

**AN EXPLORATION OF COMMUNITY ATTITUDES  
TOWARDS PEOPLE LIVING WITH  
MENTAL ILLNESSES: A CASE OF  
INANDA KWAZULU NATAL**

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## ABSTRACT

The topic of mental health is one of the many topics that are neglected in many South African communities. Although this is a burning issue that affects millions of South Africans, little to nothing has been done to raise awareness regarding this phenomenon that society still grapples with among many other pandemics. Available literature suggests that the issue of mental illnesses is among the many issues that haven't been given the necessary attention they deserve as a result of their magnitude and also the negative effects they have on many lives in our communities. Communities lack the necessary tools and services to tackle the problems associated with mental illnesses and the stigma thereof. People living with mental illnesses are continuously marginalised, violated and excluded from community programmes as a result of the stigma and negative attitudes associated with mental illnesses. This study was motivated by the fact that although mental illnesses are a huge concern for South African communities as they disrupt many lives and lead to death as many people have died by suicide as a result of mental illnesses and not being able to talk about them as a result of the negative stigma associated with mental illness, yet little has been done to provide communities, especially townships with mental health services. This study is geared towards exploring community attitudes towards people living with mental illnesses. The study was conducted at Durban Inanda, Kwa-Zulu Natal. Methodologically, the study employed a qualitative approach that involved semi-structured interviews conducted with twenty-six participants involved in the study. The study found that community members harbour negative attitudes towards those living with mental illnesses. This is a result of how people living with mental illnesses are depicted as violent, dangerous and not deserving of being treated with dignity. The study also showed that community members have false and misleading information regarding mental illness and those living with it. Another finding of the study was that the community lacked mental health services that can provide the community with the correct information regarding mental illnesses thus curbing the scourge of mental illness stigma as well as the associated repercussions. The study concludes that mental health service centres are a necessity in the community as they can play critical role in raising awareness regarding mental illness as well as facilitating programmes that can assist communities to better deal with issues related to mental illnesses without stigmatising and victimising those living with such illnesses.

## DECLARATION

I, Andile Kevin Mthembu, declare that

1. The research reported in this dissertation, except where otherwise indicated, is my original research.
2. This dissertation has not been submitted for any degree or examination at any other Institution.
3. This dissertation does not contain other people' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other people.
4. This dissertation does not contain other peoples' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
  - a. Their words have been re-written but the general information attributed to them has been referenced.
  - b. Where their exact words have been used, then their writing has been placed in italics and inside quotation marks, and referenced.
5. This dissertation does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the dissertation and in the Reference section

Signature of student: AK Mthembu

Date: 04/05/2023

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## **DEDICATION**

This research is dedicated to my mother, Miss Tholakele Elizabeth Mthembu who has been my primary motivation. She has always supported and motivated me to study further so that I could improve the quality of life for our family. I admire her strength and resilience, having raised seven children as a single parent on a domestic workers salary. She is truly a remarkable woman. Her resilience has rubbed off on me and has kept me going even when the going got tough. Thank you for always being there. The love and support you've shown me is invaluable.

To my nieces and nephews, this is also dedicated to you. I want this to be a testimony that one can reach great heights by keeping their eyes towards the price. Remember, education is a vital key to success.

## LIST OF ABBREVIATIONS/ACRONYMS

PTSD- Post-Traumatic Stress Disorder

SADAC- South African Depression and Anxiety Group

SASOP- South African Society of Psychiatrists

ANC- African National Congress

HIV- Human Immune Virus

CD- Community Development

WHO- World Health Organisation

CMHI- Community Mental Health Ideology

MHL- Mental Health Literacy

AIDS- Acquired Immunodeficiency Syndrome

KZN- KwaZulu-Natal

LGBTQI- Lesbian Gay Bisexual Transgender Queer Intersex

ADHD- Attention Deficit Hyperactivity Disorder

TV- Television

DoH- Department of Health

DoE- Department of Education

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## **CHAPTER ONE: INTRODUCTION AND BACKGROUND**

### **1.1. INTRODUCTION**

This study seeks to explore community attitudes concerning people living with mental illnesses in and around the community of Inanda. It aims to understand the views and perceptions of community members towards people living with mental illnesses. It also seeks to identify the causes of these attitudes and perceptions. Lastly, the study will describe how these attitudes affect those living with mental illnesses in the community.

This chapter commences with the background of the study, the study's location as well as the problem statement. It will also present the study's aim, objectives as well as research questions. Lastly, it will argue the significance of the study.

### **1.2 BACKGROUND OF THE STUDY**

For a while, the issue of mental health has been accepted as a public health challenge in both developing as well as developed countries (Deribew & Shiferaw, 2005 and Fuhrer & Keyes, 2019). The public health significance of mental and behavioural illnesses pointed out that mental illnesses are amongst the most critical causes of illness in primary health care settings thus leading to considerable disability (Fuhrer & Keyes, 2019). Another known cause of its high occurrences is the relatively low level of mental health literacy (Khan, Sulaiman, Hassali & Tahir, 2009 and Kutcher, Wei & Coniglio, 2016). According to Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, (1997) who is the founder of the term 'mental health literacy, mental health literacy is defined as the "knowledge and beliefs about mental illnesses which aid how they are recognized, managed or prevented". The literacy of mental health has several components, including but not limited to: the ability to acknowledge certain illnesses or distinct types of psychological distress; knowledge and beliefs regarding risk factors and their causes; knowledge and beliefs regarding self-help interventions; knowledge and beliefs regarding the available professional help; attitudes which impede recognition and relevant help-seeking; and knowledge of how to seek mental health information (Kutcher, Wei & Cogniglio, 2016). Reviewed studies revealed that the knowledge of public attitudes toward mental illness and how it can be treated is a vitally crucial requirement for the achievement of successful community-based programs. The conceding of mental illnesses is also dependent on a meticulous belief, norms, and customs associated with the person's cultural environment

(Kabir, Liyasu, Abubakar & Aliyu, 2004 and AbdAleati, Zaharim & Mydin, 2016). Other studies that were conducted around Africa made suggestions that experiencing incidents of stigma by people with mental illnesses may be widely common, but little to no information is available as to how common these pessimistic attitudes to mental illnesses may be in communities (Vigo, Thornicroft & Atun, 2016).

Mental health issues do not only affect a minor or secluded part of society. All societies are affected by mental health issues (Vigo, Thornicroft & Atun, 2016). Mental illnesses pose a serious threat to the development of community health globally. There are hardly any groups of people that are not prone to developing mental health-related illnesses. The possibility of experiencing mental illnesses is significantly high among those who are poor and homeless. Risks are also higher for the unemployed, with little to no education, victims of violent behaviour, migrants and people that are displaced, native populations, young people and children, women who have been victims of abuse, as well as the abandoned elderly (Deribew & Shiferaw, 2005 and Vigo, Thornicroft & Atun, 2016). There is a guaranteed possibility of the development of mental or neurological illnesses for as many as one in four people in the world at a given point in their lifespan. Currently, it is estimated by the World Health Organization world health report (2010) that about 450 million people are dealing with mental health issues, with mental illnesses reported to be amongst the major causes of morbidity and disability globally. About 12% of the worldwide burden of disease is related to mental and behavioural disorders. However, only about 1% of the total budget is allocated to the mental health budget or expenditure in several countries, both developing as well as developed countries (Angell, 2011). There is an imbalance in the connection between disease burden and how much is spent on managing the disease (Auerbach, Mortier, Bruffaerts, Alonso, Benjet, Cuijpers, Demyttenaere, Ebert, Green, Hasking & Murray, 2018).

Mental health problems are burning issues that can affect anyone and everyone. It is argued that approximately 1% of humans are prone to developing some form of a mental illness in their lifetime (Perry & Pescosolido, 2015). Mental illnesses cause distress and often, hinders people's ability to live meaningful and productive lives. Mental illnesses mostly make it impossible for individuals to have jobs, raise families or socially relate to other people. It also results in pain and discomfort for the patient, their friends and their families (Carlson & Carlson, 1993; Tyrer, Reed & Crawford, 2015 and Iseselo, Kajula & Yahya-Malima, 2016). Mental illnesses are illnesses that usually damage relationships between families. It is extremely hard for people living with mental illnesses to maintain relationships. Most people

living with mental illnesses suffer throughout their life span, losing career opportunities and relationships (Pastorino & Doyle-Portillo, 2006 and Tyrer, Reed & Crawford, 2015).

Mental illness costs health services millions of rands. Every year, doctors prescribe drugs costing millions of Rands to help with the treatment of mental illness (Drake & Whitly, 2014). This illness is disabling and usually results in hospitalization. The financial costs of hospitalization and the psychological costs to patients, families, and friends can be enormous (Iseselo, Kajula & Yahya-Malima, 2016).

According to the Federal Democratic Republic of Ethiopia Ministry of Health (2012), the amount of mental distress in grown-ups is particularly elevated in sub-Saharan Africa including Ethiopia. It is distinctly asserted in the National Mental health Strategy of Ethiopia (2012), that mental illnesses are the leading non-communicable disorder in terms of burden in Ethiopia. The Federal Democratic Republic of Ethiopia Ministry of Health (2012) found that an estimation of about 11% of the overall burden of disease is affecting a predominantly rural part of Ethiopia. Depression and schizophrenia are listed among the top ten most worrisome conditions, outweighing HIV/AIDS. These flabbergasting statistics denote that mental health illnesses have been tremendously neglected and there has been a failure in prioritising them in Ethiopia. Nevertheless, there is restricted information concerning the perceptions as well attitudes of the public concerning mental health problems (Tibebe & Tesfay, 2015). A study which was administered in Borana, Ethiopia, found drives for paranormal causes such as perceptions of being possessed by bad spirits, being doomed, bewitched or possessed, having 'exposure to wind', and following attacks by evil spirits in postnatal women. Furthermore, biopsychosocial causes such as infections (malaria), loss, 'over-thinking', and alcohol and drug abuse are the leading causes of mental disturbance in Ethiopia (Payne, 2012 and Teferra & Shibre, 2012). Other studies also revealed that the primary factor leading to mental illness is the stigmatization and labelling that is associated with people's beliefs. A noteworthy hurdle to positive outcomes between different cultures and nations is the stigma associated with people living with mental illness. This is pertinent to the level of threat of mental symptoms, bigotry towards diversity, and inaccurate perceptions of mental illnesses (Akinsulore, Esimai, Mapayi & Aloba, 2018).

Therefore, it is against this background that this study is conducted.

