - all about mental health. And then talking about the important points on why they should focus on mental health” (Leo).

Participants suggested two (2) main focuses of these workshops: a) workshops that are symptom-related (suggested by three (3) out of thirteen (13) participants); and b) workshops that are awareness and stigma related (suggested by four (4) out of thirteen (13) participants). Symptom-related workshops could highlight what students should look out for and preventative measures for good mental health. Awareness and stigma-related workshops could focus on breaking mental health stigma and creating a safe and non-judgmental place to promote awareness on the topic.

Integrating Hindu teachings with mental health awareness through the Hindu student’s association on campus were discussed by seven (7) out of thirteen (13) participants. Participants stated that these student organizations should facilitate meetings with mental health services on campus and collaborate to host fun days, workshops, etc.

“I think the Hindu student council should facilitate programmes on mental health/illness and care on campus. By promoting this, Hindu students will not feel stigmatized or that their feelings are invalid just because they belong to a certain religion. They will become more aware and know that it has nothing to do with religion but it’s all part of being human” (Megan).

“I know that there’s a Hindu society on campus and I feel like while it’s important to have these groups, I also feel like it should be a goal of theirs to help Hindus seek help and address the taboos and stigmas that surround mental health. Temples and other religious groups should be talking about this and encouraging

members and the like to always seek help and not just pretending like it doesn't exist”
(Ishan).

Among the interviews conducted, two (2) out of thirteen (13) participants stated that the mental health services offered on campuses were not well advertised, especially now during students studying off campus, etc. Many first students never spent any time on campus and are completely unaware of these free services offered.

“I think the university needs to create more awareness in the form of advertising, putting up information on Learn and the UKZN website. Many students don't have enough information on mental health, and they don't even know that there are services provided for free at the university” (Keenan).

“Since most students have been working remotely for the past three (3) years, many of us are unaware of the resources available at campus to assist students in this aspect. So perhaps the campus should promote these services to make students aware”
(Kiara).

An additional idea presented by one (1) participant was having support groups specifically for Hindu students, which could be facilitated by the Hindu student's association as well as other Hindu mental health professionals could create a safe space for students to speak about stigma-related concerns.

“Creating support groups that have other people as well as Indian health professionals that they can identify with to ensure that they feel accepted in their mental health battle so that they don't feel alone. Because it is a minority group it is difficult to find interventions that are refined to that demographic. In those support groups, there could be emotional coping skills that can be shared” (Mia).

Having a compulsory single term module or workshop related to mental health would ensure that all students would be well informed about topics related to services offered and symptoms thus increasing awareness and the probability of help-seeking in the future was discussed by one (1) participant.

“Incorporate a compulsory elective on mental health where students who have no interest in partaking in campaigns or talks, to at least have a background understanding of mental health” (Adam).

Discussion: Integration of findings with research objectives and literature

The following section will delve into integrating the findings displayed above with the objectives of this study as well as comparing and examining the findings within the context of other studies and literature from chapter two (2).

5.6 Exploring Hindu students’ beliefs and views towards mental health at UKZN

Overall, participants had an open and accepting view of mental health and believed that people with mental health difficulties should be treated with the same respect and love as any other person would. These findings align with a study examining MHL among university students which found that sixty-eight-point seven percent (68.7%) of students stated they could be friends with someone diagnosed with a mental illness and that these people should be awarded the same human rights and respect as everyone else (Mahfouz, *et al.*, 2016).

Having prior exposure to someone with mental health difficulties or having a personal history of mental health difficulties appeared to have a significant impact on a student’s beliefs and views about mental health. Watching family, friends, or acquaintances struggling with their mental health, made them more empathic and encouraged them to educate themselves on what the person was going through, thus, changing the way, they may have viewed mental health previously. Gorczynski *et al* (2017), yielded similar findings from their study stating those

students who had prior exposure to mental health difficulties (through themselves or others), had a better understanding of the issues.

Participants commonly shared that they believed mental health was an important part of our general health and that despite their personal feelings about it being important, within their communities, mental health was not taken as seriously as physical health. Low levels of MHL within their communities were greatly highlighted, and these findings can be substantiated by Singh *et al.* (2022), who found that levels of MHL differ by population, and higher levels of MHL were demonstrated by developed countries and lower levels of MHL were linked to developing countries.

Participants stated that low levels of MHL would perpetuate stigma and a lack of empathy towards people with mental health difficulties. These findings are closely aligned with previous study findings which state that low MHL would also result in higher levels of stigma which would subsequently deter any help-seeking or treatment (Gulliver *et al.*, 2010). All participants made some reference to stigma, lack of understanding, and the fact that mental health within the Hindu community was still a taboo topic, and something not openly spoken about in their homes. These findings have been reiterated by Gopalkrishnan (2018) who stated that within the Hindu Indian population, mental illness is still viewed as 'being crazy' and has been linked to shame and embarrassment, creating a skewed perception of mental health.

Participants overwhelmingly agreed that levels of mental health awareness at the campus was low and expressed a wish for more awareness campaigns, posters, and general attempts at raising awareness. Participants believed that although resources and services exist, little to no attempt was made to advertise or draw students in. Disappointment towards the relevant departments and stakeholders were expressed, stating that the key to educating and informing students was to ensure that services and resources were well advertised, and every

student should be made aware of what assistance is available to them. Adams *et al.* (2010) highlight the issue of campus culture and how this may influence students' views toward mental health. Each institution may have a differing but specific set of cultural beliefs, however believing that counselling services are not provided, believing that these services are inaccessible, and believing that mental health care is not viewed as a priority may be part of these cultural beliefs and maybe a huge contributing factor.

Although most participants had some idea of what mental health and mental illness meant, all responses encompassed pieces of definitions. They were unable to provide complete and well-rounded responses, which further amplifies that MHL among university students is low. Depression and anxiety were the two (2) main disorders highlighted by participants, indicating that although they have some knowledge, students are unaware of other common disorders affecting people their age, which could lead to delayed help-seeking and poor mental health outcomes. Jorm *et al.* (2012) shared similar findings, which showed that low MHL meant that people would not be able to identify early onset and symptoms which in turn would delay any possible treatment or help-seeking.

The way mental health is perceived was also directly correlated to the probability of help-seeking. Participants shared that if mental health was perceived positively, then students would be more likely to seek help and inversely if mental health is perceived negatively, students would be hesitant to help-seeking.

5.7 Exploring barriers to mental health help-seeking among Hindu students at UKZN

Throughout the interviews, participants mentioned various potential barriers they thought might hinder the help-seeking process for students. The responses were often overlapping, and participants seemed to have picked up three (3) main barriers: stigma, lack of

understanding (low MHL), and religion. Shahwan *et. al* (2020), yielded similar results and found that low MHL and stigma were some of the main deterrence to students wanting to seek help.

Stigma was resoundingly the most common barrier mentioned by participants. Both public and personal stigma were highlighted with the former being mentioned the most. These findings can be substantiated by Eisenberg *et al.* (2009), who found that perceived public stigma was considerably higher than personal stigma. Participants associated personal stigma to an individual's negative ideas and beliefs about mental health stemming from what they understand and believe about the topic. Public stigma was related to ideas and thoughts stemming from an individual's family, friends, and other external influences. Eisenberg *et. al* (2009), have explored these two (2) concepts linked to help-seeking and have found these concepts to be directly linked to a lack of help-seeking.

As mentioned above, stigma (both public and personal) is closely associated with a lack of awareness and understanding. Participants directly linked feeling ashamed and embarrassed as a barrier to help-seeking. Bringing shame to their families was highlighted, as participants felt many homes and communities were not fully accepting of those who have mental health difficulties.

Participants further mentioned that mental illness was something looked down upon within their communities and they strongly believed if people (particularly the older generation), were better educated on the topic, the level of stigma and shame associated with the topic would significantly drop. Participants shared that people fear what they don't understand, therefore if attempts to educate them were made, many misconceptions and myths may be broken. Gulliver *et. al* (2010) reiterated these findings by stating that improving MHL is imperative to help-seeking as well as improving general mental health outcomes.