### **1.3 LOCATION OF THE STUDY**

This study will be conducted in Inanda, Kwa-Zulu Natal. Inanda is primarily populated by Zulu-speaking Black Africans, and it is also widely known as the home of the struggle stalwart John Langalibalele Dube, who was the very first president of the ruling party which is the African National Congress (ANC). It is also a residence/base for the operations of the iconic Mahatma Gandhi (“Inanda, Kwa-Zulu Natal” par 1). It is a suburban area associated primarily with poor people and has a murder rate that is much higher than the average in and around Ethekwini. It also has high numbers of people living with HIV and AIDS, most of the population do not live long enough to reach old age. Inanda is located in the Eastern part of KZN, South Africa and it consists both formal as well as informal settlements within the eThekweni Municipality (Hoque, 2011).

The municipality is challenged with extremely high numbers of poverty, unemployment, illiteracy as well as Human Immune Virus (HIV) infections and a housing backlog (Roberts & O’Donoghue, 2013). Furthermore, communities in and around Inanda are poorly serviced and rates of crime are at an extreme high (Oelofse & Patel, 2010). As a result of these socio-economic factors, the awareness of mental health issues may be relatively low.

Inanda which is also known as 'eNanda' is among the townships of KwaZulu-Natal, South Africa and is located about 30 km north-west of the Durban CBD and it forms part of eThekweni, which is the Greater Durban Metropolitan Municipality. It is populated primarily by Zulu-speaking Black Africans. The community has an estimated population of about 158 600 people. The area is challenged by high levels of crime such as theft, murder and rape as well as issues such as gender-based violence and child abuse (“Inanda, Kwa-Zulu Natal” par 3)

### **1.4 PROBLEM STATEMENT**

Although South Africa celebrates twenty-eight years of democracy, many people are still marginalised, discriminated against and suffer exclusion. People living with mental illnesses are often isolated and discriminated against in communities. They are seen as abnormal and not worthy to be treated in a manner that is fair and just. Their right to dignity is often infringed on and violated by other community members who lack the necessary knowledge for them to understand that those living with mental illnesses are also human and thus must not be defined and treated harshly just because they suffer from mental illnesses. Communities need to understand that there is way more to these people than the conditions they suffer from which

usually shape most parts of their lives and hinder them from being active participants in the communities they live in. They deserve to enjoy the right to life and dignity just like all other human beings (Henderson, Robinson, Evans-Lacko, Corker, Rebollo-Mesa, Rose & Thornicroft, 2016).

Millions of South Africans suffer from mental illnesses. According to the Department of Health, one in four South Africans has or is affected by mental illness. Roughly 1% and 3% of the overall population in South Africa is most probably going to experience some form of mental health problem serious enough to need to be hospitalized. Research indicates that only 45% of South African patients with mental health problems seek help in time (Yousaf, Grufeld & Hunter, 2015 and Hom, Stanley & Joiner, 2015). There is an estimation that up to six million South Africans suffer from post-traumatic stress disorder (PTSD). Millions of South Africans are suffering from mental illnesses, yet many of them go undiagnosed (Mental Health24, 2012). Many factors in South Africa such as diseases, poverty, drug and alcohol misuse, political violence, and the decomposition of the traditional value system have contributed to mental health issues in South Africa.

Between the native population in South Africa, most people still cling to the traditional belief that mental illnesses are consequences of demonic possessions by witches and ancestors. Because of this, most individuals fear being rejected by others. As a result, they resort to keeping their mental health conditions confidential as an alternative to seeking appropriate medical attention (Henderson, Robinson, Evans-Lacko, Corker, Rebollo-Mesa, Rose & Thornicroft, 2016). This points out the fact that there is still a large number of people in South Africa suffering from mental illnesses who are currently unaccounted for in statistics (National Institute of Mental Health, 2012). According to recent statistics released by the South African Depression and Anxiety Group (SADAC), as many as one in six South African people experience mental health-related issues such as anxiety, depression and substance abuse-related issues. Furthermore, research conducted by the University of Cape Town's Department of Psychiatry and Mental Illness found that above 40% of people with HIV in SA suffer from a diagnosable mental illness when it was conducted. This study also indicated that around one in three females who live in low-income areas, as well as informal settlements around Cape Town, suffer from postnatal depression. The South African Society of Psychiatrists (SASOP), are of the notion that when you consider crime and motor vehicle accidents, roughly about six million South Africans could experience mental health-related issues such as post-traumatic



stress disorder. Recent statistics from Statistics South Africa reveal that about 30,3% of adults in SA would've suffered from some form of mental illness in their lifetime.

## **1.5 STUDY AIM, OBJECTIVES AND QUESTIONS**

### **1.5.1 AIM OF THE STUDY**

This study aims to critically explore and understand the different attitudes and perceptions community members have towards those suffering from mental illnesses.

### **1.5.2 STUDY OBJECTIVES**

- To understand the views and perceptions of community members towards those living with mental illnesses in Inanda.
- To identify the causes of these attitudes and perceptions towards those living with mental illnesses in Inanda.
- To describe how these attitudes affect those suffering from mental illnesses in Inanda.

### **1.5.3 RESEARCH QUESTIONS**

- What are the views and perceptions of community members towards those living with mental illnesses in Inanda?
- What are the causes of these attitudes and perceptions towards those living with mental illnesses in Inanda?
- How do these attitudes affect those suffering from mental illnesses in Inanda?

## **1.6 SIGNIFICANCE OF THE STUDY**

Community development is concerned with empowering and uplifting all people from the different challenges they face. Community development as a discipline seeks to address structural injustices and it seeks to enhance the standard of life for all people irrespective of their health, class or status. Community participation is believed to be the foundation of a democratic society, as it gives people at the local level a platform to participate in decision-making processes regarding their public concerns, needs and interests (AbouAssi, Nabatchi & Antoun, 2013). In modern democratic societies, there is direct and indirect participation;

indirect participation is when citizens select a representative to make decisions on their behalf, on the other hand, direct participation is when citizens rather take power and make successive decisions on issues or concerns affecting their lives (Roberts, 2008 cited in AbouAssi, Nabatchi & Antoun, 2013). Experts and Advocates for community participation suggest a bottom-up approach, as this approach sees people as ‘citizens’ of a community that can be actively involved in decision-making processes and as a result, targeted objectives can be achieved (Chirenje, Giliba, Musamba, 2013). The findings of the study will help include community members in decision-making as they will gain the power to make decisions regarding the issue of mental health in their community through direct participation. In developing countries, a top-down approach is said to be ineffective in achieving sustainable development goals, as this approach sees people as ‘clients’ in their community (Campbell & Shackleton, 2001 cited in Chirenje, Giliba, Musamba, 2013). The bottom-up approach to community development will allow the community members to be actively involved in decision-making regarding mental illness services in the community instead of an external party making the decisions on behalf of the community. This active involvement in decision-making will empower the community and ensure that they gain the necessary skills to be able to deal with other projects in future for the betterment of their lives. Moreover, scholars assert that direct participation and a bottom-up approach are the two main drivers of ensuring inclusive community participation as people are empowered to take charge of their development, hence enhancing individual capacity building and also improving modern governance resolutions in terms of distributing information about public needs and interests, and also working closely with policymakers to improve policy decisions (AbouAssi, Nabatchi & Antoun, 2013 & Chirenje, Giliba, Musamba, 2013 & Kim and Schachter, 2013). The community will thus work hand in hand with policymakers allowing them to have an influence and power over decisions relating to the issue of community development in their community.

The literacy of mental health is known as the beliefs and the comprehension of mental health-related issues as well as how they can be treated. The attitudes and beliefs of community members regarding mental illnesses are usually a product of personal information and knowledge about mental illnesses, knowing and being in communication or having access to someone living with or suffering from a mental illness, as well as cultural stereotypes. Mental health-related issues are escalating and are disturbing in almost all different parts of the world. Therefore, there is a crucial need for a study of this nature that will award the opportunity to explore the views and attitudes of community members towards those living with mental

illnesses (Henderson et al., 2016). Jeppe (1998) asserted that the widely common and globally welcomed definition of Community Development (CD) is the definition from the United Nations Department of Economic and Social Affairs of 1963 which defines community development as the process through which the attempts of the people themselves are combined and work in conjunction with those of the government to better the different aspects of life such as economic, social as well as cultural conditions of the communities, to amalgamate these communities into the existing life of the nation as a whole, and to allow them to make contributions towards national progress. This compound process is, therefore, a result of two crucial elements which include involvement as well as participation by the people themselves in the attempts to upgrade their standard of living, with as much dependency on their initiatives as possible, and the supplying of technical and other crucial services in ways that encourage initiatives, self-help as well as mutual help and making them more effective. It is conveyed in programmes that are designed to achieve many specific improvements (Jeppe, 1985).

This study will benefit the community in that it will raise awareness regarding the introduction of mental health service centres. These centres will provide the community with the relevant skills and information so that they are better equipped to deal with issues of mental illness in the community.

### **1.7 Theoretical/ Conceptual Framework**

This study made use of two Theoretical Frameworks namely: The Social Learning Theory as well as the Cultural Learning Theory. The social learning theory is pivotal for the study in that it assesses how society and the environment influences human behaviour. On the other hand, the cultural learning theory is crucial in that it purports that an individual's behaviour is influenced by his or her cultural background and upbringing. These theoretical frameworks are crucial in understanding the views and perceptions of individuals towards those living with mental illnesses.

Social learning theory, proposed by Albert Bandura, emphasizes the importance of observing, modelling, and imitating the behaviours, attitudes, and emotional reactions of others. Social learning theory considers how both environmental and cognitive factors interact to influence human learning and behaviour. The Social Learning theory is a perspective that states that people learn within a social context, where people learn from the environment and seek acceptance from the society by learning through influences (Sellers, Cochran & Branch, 2005 and Bandura & Walters, 1977). The theory suggests that children learn to exhibit aggressive

behaviour as a result of observing others acting aggressively and as a result of seeing how these behaviours are reinforced over time (Bandura & Walters, 1977). In this case, younger generations will be influenced by the older generation while they are learning from them the positive aspects which made them to be vigilant and start reflecting the knowledge learned from them.

Social settings play a vital role in shaping an individual's behaviour. Cormier et al, (2008), claim that individuals' environment has a great influence in determining their social learning level through knowledge gained in their life time. Social learning theorists acknowledged that individual experience is important; especially in terms of older generation who are embodiment of the past. They also believe that the identity that certain people acquire is formed more by the behaviours and attitudes from their peers. The individuals that are observed are called models. In society younger generation are surrounded by many influential models, such as parents within the family, media, TV and friends within their peer groups. But it is very important to consider the older generation as a role model to be observed as well as imitated, (Mearns, 2009). Therefore, if the negative attitudes towards mental illnesses are not addressed, they will be passed on from generation to generation thus promoting the stigma and discrimination of those living with mental illnesses.