A lack of understanding (low MHL) and information were highlighted as possible barriers to help-seeking. Participants shared that, being poorly educated, not having access to resources as well as misinformation could serve as a major deterrence to students seeking help. Participants mentioned the lack of understanding could come from the student or families/communities however both sources would directly impact help-seeking. Not understanding the severity of mental illness, understanding that there are treatment options, as well as understanding symptoms and their impacts, could hinder help-seeking among students. Andersson, *et al.* (2013), share similar findings and state the inability to understand mental health care, treatment options and outcomes hinders the possibility of any help-seeking. These have been linked to the increased stigma which perpetuates the cycle of being embarrassed or afraid to seek help.

Religion as a barrier to help-seeking was also mentioned by participants. People have faith in and understand aspects of their religion on a deeper level, therefore may assign explanations of symptoms as well as treatment options toward religious pathways. Participants shared that the topic of mental health was not something commonly addressed and if someone in their family had any mental health difficulties, the older generation (grandparents and other elders), would refer them to priests and temples instead of seeking help from a mental health professional. Hernandez *et al.* (2009) found comparable results about the impacts of culture and religion and their influence on how symptoms are viewed, how mental health is understood, and possible treatment options.

Participants also highlighted the fact that students do not live in a bubble and the religion and communities they come from affect the way they think and behave. Therefore, tackling the issue of mental health may lie within the community first. If students felt more comfortable and didn't have to worry about being embarrassed when dealing with mental health, perceptions may change positively, and instead of being denied that mental illness

exists, it would be accepted with more empathy and understanding. US Department of health and human services (2011) compiled a report that similarly states the importance of examining the impact and influence of culture and religion on attitudes towards mental health care and help-seeking. The report highlights that a person's religion and culture are intertwined in who they are, and their thoughts and choices were directly influenced by it.

5.8 Understanding how Hindu culture influence the decision on whether to seek help for mental health care among Hindu students at UKZN

All participants in the study mentioned that their religion/culture had some influence on their willingness to seek help or not. Although, participants did differ in responses with regards to whether it influenced them positively or negatively.

Some participants strongly believed that their religion played a significant role in whether either themselves or other young Hindu students would seek help. Participants stated that there was a large focus on prayer and rituals in Hinduism. Parents, grandparents, and other elders in the family and community would tend to encourage those experiencing mental health difficulties to pray and put their faith in God as opposed to seeking help from a mental health professional. Gopalkrishnan (2018) and Hechanova and Waelde (2017) reiterate these findings to which they believed that culture and religion significantly influenced methods of help-seeking, to the degree of turning to religious paths for treatment whether it be temples or priests as first-line interventions.

Participants further believed that certain symptoms of disorders like delusions and hallucinations would be attributed to spiritual possessions (trance) and ancestors and treatment options would mainly include prayer and seeking guidance from priests. Khosla *et al.* (2020), similarly found that witchcraft and spiritual possessions play a key role in Hinduism and for centuries have been used to explain many symptoms of various mental health disorders.

These ideologies and beliefs were passed on through generations and proper information on mental health care was not provided. Participants shared that this misinformation has created many misconceptions about mental health care hindering any help-seeking. These misconceptions give rise to many stigmas and stereotypes about mental health care. Participants stated that it was impossible for young Hindus today not to be influenced by these religious beliefs because it is part of how we are all raised, and we are largely influenced by our families and communities. Therefore, religion (Hinduism) does directly impact the probability of help-seeking on campus.

On the contrary, some participants believed that their religion would positively impact help-seeking. Some participants shared that attending religious services and prayer meetings at the temples kept them grounded, taught them discipline, and allowed them to engage with like-minded people which had a positive impact on how they viewed the world and themselves. Literature does show that engaging in religious and spiritual activities has multiple benefits towards promoting better mental health behaviours (Kurahde *et al.*, 2022).

Participants believed that the proper teachings of Hinduism should foster acceptance, and understanding and should cater to an individual's specific needs whether it be prayer or counselling. Participants stated that the true essence of Hinduism teaches us about healthy minds and bodies and striking a positive balance. Participants felt that taking care of their mental health would be something accepted and encouraged in true Hinduism. Therefore, students should feel comfortable with help-seeking, and it would be seen as a positive step. There are similar studies that substantiate these findings about the positive correlation between Hinduism and good mental health care practices. Francis *et. al* (2008) and Nandika and Nagalakshmi (2022) yielded comparable results which revealed that higher degrees of religiosity were linked to higher levels of probable help-seeking and positive attitudes towards general mental health.