Cultural learning theory states that an individual's learning is a product of his or her cultural background and upbringing. For this study, the researcher reviewed the theory on learning, the role culture plays within the theory, and the advantages and disadvantages of using culture as a means of understanding learning and their impact on transferring information and attitudes about those living with mental illnesses, (Katz & Earl, 2010). Cultural Learning theory is the way an individual or groups of people within a society tend to learn and pass on their knowledge. Learning methods are greatly influenced by how a culture socializes with its younger generation (van Oers, 2008). Some scholars believe that cultural learning differences may be responses to the physical environment in the areas in which a culture was initially founded (Javidan, House, Dorfman, Hanges & Sully de Luque, 2006). This also goes with the three objectives which are as follows: to explore the views and perception of community members towards those living with mental illnesses, to explore the causes of these views and perceptions towards those with mental illnesses and lastly to describe how these attitudes affect those suffering from mental illnesses.

Tomasello, Kruger & Ratner (1993) stressed that certain individuals are attached to their cultural values and immediate community which can be noticed in their health-seeking behaviour. The researcher thought when younger generation are told to listen to the words of the older as one form of learning his cultural values. The above was realized during the study, for instance, attitude and norms also influenced both younger and older generation within their processes of learning from each other. Cultural learning theory is also known as cultural transmission which is a process and method of passing on socially learned information or knowledge. Within a species cultural transmission is greatly influenced by how adults who socialize with younger generation. Differences in cultural transmission across species have been thought to be largely affected by external factors, such as the physical environment, that may lead an individual to interpret a traditional concept in a novel way. The environmental stimuli that contribute to this variance can include climate, migration patterns, conflict, suitability for survival, and endemic pathogens. Cultural transmission is hypothesized to be a critical process for maintaining behavioural characteristics over time, and its existence relies on innovation, immigration and communication to create and propagate various aspects of behaviour seen today (Tomasello, 2016).

The Social Learning theory will allow this study to understand the views and perceptions of community members towards mental health patients which the people may have learnt through their social context. This theory will allow the study to understand whether these views are as a result of learning from the environment through seeking acceptance or whether they are a result of learning through influences. The Cultural Learning theory will allow the study to observe the attitudes, perceptions and behaviours of community members towards mental health patients to understand whether there is any relation between these attitudes and the cultural background of these communities.

### **1.8 Chapters/ structure of the Thesis**

This dissertation consists of five chapters:

**Chapter one:** provides the background to the study, problem statement, aim objectives and research question. Furthermore, the profile of the location of the study and the importance of the study. This study also discusses the theoretical framework of the study.

**Chapter two Literature Review:** This chapter reviews the available literature in the context of mental illnesses and community members' interactions with people living with mental illnesses.

**Chapter three Research Design and Methodology:** This chapter presents the qualitative research design which was employed for data collection. It further discusses the research design, sampling and data collection methods, the methodology and the analytical framework employed for data collection.

**Chapter four Presentation and Discussion of the Study Findings:** This chapter discusses the emerging findings of the study.

**Chapter five Recommendations and Conclusion:** The last chapter summarizes the study's major findings and provides suggestions and recommendations for future research. It also provides the conclusion.

## CHAPTER TWO

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

#### 2.1 Introduction

Negative attitudes directed at people living with mental illnesses as well as discrimination against such people is still very widespread in the general public population (Angermeyer & Dietrich, 2006 and Angermeyer, van de Auwera, Carta & Schomerus, 2017). This is believed to be one of the major barriers to prosperous treatment, recovery and inclusion of those with mental illnesses back into society. The issue of being unemployed, and the loss of income (Sharac, McCrone, Clement, & Thornicroft, 2010), not looking for help or delaying seeking care (Andrew, Henderson, & Hall, 2001 and Yousaf, Grunfeld & Hunter, 2015), a restricted social network (Livingston & Boyd, 2010; Thornicroft, Brohan, Rose, Sartorius, Leese, & INDIGO Study group, 2009), damaged self-esteem (Ilic, Reinecke, Bohner, Hans-Onno, Beblo, Driessen, Frommberger & Corrigan, 2012), separation or segregation and being lonely are the consequences of stigma and discrimination for many people living with mental illnesses. Shame also affects the development of the disease and recuperation (Yousaf, Grunfeld & Hunter, 2015). Reviewed studies that have been conducted regarding public attitudes in relation to people living with mental illnesses reveal that the public's views and attitudes have not changed remarkably in recent years (Angermeyer, van de Auwera, Carta & Schomerus, 2017).

The aim of this chapter is to review literature surrounding the topic of mental illness. It will also outline the study's theoretical framework.

#### 2.2 Definition of Mental Illnesses

Butcher, Mineka and Hooley (2010) define mental illness as a wholly span of abnormal behaviour patterns. According to the World Health Organisation (WHO), 2004, mental health is a state of well-being whereby an individual realises his or her own abilities, and can cope with day to day challenges and stresses that come with life, is able to work fruitfully and productively, and where an individual is capable of making positive contributions to his or her community. Mental illness is a significant problem which can affect anyone and everyone. It is evident that roughly 1% of humans develop one or more forms of mental illnesses in their lifetime (Perry & Pescosolido, 2015). Mental illnesses may result in discomfort and may often

impinge on people's ability to live fruitful and productive lives. It mostly makes it impossible for people to have and hold jobs, look after their families or to have social relations with others. It also leads to unbearable pain and irritation to the person suffering from the illness, their friends as well as their loved ones (Clement, Schauman, Graham, Maggioni, Evans-Lacko, Bezborodovs, Morgan, Rusch, Brown & Thornicroft, 2015). Mental illnesses are diseases that can result in damaged relationships amongst families. It is extremely difficult for those suffering from mental illnesses to have and maintain healthy relationships with others. Mostly, people who suffer from mental illnesses suffer the whole of their lives, missing out on chances to have careers and to form relationships (Pastorino & Doyle-Portillo, 2006 and Henderson, Robinson, Evans-Lacko, Corker, Rebollo-Mesa & Thornicroft, 2016). Mental illnesses cost the health department and service millions of rands. Yearly, psychiatrists and doctors make drug prescriptions that cost fortunes to treat mental illnesses. Mental illnesses are disabling and often results to hospitalisation. This leads to huge financial and psychological costs to the patients, their friends as well as their loved ones as a result of hospitalisation (Trautmann, Rehm & Wittchen, 2016).

### **2.3 Families with members suffering from Mental Illnesses**

The families and significant others in the lives of people living with mental illnesses have a vital role to play (Umberson, Thomeer & Williams, 2013). People suffering from mental illnesses tend to be dependent on the members of their families for support and survival. The relationships with their loved ones may be the closest thing they have to proper relationships as they may fail to have meaningful relationships with other people. (Morgan, Reayley, Jorm & Beatson, 2017). A survey (2012) conducted to uncover discrimination towards those living with mental illnesses in New Zealand discovered that those living with mental illnesses mostly suffer discrimination and stigma from those closest to them such as their friends and families. An Australian national survey conducted to identify the discrimination experienced by people living with mental illnesses as well as the support they get from significant people in their lives such as friends and family also had similar findings (Peterson, Pere, Sheehan & Surgenor., 2004 and Morgan, Reayley, Jorm & Beatson, 2017). This means that although families have significant roles to play in the lives of their family members living with mental illnesses, their behaviours and attitudes, whether consciously or unconsciously, are not always to the advantage of and effective in offering support to people with experiences of mental illnesses.



Families of people living with mental illnesses have traditionally been associated with having contributions to mental illnesses either by causing these illnesses or by exasperating these illnesses (Riebschleger, 2001; Rethink, 2003 and Reupert, Maybery, Cox & Scott, 2015). Family members have at a number of times supported the idea of institutionalisation and did this by committing their family members with mental illnesses to psychiatric institutions (Jones, 2002 and Yesufu-Udechuku, Harrison, Mayo-Wilson, Young, Woodhams, Shiers, Kuipers & Kendall, 2015). Families also played a huge role in the recent idea of deinstitutionalisation. A number of families take the role of taking care of their family members suffering from mental illnesses (Rossler, 2016 and Mason, 1996). A number of mental health professionals see the families of those living with mental illnesses as an annoyance (Angermeyer, Schulze & Dietrich., 2003). Mental health professionals see family members as being over-protective and showing interference (Rossler, 2016). They are therefore seen as lacking the vital and necessary information about mental illnesses and its treatment (Rossler, 2016). Also, family members usually have tainted relationships with mental health practitioners as they have the belief that these professionals are discriminatory towards them (Rusch, Angermeyer & Corrigan, 2005 and Angermeyer, Van Der Auwera, Carta & Schomerus, 2017). This may be the result of the fact that mental health practitioners may see family members as having contributions to their family members' mental illness and thus hindering the treatment process.

Work conducted early in the field purported that stigma may have been less common in African countries, especially in Muslim countries (Crabb, Stewart, Kokota, Masson & Chabunya, 2012). Evidence to discredit this panorama emerged from Islamic states including Morocco where stigmatising attitudes proved to be a paramount burden to families of those living with mental illnesses (Krishnadas, 2012). Generally, there is a shortage of available research regarding attitudes toward issues of mental illness in Africa and the readily available information is usually collected from extremely distinct areas of the African continent. There have been suggestions that earlier observations regarding the lack of stigma towards mental illness in Africa were a result of little to no research conducted on the field instead of a more culturally open-minded attitude toward mental illness (Krishnadas, 2012). In fact, more studies recently conducted across African countries have proposed that experiences of stigma were possibly pre-eminent in individuals living with mental illnesses, their families as well as the community at large. Studies administered in Ethiopia, a country in Eastern Africa proposed that experiences of stigma by people living with mental illnesses may be widely common with

three-quarters of family members of individuals with a mental illness experiencing stigma (Girma, Möller-Leimkühler, Müller, Dehning, Froeschl, & Tesfaye, 2014). Surveys conducted around community attitudes toward mental illnesses in South Africa, found that members of the public were found to attribute mental illnesses to stress or a lack of willpower instead of a medical illness (Baron, Hanlon, Mall, Honikman, Breuer, Kathree, Luitel, Nakku, Lund, Medhin & Patel, 2016). Most studies that have been conducted surrounding community attitudes towards mental illness have been conducted in West African countries and have indicated poor knowledge concerning causation, the widespread negative views toward mental illness as well as an overwhelming majority are of the belief that those living with mental illness are dangerous and are not suitable for normal social contact (Tasca, Rapetti, Carta & Fadda, 2012). In those attending outpatient clinics in Nigeria supernatural reasons were found to be the most common explanations for mental illnesses amongst both carer-givers and patients while psychosocial explanations were least common, a remarkable difference from findings from international studies (Crabb, Stewart, Kokota, Masson & Chabunya, 2012). Family members of people living with mental illness in Nigeria were also found to have experienced a higher prevalence of anger and stigma (Crabb et al., 2012). It is hard to hypothesize attitudes towards mental illnesses even in the same geographical region of the African continent. For example, in nearby Ghana there seems to be a substantial reliance to culturally specific explanations associated with more acceptance and support in rural areas (Opare-Henaku & Utsey, 2017).