These two (2) opposing views pose an interesting question about what would influence participants in answering so differently. An additional set of responses during interviews may serve as an explanation. Participants referred to their religion (Hinduism) and their communities (Indian communities) and believed Hindu beliefs and scriptures were influenced by societal beliefs and values, therefore producing two (2) different ideologies. Sometimes our religious beliefs may become entangled with societal norms, values as well as attached stigma. These contradicting responses may indicate that although we may belong to the same religious group, the values and morals we are taught may significantly differ.

5.9 Chapter summary

The previous chapter comprehensively outlined the steps and procedures followed during the data collection and data analysis process. This chapter presented all the findings that emerged once data was analysed. The five (5) umbrella themes that emerged were broken down to form sub-themes and these themes and sub-themes were tabulated at the beginning of this chapter. Thereafter each theme and sub-theme was presented in detail. Samples from the transcribed interviews were provided under the relevant themes and sub-themes. This assisted in deepening the understanding and integration of the themes and sub-themes. These excerpts provided a unique opportunity to the reader to understand the themes and sub-themes through the participants actual words and further enhanced the credibility and transparency of the research. This chapter further elaborated on the findings of the study by exploring and discussing it within the lens of the objectives displayed in Chapter one (1). The findings were also discussed and compared to previous studies and literature within the study field.

CHAPTER 6: CONCLUSION, REFLECTIONS, LIMITATIONS AND RECOMMENDATIONS

6.0 Introduction

The previous chapter presented and outlined all findings in this study. This chapter concludes the study by reviewing the purpose and objectives of the study and highlighted relevant findings within the context of previous literature. Reflections of the researchers experiences throughout this study are explored in this chapter. This chapter further examines limitations that the current research may have encountered and remedies to these limitations. This chapter concludes by exploring recommendations for future research.

6.1 Conclusion

The purpose of this study was to explore mental health literacy and awareness of help-seeking among Hindu students at UKZN. In doing so, it attempted to provide an understanding of mental health literacy and help-seeking behaviour of Hindu students in relation to any religious/cultural understanding of mental health presentations.

The findings of this study were in correspondence to previous findings of other studies done, although it did bring out new and vital information about a specific population group, that can contribute to increasing the knowledge we have about mental health and help-seeking. Context-specific and population-specific research is imperative, as these can largely influence mental health outcomes. Findings have established that there exists a lack of mental health awareness among Hindu students at UKZN.

Some of the main findings in this study highlighted that overall, participants had an open and accepting view of mental health and believed that people with mental health difficulties should be treated as equally as everyone else. This study also highlighted the

various barriers that Hindu students at UKZN may face concerning help-seeking. Furthermore, findings have highlighted stigma linked to a lack of mental health literacy (MHL), as possibly the main barrier to help-seeking. Participants commonly shared that they believed mental health was an important part of our general health and that despite their personal feelings about it being important, within their communities, mental health was not taken as seriously as physical health. Low levels of MHL were a serious concern. Participants stated that low levels of MHL would perpetuate stigma and a lack of empathy towards people with mental health difficulties. Bringing shame to their families was highlighted, as many homes and communities were not fully accepting of those who have mental health difficulties. Mental illness was something looked down upon within their communities and it was strongly believed if people (particularly the older generation), were better educated on the topic, the level of stigma and shame associated with the topic would significantly drop.

Results have also confirmed a link between culture/religion (Hinduism) and the way mental health is perceived and understood, but also highlighted a new aspect which is societal norms (Indian societies). Religion as a barrier to help-seeking was highlighted. People have faith in and understand aspects of their religion on a deeper level, therefore may assign explanations of symptoms as well as treatment options toward religious pathways. It was strongly believed that religion played a significant role in whether either themselves or other young Hindu students would seek help. Participants stated that there was a large focus on prayer and rituals in Hinduism. Parents, grandparents, and other elders in the family and community would tend to encourage those experiencing mental health difficulties to pray and put their faith in God as opposed to seeking help from a mental health professional. Participants further believed that certain symptoms of disorders like delusions and hallucinations would be attributed to spiritual possessions (trance) and ancestors and treatment options would mainly include prayer and seeking guidance from priests.