Families with relatives who suffer from mental illnesses are challenged with a number of stereotypes. These include being perceived as dysfunctional, inadequate, burdened or brave (Banks, 2003 and Ross, Morgan, Jorm & Reavley, 2019). The Advisory Council on Mental Health of the British Columbia health minister (2002), purports that such stereotypes have negative impacts on the families of those living with mental illnesses. Quinn, Williams, & Weisz (2015) also argue that the stereotypes against mental health patients have negative implications on their families. These stereotypes lead these families to have broken relationships with other people, and suffer fear, conflict, stress, guilt as well as a very low self-esteem (Woo, Bhalerao, Bawor, Bhatt, Dennis, Mouravska, Zielinski, & Samaan, 2017). Although mental health services have adapted and improved in the past decade or so, the load on the shoulders of family members who have relatives who live with mental illnesses has not lessened (Ostman, Hansson & Anderson., 2000). Angermeyer et al. (2017), concisely states that family members with members who suffer from mental illnesses are characterised by

responsibility. This means that they act as the primary caregivers and have relations that have special emotional closeness (Angermeyer et al., 2017). This caring role played by family members has its own implications. These people's lives are affected in all aspects as they have to spend most of their time taking care of their loved ones (Ross et al., 2019).

When families make the decisions of what they believe to be the what causes mental illnesses, they usually specifically think about their circumstances and that of that of their relative living with a mental illness, thus resorting to the individual approach instead of being holistic and thinking about the causes in a general aspect (Novak, 2015 and Magliano, Fiorillo, De Rosa, Malangone & Maj., 2004). Views tend to differ when it comes to how to what families believe to be the causes of mental illnesses. A group of researchers have the belief that families are strong members of the medical model of mental illnesses (Jones, 2002 and Arestedt, Benzein & Persson, 2015). This model purports which is that mental illnesses are a result and are caused by brain diseases. Other researchers believe that families align themselves with the psychological model of mental illness (Magliano, Guameri, Fiorillo, Marasco, Malangone & Maj., 2001 and Peterson, Fairall, Bhana, Kathree, Selohilwe, Brooke-Sumner, Faris, Breuer, Sibanyoni, Lund & Patel, 2016; Magliano, Fiorillo, De Rosa, Malangone & Maj, 2004). Marshall, Solomon, Steber & Mannion. (2003) argue that families hold both the biological model of mental illness as well as the family causations belief about mental illness concurrently, with families usually shifting the blame to themselves in the initial stages of the recovery process of their loved ones. Boyd, Otilingam & DeForge (2014) argues that families usually believe in the power of thinking positively as a tool which can be used to deal with mental illnesses, suggesting that people have the ability to have total control over their symptoms and behaviours.

#### **2.4 Stigma and Mental Illnesses**

The stigma, stereotype as well as discrimination aimed at those living with mental illnesses is prevalent and highly common (Sayce, 1998; Crisp, Gelder, Meltzer & Rowlands., 2000 and Quinn et al., 2015). This discrimination affects the self-esteem, resulting in a lowered self-esteem (Sheehan & Ali, 2016 and Vass, Morrison, Law, Dudley, Taylor, Bennett & Bentall, 2015) and also affects the recovery process of those living with mental illnesses thus also affecting all aspects of their lives (Perlick, 2001; Penn & Wykes, 2003 and Vass et al., 2015). Discrimination takes place when one person is treated differently to another in the same or similar context. This is a result of the stigma and stereotypes against those suffering from

mental illnesses resulting in prejudice, which ultimately leads to discrimination (Quinn et al., 2015). However, for discrimination to take place, the person who is being prejudiced must hold a position of power or advantage which is then exercised (Mak, Cheung, Wong, Tang, Lau, Woo & Lee, 2015). Although most people face and suffer discrimination as a result of their race, gender, class and disability among a wide range of others, Gordon, Tantillo, Feldman & Perrone. (2004) argue that evidence shows that discrimination against those living with mental illnesses or intellectual disability are the most prevalent negative attitudes in comparison to all the others. Findings also depict that discrimination against those suffering from mental illnesses continues to be an issue irrespective of what cultural or ethnic group the person belongs or identifies with (Oliveira, Esteves, Pereira, Carvalho & Boyd, 2015).

People living with mental illnesses suffer from two battles – first, the debilitating symptoms that usually hinder their mental, social as well as physical functioning and second, the usually negative beliefs which the general public have that usually lead to the discrimination as well as the rejection of those living with mental illness (Angermeyer & Dietrich, 2006; Chaudhuri, 2006; Corrigan, 1998, 2000; Corrigan, Green, Lundin, Kubiak, & Penn, 2001; Corrigan & Watson, 2002; Link & Phelan, 2001; Rüsçh et al., 2005; Angermeyer et al., 2016 and Schomerus et al., 2019). As a matter of fact, stigma surrounding mental illness and those living with mental illnesses is widely common (Chaudhuri, 2006; Corrigan, 2000; Corrigan & Watson, 2002; Tawiah, Adongo & Aikins, 2015 and Schomerus et al., 2019). Stigma surrounding mental illness is not only limited to the public. As a matter of fact, soaring rates of stigma toward mental illness are also found family members as well as friends of people living with a mental illness and such stigma is also found in skilled professionals such as doctors, psychologists, psychiatrists as well as nurses (Kirkby & James, 1978; Ku, 2007; Magliano, Fiorillo, de Rosa, Malangone, & Maj, 2004; Ngirababyeyi, 2012; Sévigny, et al. 1999; Tanaka, et al. 2004; Vibha, Saddichha, & Kumar, 2008; Tawiah et al., 2015 and Seow, Chua, Xie, Wang, Ong, Abdin, Chong & Subramaniam, 2017). For instance, some studies have found that the general public holds significantly positive attitudes and beliefs regarding recovery when compared to mental healthcare professionals (Caldwell & Jorm, 2001; Magliano et al., 2004). The public also holds more positive outcome beliefs such as having a successful marriage or being a good and caring parent (Jorm, Korten, Jacomb, Christensen, & Henderson, 1999). They also have significantly low negative outcome beliefs such as having violent behaviour, suffering from the abuse of alcohol as well as excessive drug use. Their negative outcome beliefs are far outweighed by those of health professionals (Jorm et al.,

1999). Having said that, skilled mental health professions indicate positive attitudes and views regarding community mental healthcare compared to the public (Lauber, Anthony, Ajdacic-Gross, & Roessler, 2004; Keogh, Callaghan & Higgins, 2015; Stefanovics, He, Cavalcanti, Neto, Ofori-Atta, Leddy, Ighodaro & Rosenheck, 2016 and Seow et al., 2017).

Stigma usually hinders those living with mental illnesses from utilising opportunities that would assist them in fulfilling their life goals (Corrigan, 2004; Dixon, Holoshitz & Nossel, 2016 and Angermeyer et al., 2017). The Mental Health Foundation (2015) reported that in comparison to many other long-term health related conditions or disabilities, people living with mental illnesses are less likely to be involved in long-term relationships, live in decent accommodation or be amalgamated in their communities. It is also reported that individuals living with mental illnesses have slight chances of being offered or hired for jobs (Chaudhuri, 2006; Tsang, Tam, Chan, & Chang, 2003; Kapungwe et al., 2010) and usually pressured into quitting their jobs (Arthur et al., 2010). For example, a survey conducted in the UK found that about 39% of individuals living with mental health related problems left their work as a result of feeling little to no support and sympathy from their employers (Citizens advice, 2004). Rusch, Corrigan, Waldmann, Staiger, Bahemann, Oexle, Wigand and Becker (2018) also found that mental health patients prefer not to disclose their mental health problems as it affects their reemployment. Additionally, some people living with mental illnesses usually suffer from self-inflicted stigma (Corrigan & Watson, 2002; Corrigan, Watson, & Barr, 2006; Rüscher et al., 2005; Watson, Corrigan, Larson, & Sells, 2007 and Holubova, Prasko, Hruby, Latalova, Kamaradova, Marackova, Slepecky & Gubova, 2016). Individuals who encounter more self-stigma have reported having a low self-esteem as well as self-efficacy (Corrigan et al., 2006; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2014; Livingston & Boyd, 2010; Watson et al., 2007). They have also reported having great hopelessness (Livingston & Boyd, 2010). People living with mental illnesses have also reported stigma as the major barrier hindering them from seeking medical help for their symptoms (Masuda, Hayes, Twohig, Lillis, Fletcher, & Gloster, 2009; Van Hook, 1999).

A variety, of stigmatising, beliefs have been examined in the literature, including blaming individuals for the onset of their mental illness (Feldman & Crandall, 2007 and Tzouyara, Papadopoulos & Randhawa, 2016), a pessimistic outlook for recovery (Fokuo et al., 2017), perceiving people with a mental illness as a nuisance (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005 and Tzouyara et al., 2016), as unpredictable, (Angermeyer & Matschinger, 1996), dangerous, (Angermeyer et al., 2016; Anglin et al., 2006) or violent

(Anglin et al., 2006 and Corrigan, 2016), and the endorsement of blaming people with a mental illness for such violent behaviours (Anglin et al., 2006 and Corrigan, 2016), or preference for social distance (Angermeyer et al., 2016; Angermeyer et al., 2017 and Arkar & Eker, 1994; Lauber et al., 2004). Several studies have carried out factor analysis to better understand the main types of stigmatising beliefs held by the public towards people with mental illnesses (Brockington et al., 1993; Cohen & Struening, 1962; Rahav, Struening, & Andrews, 1984; Taylor & Dear, 1981; Taylor, Dear, & Hall, 1979; Corrigan, 2016 and Tzouyara et al., 2016). Depending on the sample and the beliefs that were investigated, different factors emerged. However, the main four that were held across the studies were: authoritarianism, benevolence, community mental health, ideology and social distance or social restrictiveness. The first, authoritarianism, embodies the belief that people with mental illnesses are different and inferior to people who are not mentally ill and that their life decisions should be made by others. This prejudicial attitude encompasses aspects such as that a person with a mental illness should not be treated with respect and that people should not marry a mentally ill person. It also includes that a person with a history of mental illness should not be allowed to take public office (Rahav et al., 1984; Wolff, Pathare, Craig, & Leff, 1996; Subramaniam, Abdin, Picco, Pang, Shafie, Vaingankar, Kwok, Verma & Chong, 2017 and Morabito & Socia, 2015). The second aspect which is benevolence represents the belief that people with mental illnesses are childlike and need to be taken care of. This attitude encompasses a positive yet patronising view and includes aspects such as that the public is responsible for people with mental illness and that more funding should go towards mental health services (Wolff et al., 1996 and Subramaniam et al., 2017). Thirdly, Community Mental Health Ideology (CMHI) represents the acceptance of mental health facilities and people with mental illness in the community. This includes the impact of mental health facilities on the community, the merit of deinstitutionalised care and the therapeutic value of the community (Taylor & Dear, 1981 and Muir-Cochrane, O’Kane & Oster, 2018). Finally, social distance or social restrictiveness embodies the fear and the desire for excluding people with a mental illness from the community. This factor encompasses a reluctance to work with, live next to or marry someone with a mental illness (Morabito & Socia, 2015).

Angermeyer et al., (2017) conducted a systematic review of the literature on beliefs about mental illness. Age has generally been shown to be significantly positively associated with mental illness stigma with older participants endorsing more negative beliefs about mental illness (Angermeyer et al., 2017 and Angermeyer et al., 2016). For example, age significantly

and positively predicted social distance (Angermeyer & Matschinger, 1996; Corrigan et al., 2001; Ku, 2007; Lauber et al., 2004; Angermeyer et al., 2016 and Angermeyer et al., 2017) and endorsing the responsibility of individuals for their mental illness (Freeman, 1961) as well as significantly negatively predicting recovery prognosis (Freeman, 1961) and perceived unpredictability of patients with mental illness (Angermeyer & Matschinger, 1996). Gender in relation to mental illness stigma generally shows mixed results (Angermeyer & Dietrich, 2006). Most studies show no significant association, (Angermeyer & Dietrich, 2006; Angermeyer & Matschinger, 1996; Dietrich et al., 2004). Some studies found that men endorse mental illness stigma significantly more than women (Lauber et al., 2004; Mojtabai, 2010) and yet others found the reverse relationship (Angermeyer et al., 2016). Similar to gender, education shows mixed results in relation to beliefs about mental illness (Angermeyer & Dietrich, 2006 and Angermeyer et al., 2017). While some studies found that more educated participants endorsed mental illness stigma less (Angermeyer & Matschinger, 1996; Freeman, 1961; Mojtabai, 2010). Several studies also found no significant association between education level and their endorsement of mental illness stigma (Angermeyer & Dietrich, 2006).

## **2.5 Awareness of Mental Illnesses**

Indeed, sound knowledge and positive attitudes about mental illness and mental healthcare are significantly associated with more positive beliefs about seeking professional help for symptoms of mental illness (Corrigan, Druss, & Perlick, 2013; Golberstein, Eisenberg, & Gollust, 2008 and Schomerus, Matschinger, & Angermeyer, 2009). For example, Wright, Jorm, Harris, and McGorry (2007) found that correctly recognising symptoms of mental illness and labelling them as such was on the one hand significantly associated with choosing the most appropriate type of help and treatment (seeing a psychiatrist, psychologist or social worker, going for counselling or taking antipsychotics) and on the other hand also significantly lowering the likelihood of endorsing inappropriate help (e.g., not seeking, any help, abusing alcohol, cigarettes or, marijuana). Vigo, Thornicroft & Atun (2016) also found that the correct recognition of symptoms of mental illness is directly linked to choosing the most appropriate remedy. Similarly, more positive attitudes towards mental illness and healthcare are significantly associated with greater endorsement of seeking professional help (Barney, Griffiths, Jorm, & Christensen, 2006; Corrigan, Druss, & Perlick, 2014; Mojtabai, 2010). Mental healthcare use is significantly lower among individuals who believe that their family would be upset if they knew about their mental illness (Hodgkinson, Godoy, Beers & Lewin, 2017). People who develop a mental illness often prolong seeking help from a professional

because they may be embarrassed about other people knowing about their illness (Gaebel, Klosterkötter, Weßling, Baumann, Köhn & Zäske, 2004; Altweck, 2016). Indeed, individuals with a mental illness report that the fear of being stigmatized acts as a barrier to mental healthcare use (Cooper-Patrick, Powe, Jenckes, Gonzales, Levine & Ford, 1997; Gäbel et al., 2004; Rüsçh, Angermeyer, & Corrigan, 2005 and Angermeyer et al., 2017). Corrigan, Bink, Schmidt, Jones, & Rüsçh, (2016) purports that the avoidance of being labelled is perhaps the most significant barrier to seeking professional help.

In the same fashion, familiarity with mental illness also shows an ambivalent association with mental illness stigma (Angermeyer & Dietrich, 2006). Familiarity with mental illness ranges from having no experience with mental illness to having watched a movie or documentary about mental illness, to being friends with, working with, or having a mental illness oneself (Morris, 2016 and Holmes, Corrigan, Williams, Canar & Kubiak, 1999). Overall, the public shows great experience with mental illness. For example, Corrigan, and colleagues (2001) found that more than 90% of participants had some kind of previous experience with mental illness. Research has found that greater familiarity was significantly associated with greater endorsement of authoritarianism (Ku, 2007 and Mak, Cheung, Wong, Tang, Lau, Woo, & Lee, 2015), lesser endorsement of dangerousness (Penn, Guyan & Daily, 1994, 1999 and Follmer & Jones, 2018) and greater endorsement of social distance (Corrigan et al., 2001; Ku, 2007; Penn, Guyan & Daily, 1994; Quinn, Williams & Weisz, 2015; Reta, Tesfaye, Girma, Dehning & Adorjan, 2016 and Muir, O’Kane & Oster, 2018 ). Schema theory purports that when new information is assessed, it is either assimilated (i.e., the information is congruent with the existing schema) or it is accommodated (i.e., the information is inconsistent with the existing schema and therefore the schema needs to be updated (Trunnell, 1964). Thus, becoming more familiar with mental illness potentially exposes individuals to new and incongruent information which in turn would update the mental illness schema. However, Angermeyer and Dietrich (2006) also noted several studies that did not find a significant relationship.

When families make the decisions of what they believe to be what causes mental illnesses, they usually specifically think about their circumstances and that of their relative living with a mental illness, thus resorting to the individual approach instead of being holistic and thinking about the causes in a general aspect (Magliano, Fiorillo, De Rosa, Malangone & Maj., 2004). Views tend to differ when it comes to what families believe to be the causes of mental illnesses. A group of researchers have the belief that families are strong members of the medical model of mental illnesses (Jones, 2004) which is that mental illnesses are a result and are caused by



brain diseases. Other researchers believe that families align themselves with the psychological model of mental illness (Magliano, Guameri, Fiorillo, Marasco, Malangone & Maj., 2010; Magliano, Fiorollo et al., 2014). Marshall, Solomon, McNeil (2013) argues that families hold both the biological model of mental illness as well as the family causations belief about mental illness concurrently, with families usually shifting the blame to themselves in the initial stages of the recovery process of their loved ones. Boyd, Otilingam & DeForge (2014) argued that families usually believe in the power of thinking positively as a tool which can be used to deal with mental illnesses, suggesting that people have the ability to have total control over their symptoms and behaviours.

## **2.6 Mental Health Literacy**

Mental health literacy (MHL) refers to the knowledge and beliefs about mental illnesses which aid their recognition, management or prevention (Jorm, Korten, Jacomb, Christensen, Rodgers, & Pollitt, 1997, 143). The concept of MHL is multifaceted and includes: (1) the ability to recognise symptoms of mental illness, (2) knowledge of causes of mental illnesses, (3) beliefs that promote recognition and seeking appropriate help, and knowledge of (4) lay sources of help and (5) professional sources of help (Jorm et al., 1997).

### **2.6.1 The ability to correctly recognise symptoms of mental illness**

The first aspect of MHL is the ability to correctly recognise symptoms of mental illness. Many members of the public display poor recognition of mental illnesses and do not understand meanings of psychiatric labels (Angermeyer & Dietrich, 2006; Dahlberg, Waern, & Runeson, 2008 and Kutcher et al., 2016). For example, schizophrenia is often incorrectly associated with a split conscience or personality (Bonabi, Muller, Aidacic-Gross, Eisele, Rodgers, Seifritz, Rossler & Rusch, 2016), while symptoms of depression are sometimes perceived as a physical disorder such as a virus, nutritional deficiency or cancer (Bonabi et al., 2016). Goldney, Fisher, and Wilson (2001) investigated MHL in a public sample and compared participants with and without depression. They found that both the depressed and the non-depressed samples did not significantly differ in their recognition of depression from a vignette, showing poor recognition overall (49-56%). This underlines that having symptoms of a mental illness does not automatically imply knowing the implications and the type of help available to deal with these. Individuals who are confronted with symptoms of mental illness – by developing a disorder themselves or by encountering someone who has – will endeavour to manage these and an individual's approach will depend on their mental health literacy. Thus, better knowledge and

more positive beliefs about mental illness will positively alter patterns of help-seeking as well as responses to treatment (Jorm, 2000, 2011; Bonelli & Koenig). Good knowledge of mental illness is also important due to the strong association between recognition of mental illness with the other aspects of MHL. Labelling symptoms as a mental illness may activate a schema that outlines the type of action to take (Jorm, 2015). Schema theory purports that when information is memorised it is automatically organised in a meaningful way (Miller, S.A. and Brownell, C.A., 1975 and Zedelius, Muller & Schooler, 2017). Schema are blocks or units of knowledge that help shape how people understand and respond to the environment (McLeod, 2015). These units are a “richly connected network of information relevant to a given concept” (Fiske & Linville, 1980). That is, knowledge is stored according to similarity – e.g., an animal can be similar to other animals in several ways: size, reproductive characteristics, geographical location, presence of vertebrae, etc. – which allows for great richness and flexibility in cognitive processing (Mandler, 2014). Returning to the MHL model, schema theory implies that knowledge and information about mental illness – including causality, symptoms, course, treatments, recovery outlook, etc. – would be stored in a manner that is interconnected. Indeed, research has shown that better knowledge about mental illnesses in general is a good indicator of knowledge about treatment options and beliefs about causes of mental illnesses (Jorm et al., 1997; Lauber, Falcato, Nordt & Rössler, 2003; Lauber, Nordt, Falcato & Rössler, 2003; Kelly, Jorm & Wright, 2007 and Kutcher, Wei & Coniglio, 2016). Labelling symptoms as a mental illness is associated with identifying the need to seek professional help and, indeed, greater endorsement of seeking help from a professional (Lauber, Nordt, Falcato & Rössler, 2003; Kelly, Jorm & Wright, 2007 and Bonabi, Müller, Ajdacic-Gross, Eisele, Rodgers, Seifritz, Rössler, & Rüschi, 2016). Further, better recognition of mental illness is related to lesser endorsement of lay coping strategies – such as drug use (Kelly, Jorm, & Wright, 2007). Labelling symptoms as a mental illness may activate a schema that outlines the type of action to take (Wright, Jorm, & Mackinnon, 2011); and that better knowledge about mental illnesses would encourage a preference for professional compared to lay help. Furthermore Hillert, Sandmann, Ehmig, Weisbecker, Kepplinger, & Benkert, (1999) found that participants who somatised symptoms of mental illness were more likely to recommend seeking help from a doctor and taking medication, while participants who described symptoms psychologically or psychiatrically advised to go to therapy. Thus, recognising symptoms as a mental illness and the ability to describe these in clinical terms to a professional enables better detection of said mental illness and thus access to appropriate treatment.