However, it was also concluded that both positive and negative cultural/religious influences were emphasized. Participants believed that the proper teachings of Hinduism should foster acceptance, and understanding and should cater to an individual's specific needs whether it be prayer or counselling. Participants stated that the true essence of Hinduism teaches us about healthy minds and bodies and striking a positive balance. Participants felt that taking care of their mental health would be something accepted and encouraged in true Hinduism.

Other important data that emerged from this study was the positive influence that prior history or exposure to others with mental health difficulties has on mental health literacy and awareness of help-seeking. Family/friend influence, personal bias, and social media were also highlighted as influences on help-seeking among Hindu students at UKZN.

Other conclusions to be drawn from this study was the need for more to be done to promote mental health and educate students on campus, however it also highlights the important need to examine the communities that students come from much closer. The key to increasing help-seeking and mental health awareness among students may be targeting their communities first. This may lead to decreased stigma and misconceptions.

6.2 Researchers' reflections

As a researcher, it is important to reflect and be aware of any judgements, prejudices or biases during the research process. As an Indian, Hindu student, the research topic was of high importance to the researcher and personal experiences and observations did influence the birth and conception of this research topic. Coming from within the research population, efforts were made to ensure personal knowledge and opinions did not skew or influence the research process or outcomes. Being enmeshed in the religion and culture may be viewed as a disadvantage and having an unbiased view of the topic may be of concern however, one way of ensuring this did

not happen was that relevant literature was sourced and referenced wherever necessary to back up and support any claims made by the researcher. The researcher ensured that data was literature and participant driven.

Prior to the research, the researcher may have had personal opinions about the topic, and it was an interesting and insightful process of learning from participants and expanding knowledge from existing literature. The lack of research within the South African context on Hinduism and mental health was highlighted strongly for the researcher during this process which embeds the need to engage in further research in this area.

Many skills were developed and learnt during this research process, with regards to academic writing, how to conduct interviews telephonically etc. All the ethical guidelines were followed during the recruitment and data collection process to avoid any unethical or unlawful practices.

6.3 Limitations and remedies to limitations

Firstly, the small sample size makes it very difficult to generalize about entire populations as results do show discrepancies among the same population group. A small sample had to be used due to time constraints and the in-depth, qualitative nature of the study. However, some researchers argue that the purpose of in-dept qualitative data is not to generalize but rather to describe and explore that given samples experiences.

Data was collected through interviews, and due to the sensitive and intimate nature of this data collection method, participants may have felt scared to talk freely, and participants could have possibly altered responses to what they believed was expected. However great effort was taken to build rapport with participants during initial telephonic contact and the confidentiality agreement was explained in detail before consent was given.

An important aspect that arose through data collection, was the difference between a student's religion (Hinduism) and belonging to a specific culture/society (Indian). Participants believed there was a vast difference between these two (2) concepts, and this may have not been taken into consideration in the research and interview questions. However, research does allow for new concepts and ideas to emerge during research, and this will be considered in recommendations for future research on this topic.

Another limitation was similarities in participants responses which made analysing and grouping data difficult. For example, once participants began answering the interview questions, they may have mentioned something in question one (1) which would have been relevant in question two (2). However, data was critically analysed using thematic analysis and the use of sub-themes assisted in categorizing the data correctly.

6.4 Recommendations for future research

Research should be conducted on a larger scale, with a larger number of participants to account for discrepancies among the same population group.

Possible quantitative research using surveys may assist in reaching a larger target group. Quantitative research using surveys may also account for students adjusting responses and may be more comfortable responding honestly.

This study only consisted of students between the ages of eighteen and twenty-five (18-25) years. Future studies should have a wider age range to account for this possible limitation. This may result in more inclusive data.

Incorporating and accounting for the difference between religion and cultural/societal differences through interview questions and ensuring that both these aspects were explored exclusively.