### **2.6.2 Beliefs about the causes of Mental Illnesses**

A further facet of MHL concerns beliefs about the causal beliefs of mental illnesses. People believe that understanding the occurrence of an event helps them control this behaviour in the future or will at the least help predict its re-occurrence (Fiske & Taylor, 1991; Malle, 2011 and Eliis, Every-Palmer & Einstein, 2017). Malle (2011) purported that lay people are ‘naïve scientists’ in that they attribute (unobserved) causes to observed behaviours, which assigns meaning to the behaviour. Betancourt, Newnham, Birman, Lee, Ellis, & Layne, (2017) further asserted that people aim to determine responsibility for a behaviour; that is, whether the behaviour was due to internal (due to the person’s character, e.g., ability, personality, mood, attitude, motivation) or external (as a result of the environment or social situation, e.g., the task, other people, luck) factors. Thus, social information is perceived, processed and stored with an explanation, and so causal attributions can form the basis of other thought processes, emotions and behaviours (Jones, Kanouse, Kelley, Nisbett, Valins, & Weiner, 1972 and Novak, 2015). When explaining causes of mental illnesses psychopathological models draw on social and biological factors, yet amongst patients with a mental illness there is great variability in causes attributed to their symptoms (Lloyd, Jacob, Patel, Louis, Bhugra, & Mann, 1998; McCabe & Priebe, 2004 and Boyce & Berk, 2016). These may include interpersonal factors (e.g., an ended relationship), supernatural factors (e.g., evil forces), work-related stress, drug or alcohol abuse, bad childhood events (e.g., physical or sexual abuse) or not knowing the cause (Boyce & Berk, 2016). In the Western public, psychosocial factors – including stress, life events, day-to-day problems, traumatic events, recent death and childhood events – are often perceived as the most important cause of mental illness while biological factors – e.g., hereditary or brain disease – are seen as less important (Angermeyer & Dietrich, 2006; Angermeyer & Matschinger, 1996, 1999; Jorm et al., 1997; Lauber, Falcató, et al., 2003 and Angermeyer et al., 2016). It is noteworthy that the public’s attributions vary according to different mental illnesses (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999 and, Schomerus, Stolzenburg, Freitag, Speerforck, Janowitz, Evans-Lacko, Muehlan, & Schmidt, 2019). For example, biological causes are generally rated as more important in relation to schizophrenia than depression, while social factors are attributed significantly more to the latter (Boyce & Berk, 2016). Further, the literature shows a relationship between correctly recognising a mental illness as such and types

of causal factors attributed to it (Angermeyer & Matschinger, 1996; Jorm et al., 1997; Lauber, Nordt, Falcato, & Rössler, 2003 and Novak, Feder, Ali & Chen, 2019). For instance, Angermeyer and Matschinger (1996) found that in relation to schizophrenia, participants were significantly more likely to endorse social causal beliefs (e.g., psychosocial stress or family environment) if they had correctly recognised the mental illness. Similarly, Jorm and associates (1997) found that respondents who correctly recognised symptoms of depression were less likely to endorse ‘virus’ or ‘weakness of character’ as a likely cause of the illness. Angermeyer et al., 2016 also had similar findings. This argues that correctly recognising the symptoms of a mental illness is directly linked to seeking the appropriate help. Along the same lines, a strong association between causal beliefs of mental illnesses and endorsed treatments has been shown (Angermeyer, Matschinger, & Riedel-Heller, 1999 and Angermeyer et al., 2016). For instance, Riedel-Heller, Matschinger, and Angermeyer (2005) found that participants who attributed the cause of the mental illness to brain disease were more likely to endorse psychotherapy and psychotropic drugs and less likely to endorse relaxation, meditation or yoga. On the other hand, if life events were perceived as the cause, then psychotherapy was endorsed more. And, further, if work stress was the cause for the mental illness, then relaxation and natural remedies were more often endorsed. The clinical literature purports that a mental illness is caused by a combination of psychological, social and biological factors. This is mirrored in patients and their families who simultaneously hold multiple and often contradictory causal beliefs (Charles, Manoranjitham, & Jacob, 2007; Joel, Sathyaseelan, Jayakaran, Vijayakumar, Muthurathnam, & Jacob, 2003; Ohaeri & Fido, 2001; Lamont & Dickens, 2019 and Schomerus et al., 2019). Joel and colleagues (2003) reported that 88% of patients attributed their mental illness to multiple non-biological causes (e.g., non-disease concept, black magic, evil spirits). Patients holding multiple causal theories reported utilising multiple systems of medicines, that is, clinical as well as traditional or religious healers (Charles, Manoranjitham & Jacob, 2007). This underlines the close link between causal and treatment beliefs and ultimately types of help sought for symptoms of mental illness.

### **2.6.3 Beliefs about help-seeking for symptoms of Mental Illnesses**

Another aspect of MHL examines beliefs about help-seeking for symptoms of mental illnesses. Overall, the public generally holds very negative views towards the use of psychiatric medication, electroconvulsive therapy and admission to a psychiatric ward, whereas speaking with family, friends, an herbalist or taking vitamins and minerals is generally believed to be more helpful (Jorm et al., 1997 and Aphane, 2015). Vogel and Wester (2003) found that

patients' anticipated comfort of disclosing information about their mental illness and their expected helpfulness of doing so was significantly positively related to positive help-seeking beliefs. This means that patients who felt more comfortable to talk about their symptoms and who expected that doing so would be helpful were more likely to hold positive beliefs about seeking help from a professional. Thus, individuals who do not perceive seeking professional help for symptoms of mental illness as helpful would not endorse seeking this type of help. The type of help perceived as helpful further differs depending on the mental illness (Riedel-Heller, Matschinger & Angermeyer, 2005 and Bonabi, Müller, Ajdacic-Gross, Eisele, Rodgers, Seifritz, Rössler & Rüsç, 2016). For instance, Angermeyer and colleagues (1999) showed that in regard to schizophrenia, seeing a psychiatrist was the highest recommended solution, whereas for depression, a close family member or friend was recommended most often. This follows the notion that knowledge and awareness of schizophrenia appears to be greater than other mental illnesses (Kohn, Sharma, Camilleri, & Levav, 2000 and Corrigan, Bink, Schmidt, Jones & Rüsç, 2016). For instance, Kohn and colleagues (2000) found that virtually the entire public sample recognised that 'something was wrong' with persons described in both schizophrenia and depression vignettes (97% and 91% respectively). However, when participants were faced with a vignette of symptoms of schizophrenia, 71% reported that it displayed a mental illness, while only 26% reported this in regard to depression; further, 70% agreed that the schizophrenia vignette displayed a serious problem, while only 50% agreed to this in regard to depression. Indeed, Banks and Kohn-Wood (2002) found that 23% of the public sample was uncertain of the problem displayed in the depression vignette. These findings indicate that the type of treatment recommended for symptoms of a mental illness depends on its recognition as a mental illness and the perceived severity of these symptoms.

## **2.7 Studies from African countries other than South Africa**

In a study conducted in Agaro, Ethiopia with the aim of assessing how mental health problems are perceived by a community, a considerable number of people implicated supernatural powers as causing mental health problems which is in agreement with other studies conducted in Ethiopia (Deribew, Amare & Yonas Shiferaw Tamirat, 2005). The study identified important information on community perceptions towards mental illness. A significant number of the respondents from Gimbi community had poor perception of mental illness. This study is in line with the study conducted in Sub-Saharan Africa where about 59.7% of the population were found to have poor perception about mental illness. The study found that the general population demonstrated strong supernatural beliefs that influenced peoples' perception of mental heal

illnesses (Spittel, Maier & Kraus, 2019). Furthermore, it is consistent with the study done in Uganda where 49% of the respondents had poor perceptions of mental illness (Rasmussen, Kakuhikire, Baguma, Ashaba, Cooper-Vince, Perkins, Bangsberg & Tsai, 2013).

This study demonstrated that there was higher proportion of poor perception of mental illness among those above 39 years of age compared to the youth. The finding is not consistent with a study done in North Western Ethiopia, Agaro town, where younger respondents were more likely to hold socioenvironmental deprivation responsible for mental and physical illnesses than older respondents (Benti, Ebrahim, Awoke, Yohannis & Bedaso, 2016). This could be due to the difference in educational level between these two groups or may be due to the fact that the younger respondents may have access to information. Also, in study done in Iraq and India no significant association was found with age regarding the community's view of mental illness (Abolfotouh, Almutairi, Almutairi, Salam, Alhashem, Adlan & Modayfer, 2019).

Educational level was found to be one of the sociodemographic characteristics significantly affecting perception of mental illness in this study. Respondents who have no formal education are by 90% more likely to have poor perception when compared with degree holders and above. This finding is in agreement with the study done in Agaro town (Benti et al., 2016). Study done in Nigeria also found out that perception of mental illness correlates with educational level (Benti, Ebrahim, Awoke, Yohannis & Bedaso, 2016). Less educated respondents were more likely to attribute mental illnesses to supernatural retribution. This could be due to poor understanding of scientific explanation regarding causation of mental illness. Family history of mental illness is also another factor found associated with perception of mental illness among Gimbi community. Those who do not have family history of mental illness are found more likely to have poor perception of mental illness than those having family history of mental illness. This may be due to the fact that those having family history of mental illness may share experience. This experience may help them to develop good perception. This factor is also supported by psychologists' explanation. According to Bill, perceptual experiences are experiences of mind-independent things and are themselves an account of the way in which they provide peculiarly basic reasons for beliefs about the world around the perceiver (Benti et al., 2016).

Such traditional views whereby supernatural powers are attributed to controlling the wellbeing of an individual's mind are widespread in all ethnic or religious groups in Ethiopia. Similar results were also observed in other African studies (Deribew, & Shiferan, 2015). In the

developing countries like India and Morocco, a vast majority of people attributed the schizophrenic symptoms to supernatural phenomena, drug use, stressful life events and hereditary or personal deficiencies (Shah, Khalily, Ahmad & Hallahan, 2019). As shown in another study conducted in Iraq, the population did have a reasonable understanding of the aetiology of mental illnesses, citing genetic factors, negative life events, brain diseases and substance abuse as key causes although God's punishment and personal weakness were also viewed as major factors (Beukes, 2014). Evidence from rural Cameroon shows that Christians had a greater tendency to associate epilepsy to witchcraft with respect to Muslims (Bain, Awah, Takougang, Sigal & Ajime, 2013). Regarding gender differences in knowledge and belief about the aetiology of mental illnesses, findings indicate that more women than men believed that mental illness is due to possession by evil spirits (Kassis, Ghuloum, Mousa & Berner, 2014).

Reviewed studies from two African countries (Ethiopia and Nigeria) concerning public recognition of mental illnesses have been consulted. Respondents in a study from Ethiopia recognised only overt psychotic symptoms such as talking to oneself, excessive talkativeness and aggression as signs of mental health problems (Deribew & Shiferaw, 2015). Similarly, the most common symptoms proffered by respondents in the Nigerian study as manifestations of mental illness included aggression, talkativeness, eccentric behaviour and wandering (Kabir, Liyasu et al., 2014). In one study designed to investigate the experience of internalised stigma in mentally ill persons in Tehran, many expressed a concern about being recognised as having a mental illness causing problems in their family rewrite. Many told that they tried to conceal the fact that they were mentally ill from their family and from those close to them in order to avoid problems for themselves, their relatives, and those near to them. Another issue was feeling that mentally ill people are considered violent and dangerous- a recurring theme in studies of perceptions of the mentally ill worldwide (Ganesh, 2011).

Reviewed studies conducted in Africa have suggested that the experience of stigma by people with mental illness may in fact be common (Kapungwe, Cooper, Mwanza, Mwape, Sikwese, Kakuma, Lund & Flisher 2010). Results from the study in Zambia revealed that stigma and discrimination towards mental illness and those affected are ubiquitous and insidious across Zambian society (Kapungwe, Cooper, Mwanza et al., 2010). In Uganda, people with mental illness were believed to be mentally retarded, to be a public nuisance and to be dangerous (Quinn, & Knifton, 2014). Similar Nigerian study in 'Karfi' village ascertained that the majority of the respondents harboured negative feelings towards the mentally ill, mainly in the form of fear and avoidance. Literate respondents were seven times more likely to exhibit

positive feelings towards the mentally ill as compared to non-literate subjects (Liyasu & Habib, 2015). In another study conducted in Iraq to assess public perceptions of mental health, around half of the respondents thought people with mental illness should not get married, and that people with mental illnesses should not have children while just under half thought one should avoid all contact with people with mental illness. Just over half thought they could maintain a friendship with someone who had a mental illness, but less than one fifth thought they could marry someone with mental illness (Sadik, Bradley, Al-Hasoon & Jenkins, 2010). Similar results were reported from Tehran Iraq, all respondents reported that they have experienced feelings of alienation, discrimination and social withdrawal (Ghanean, Nojomi, & Jaccobsson, 2011).

## **2.8 South African Studies on Mental Illnesses.**

Studies conducted in South Africa have shown that there is a clear correlation between mental illnesses and HIV and AIDS. Cluver, Orkin, Gardner and Boyes (2012) found that AIDS orphaned children displayed higher levels of mental illnesses such as depression, anxiety and post-traumatic stress disorder in comparison to other orphaned children and non-orphaned children. This is believed to be the result of the stigma associated to HIV and AIDS. In another study Kleintjes, Lund & Swartz (2012), found that although mental health issues are recognised as a crucial issue for public health, mental health services still remain under-resourced. Another study established that stigma has a significant role in the tenacious pain and suffering, disability as well as the economic repercussions related to mental illnesses (Pescosolido, 2013). There is a strong argument that practical plans of action are crucial and have a major role to play toward increasing mental health awareness as well as reducing the stigmatising and discriminating attitudes associated with mental illnesses (Kakuma, Kleintjes, Lund, Drew, Green & Fisher, 2010). A study conducted by Sorsdahl and Stein, with the aim of assessing the awareness of attitudes and stigma associated with psychiatric disorders among South Africans, found that respondents held more stigmatising attitudes towards mental health patients who suffer from drug and alcohol abuse as well as individuals that are schizophrenic in relation to those suffering from post-traumatic stress disorder (PTSD) which were stigmatised remarkably less in comparison to various other conditions (Sorsdahl & Stein, 2010).

Traditional beliefs and practices regarding illness and health are still extensively followed in South Africa (Schierenbeck, Johansson, Andersson & van Rooyen, 2013). These beliefs and practices form a coherent system that has maintained individual and social equilibrium for



generations (Louw & Edwards, 2016). Amidst the differences across cultures and ethnicity in Africa, there still remains a general belief that diseases are sourced from external causes such as: “a breach of a taboo or custom, disturbances in social relations, hostile ancestral spirits, spirit possession, demonic possession, evil eye, sorcery, natural causes, and affliction by God or gods”(Nwokocha, 2010). Ancestors are highly respected in the African context and it is believed that when a person dies, he/she goes on to become an ancestor and integrates with ancestral spirits (Nwokocha, 2010). The individual still keeps in contact with the family, watches over them and protects them from misfortune. Africans perceive the balance between the living and their ancestors as a dependent factor for health. If the behaviour of the living members does not please the ancestors, they withdraw protection and cause illness within the living members (Ngirababyeyi, 2012). Mental illness is thus alleged to be caused by ancestors in an attempt to make a family member aware that their ways displease them and should be changed (Nxumalo & Mchunu, 2017).

In the African culture the community is an important determinant of most aspects including health and this is emphasised by the well-known African proverb “Umuntu ngumuntu ngabantu” which means a person is who they are because of other people (Manyike & Evans, 1998). In the African perspective the balance between the living members of the community, the environment and their ancestors are important in maintaining health (Nxumalo & Mchunu, 2017). Physical and mental illness occur when there is instability between an individual and their surroundings, which may include family, society and the ancestors of the individual (Ngirababyeyi, 2012).

According to Ngubane (1977), *Amafufunyana* is described as a form of spirit possession that results from sorcery. It is recognised among the Zulu and the Xhosa cultures of South Africa. The spirit possession is caused by a mixture of soil and ants that are taken from a graveyard, supposedly having fed from a dead body; the mixture is then placed in the path of the targeted victim (Ngubane, 1977). After stepping on the mixture, the victim will present with symptoms similar to those of hysteria, they throw themselves on the floor, tear off their clothes and they may even harm themselves through violent acts and try to commit suicide. According to Zabow & Kaliski (2006), *Amafufunyana* is recognised as an indigenous name and concept for mental illness among the Xhosa people.

Although most of the causes of illness are believed to be due to ancestral spirits, witchcraft is another phenomenon that is suspected when one suffers from mental illness (Stefanovics, He,

Cavalcanti, Neto, Ofori-Atta, Leddy, Ighodaro & Rosenheck, 2016). According to Stefanovics et al (2016), there are two types of witchcraft: The witch who inherits the trait and functions at night and a witch who uses medicine to bring others misfortune. Hammond-Tooke (2002) refers to the terminologies of witches and sorcery in African terms, with witches being referred to as “abathakathi” in the Nguni and “baloyi” in the Sotho languages. The sorcerer uses medicines which may be in the form of poison which when taken can cause illness. The Zulu call this illness “idliso” and the Pedi refer to it as “Selesho” which occurs after one has been poisoned through food (Ngubane, 1977). Witchcraft is motivated by numerous factors, with the most common being jealousy especially by people close to the victim who are not pleased with his/ her success and poison him/ her to cause mental illness (Koning, 1993).

Lombo (2010) conducted a study on mental healthcare practitioners’ perspectives of mental illness within the Isixhosa cultural context. The research participants belonged to the Isixhosa ethnic group, were able to speak Isixhosa and were mental health care practitioners from various professions employed by Komani hospital for at least a period of three years. The study discovered that participants in the study generally perceived mental illness as characterised by strange behaviour as well as a painful disease where one loses his dignity (Lombo, 2010). Scientific causes of mental illness were mentioned; however, more than half of the participants referred to mental illness as resulting from factors such as: failure to observe cultural practices, witchcraft and failure to accept the calling of being a traditional healer (ukuthwasa) (Braathen, Vergunst, Mji, Mannan & Swartz, 2013). The mental healthcare practitioners expressed that knowledge of these cultural causes makes it easier for them to manage and treat mental illness, as this gives them insight into the patient’s own understanding of their illness. The family is used as a support system that aids the health care professionals with continued care.

Sorsdahl, Flisher, Wilson, and Stein (2009) conducted a study with a convenient sample of 50 traditional healers from those who attended a workshop conducted by the South African Depression and Anxiety Group (SADAG) in Mpumalanga province. The traditional healers were from Lydenberg, Sabi, Standerton, Bethal, Bushbuckridge and Komatipoort. The study focused on explanatory models of mental illnesses and treatment practices among traditional healers in Mpumalanga, South Africa. The findings of the study revealed that participants believed that mental illness resulted from factors such as family problems, substance abuse and poverty that were left untreated and progressively became more severe. Furthermore, the study revealed that the symptoms presented by a mentally ill patient are predominantly behavioural and include undressing and urinating in public, violent and aggressive behaviours not

acceptable within those cultural boundaries. According to the traditional healers, the effects of mental illness extend beyond the illness itself; there are social factors involved such as the mentally ill losing their jobs and not being able to care for their families. They are also mocked by the community and became very lonely and isolated. According to the study the causes were described as including witchcraft, possession by an evil spirit, substance abuse, life stressors and calling to be a healer (Schierenbeck, Johansson, Andersson & van Rooyen, 2013).