Research questions could also be analysed in greater detail and changed to ensure they are not similar and examine different aspects of the study to avoid any overlapping data due to this limitation.

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APPENDIX 1 - ETHICS APPROVAL



18 May 2020

Miss Melissa Moodley (214515128)
School Of Applied Human Sc
Howard College

Dear Miss Moodley,

Protocol reference number: HSSREC/00001286/2020

Project title: Exploring mental health awareness and help-seeking behavior, among Hindu students at the University of KwaZulu Natal

Degree: Masters

Approval Notification – Expedited Application

This letter serves to notify you that your application received on 14 April 2020 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

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

This approval is valid until 18 May 2021.

To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,



Professor Dipane Hlalele (Chair)

/dd

Humanities & Social Sciences Research Ethics Committee
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Tel: +27 31 260 8350 / 4557 / 3587
Website: <http://research.ukzn.ac.za/Research-Ethics/>

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

INSPIRING GREATNESS

APPENDIX 2 - INFORMED CONSENT



UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

School of Applied Human
Sciences, College of Humanities
University of KwaZulu-Natal,
Howard College (Durban)

Dear Participant

INFORMED CONSENT LETTER

My name is Melissa Moodley, I am a Masters in Social Science, Counselling Psychology candidate studying at the University of KwaZulu-Natal, Howard College campus, South Africa.

I am interested in learning about the perceptions around mental health and help-seeking behaviour among South African Hindu students at UKZN Howard College. To gather the information, I am interested in asking you some questions.

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person but reported only as a population member opinion.
- The interview may last for about sixty (60) minutes.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after five (5) years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- The research aims at exploring awareness and perceptions around mental health and help-seeking behaviour among the Hindu student population at UKZN. Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio equipment		

I can be contacted at:

Email: [REDACTED]

Cell: [REDACTED]

My supervisor is Ms. Ntombekhaya Mtwentula who from the School of Applied Human Sciences, at University of KwaZulu-Natal, Howard College Campus.

Contact details: email: mtwentulan@ukzn.ac.za

You may also contact the Research Office through:

P. Mohun

HSSREC Research Office

Tel: 031 260 4557

Email: HssrecAes@ukzn.ac.za

Thank you for your contribution to this research.

DECLARATION

I (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT

DATE

.....

.....

APPENDIX 3 - INTERVIEW SCHEDULE



UNIVERSITY OF
KWAZULU-NATAL

INYUVESI
YAKWAZULU-NATALI

Research Project Title: Exploring Mental Health Literacy and Awareness of Help-Seeking Behaviour including Barriers thereof, Among Hindu Students' at UKZN

Researcher: Melissa Moodley

Research supervisor: Ntombekhaya A. Mtwentula

Main guiding questions

- 1) What do you understand by the term “mental health”?
- 2) What do you understand by the term “mental illness”?
- 3) What are your views on mental health and mental illness?
- 4) Does religion i.e. being Hindu influence the way you think and behave?
- 5) What influences the way you perceive and view mental health?
- 6) Are you aware of any services that provide mental health care on campus?
- 7) have you ever sorted help for mental health care on campus?
- 8) What are some of the things that influence your decision to seek help or not?
- 9) What are some of the barriers you think could interfere with Hindu students specifically, seeking help?
- 10) Do you think you are knowledgeable enough about mental health care?
- 11) What other suggestions do you have, that can be implemented to help Hindu students to be more aware and receptive to mental health care on campus?

APPENDIX 4 - GATEKEEPER LETTER



13 May 2019

Ms Melissa Moodley (SN 214515128)
School of Applied Human Sciences
College of Humanities
Howard College Campus
UKZN
Email: [REDACTED]

mtwentulan@ukzn.ac.za

Dear Ms Moodley

RE: PERMISSION TO CONDUCT RESEARCH

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

"Exploring mental health awareness and help-seeking behavior, among Hindu students at UKZN".

It is noted that you will be constituting your sample by conducting interviews with students on the Howard College campus.

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

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

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

Yours sincerely

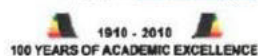
[REDACTED]
MR SS MOKOENA
REGISTRAR

Office of the Registrar

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