Mental illness is treated in hospitals with the aid of professionals who have been trained to treat mental illness such as Psychologists, Psychiatrists and Psychiatric Nurses (Horwits, 2020). The western approach of treatment which is used in the training of these professionals is used in the treatment of mental illness that people present with (Horwits, 2020). However, in the African cultures treatment for mental illness is often sought from traditional healers, this is motivated by the belief that the cause of mental illness is more religious/spiritual than it is physical (Vaughn, Jacquez, & Baker, 2009). In African culture the traditional healer diagnoses the cause of illness, which may be brought about by the ways of the victim that do not please the ancestors or the relation one has with the environment, as it is believed balance is maintained through the relations one has with the environment, their fellow community members and the ancestors (Saayman & Kriel, 1992). Hammond-Tooke (2002) distinguishes between two types of traditional healers: herbalists and diviners. The diviner is referred to differently across cultural groups in South Africa. The Xhosa refer to the diviner as “imagqira”, the northern Sotho as “ngaka”, the Southern Sotho as “selaoli” and the Venda and Tsonga as “mangome” (Truter, 2007). The diviner is called by the ancestors and trained by an experienced diviner. After training he/she then functions as a medium of communication between people and their ancestors (Vaughn, Jacquez, & Baker, 2009). The diviner receives powers from the ancestors that allow for him/her to diagnose and provide medicine. According to Truter (2007), 90 % of diviners in South Africa are female.

The herbalist commonly known as “inyanga” utilizes medicines derived from different substances such as plants and roots to treat the illnesses that his clients present with (Hammond-Tooke, 2002). Unlike the diviner who is chosen by the ancestors; anyone who desires to be a herbalist may do so by acquainting himself with an experienced herbalist who will educate him on the different herbs (Truter, 2007). Traditional healers recognise the disorders treated by mental health care providers such as psychiatrists, however, their methods differ as they consist mainly of herbal treatment, fortune telling, exorcism and rituals believed to help heal mental illnesses. According to Mporu, Peltzer and Bojuwoye (2011), some of the ways used to treat

mental illness in African culture are through ritual enactment, dream interpretation, cleansing, scarification, aromatherapy and fumigation. Negative spiritual influences are removed through ritual enactment, the patient who has a spiritual influence that affects their health works in collaboration with the healer to name the spirit and then cast it into the wild or to a domestic animal. It is the belief that the malicious spirit has been cast away that leads the patient towards recovery (Mpofu, Peltzer & Bojuwoye, 2011). The treatment process takes a holistic approach.

Sorsdahl, Stein, Grimsrud, Seedat, Flisher, Williams & Myer (2009) in their study with a sample of 50 traditional healers reported a majority of the healers stating that they possessed the skills and knowledge required to cure a mental illness and often treated the patient by encouraging them to live with them in their home or visiting them on a regular basis. The duration of this treatment ranged from two weeks to a year and a half. In cases where the patients get violent and would not take their medicine the healers tie them with ropes and chains. All the healers reported that mentally ill patients would be given “muti” to drink and bathe with, while others described treatment involving sniffing herbs through the nose. However, there is not a sole reliance on traditional healing. Lombo (2010) working with a sample of mental health practitioners from Komani hospital found that mental health care users are often treated by traditional healers before being admitted to the hospital. The practitioners expressed the importance of understanding the cultural beliefs of patients as a factor in managing mental illness. Komani Hospital uses a bio-psychosocial approach which understands behaviour within a context of biological, psychological and social factors (Buamann, 1998). The mental health workers take into account the different factors that influence a patient in their treatment with the aim of treating the patient appropriately. The treatment measures consist of Psychotropic medicine and Counselling. The severity of the symptoms guides the practitioner on which method to use, a combination of treatments may be used (Lombo, 2010).

## **2.9 Mental illness and Community Development**

Patel and Prince (2010) proposes psychological empowerment as an orientation and targeted outcome for community development efforts. Psychological empowerment has been the focus of many studies in community psychology, where it has been defined as the psychological aspects of processes through which people, organizations, and communities take greater control over their affairs. Psychological empowerment has been found to increase with greater levels of community participation, and to have protective mental health effects. Community and

organizational processes that are psychologically empowering are promising as approaches to sustainably promote both subjective well-being and objective changes in local systems (Patel & Prince, 2010).

Patel and Prince (2010), argue that power should be central to discussions of global mental health and community development. Unfortunately, emerging conceptions of global mental health as a field do not address issues of power, but instead focus exclusively on ‘scaling up’ services, including professional intervention and drug treatments, for those experiencing mental distress (Patel & Prince, 2010). While it is true that many services should be made more accessible to more people, the notion that professional mental health services could be scaled up to meet the needs of the world’s rapidly growing population is unrealistic, to say the very least. Mental health services and treatments are often costly, and many of the people who might benefit most from them lack access to resources needed to meet more basic and urgent needs and concerns, which, if addressed, might well have larger positive impacts on mental well-being. Even in wealthier societies, some observers have long recognized the impossibility of approaching mental health at a population level from the perspective of treatment and professional service provision (Prilleltensky, 2011).

Seymour Sarason purported that his earlier realization was that United State societies did not possess nor would it ever possess the professional resources to deal with troubled individuals. Put another way, as long as we define the problems of individuals in a way so as to require solution by highly trained professionals, the gap between “supply and demand” becomes scandalously greater with time (Sarason, 1976, p. 318). This realization led Sarason and community psychology, a field of study he helped to initiate, away from mental health services and treatments to a focus on promoting well-being and empowerment. Research in community psychology has discovered that positive psychological outcomes, such as well-being and resilience, are systemic and can have compounding effects (Prilleltensky, 2012). Psychosocial benefits accrue not only to those fortunate enough to avoid trauma and other risk factors, but also to those who become actively engaged in community organizations and other democratic processes. This is particularly true for those who became engaged in certain types of community and organizational settings – namely, those settings that have structures that permit many people to play meaningful roles, those that provide social support, those that provide access to social networks in different organizations, and those that implement community action (Peterson and Zimmerman, 2004). These empowering community settings can contribute simultaneously to individual psychological development, community development,

and positive social change (Maton, 2008). That is to say, they can build power, resilience, and sociopolitical control at the psychological, organizational and community levels. Identifying, sustaining, and proliferating such settings have become central tasks for scholars and practitioners of community psychology. Empowerment processes in community and organizational settings also represent a promising conceptual framework and orientation for efforts to promote global mental health. Community development is uniquely positioned, as a field, to encourage the development of empowering community settings in many places across the globe, and thereby promote sustainable gains in mental health and local power in decision making.

Members of every society and social class experience symptoms of mental distress. Yet, research on mental health across nations and groups demonstrates that threats to mental health can be understood at a macro-level, and are heavily influenced by inequality and community context. For instance, young people who experience the traumas associated with mass violence and war are more likely to develop adverse mental health conditions. Palestinian youth, for example, are particularly vulnerable to emotional and behavioural disorders as a result of cumulative exposure to two types of trauma: (i) directly witnessing killing, violence, and the destruction of homes and communities, and (ii) the chronic insecurity and stress that comes from the ever-present threat of atrocities or destruction of communities (Qouta, Punamaki & El Sarraj, 2008). However, it is not only mass violence that creates vulnerability. In a study of the impacts of the terrorist attacks of 11 September 2001 on the mental health of young people living in New York City, Aber et al. (2004) found that exposure to that particular traumatic event had minimal effects on mental health outcomes when compared with the young people's direct exposure to 'everyday' violence in their own communities. It is the most marginalized or least powerful members of societies – women, minorities, the poor, and the young – who experience the greatest vulnerabilities and instabilities in their community contexts. Moreover, these are the same groups most likely to manifest symptoms of mental distress as a result of traumatic experiences (Wadsworth, 2010). Poverty, racism and stigmatization, exposure to violence, and the threat of violence are all disproportionately experienced by people with less relative power, who are, in turn, more vulnerable to mental distress. Mounting evidence supports linkages between racism and health disparities, including psychological symptoms (Williams and Mohammed, 2009). Racial minority populations in impoverished inner cities in the United States, for example, face a daunting set of compounding pressures and increased vulnerabilities (Ginwright, 2010). Across societies, the subjective experience of poverty is one

that often involves frustration, stress, insecurity, unease, a sense of dread about the future, disrupted family relations, and increased likelihood of experiencing depressive/anxious symptoms (Santiago, Stump and Wadsworth, 2011; Underlid, 2007). When people living in poverty are faced with negative life events and crises, the results more often include mental distress (Anand and Lea, 2011). Similarly, gender-based violence is increasingly being recognized as a pandemic with negative consequences for women's mental health (Gelaye et al., 2009). The relationships between marginalization and mental health extend beyond race, gender, and socioeconomic status. For example, despite significant progress in reconciliations between socio-religious and ethnic groups in Northern Ireland, little progress has been made in extending intergroup tolerance to sexual minority youth – those who identify as lesbian, gay, bisexual, or transgender – and the hostilities experienced by these youth are leading to adverse mental health outcomes (Schubotz and O'Hara, 2011). Moreover, because poor mental health creates additional vulnerabilities through loss of control and self-determination, the impacts on members of marginalized groups and communities are compounding, leading to even greater powerlessness. Indeed, while socioeconomic status is consistently found to influence psychological well-being, by itself, it is a weak predictor (Rojas, 2011). Improved economic circumstances can lead to increases in subjective well-being, but mainly for the very poor, while increases in well-being beyond the poverty threshold appear to depend more on social and political freedoms, social tolerance, belief systems, and a sense of control (Inglehart, Foa, Peterson & Welzel, 2008). Attempts to sustainably promote well-being, therefore, must consider power, and the processes that might lead to greater relative power and control for marginalized people and groups.

Empowerment has most often been defined as the mechanism by which people, organizations, and communities gain mastery over their affairs (Rappaport, 1987). A more expansive definition is 'a group-based, participatory, developmental process through which marginalized or oppressed individuals and groups gain greater control over their lives and environment, acquire valued resources and basic rights, and achieve important life goals and reduced societal marginalization (Maton, 2008). In the community development literature, most definitional efforts have focused on the concept of community empowerment (Laverack, 2001). Yet, it remains uncommon for community development to focus on empowerment at the psychological level. Particularly alongside the emerging focus on global mental health (World Health Organization, 2010), it would appear an auspicious time for more thorough

consideration of psychological empowerment in the design, implementation, and evaluation of community development projects.

In the context in which it has been studied, psychological empowerment has been found to be associated with greater levels of community participation and psychological sense of community (Christens, Peterson & Speer, 2011), and to have protective effects on psychological wellbeing (Christens and Peterson, 2012). The mechanisms for these beneficial effects of psychological empowerment relate to the nature of environmental stress (Israel, Checkoway, Schulz & Zimmerman, 1994). Many of the sources of environmental stress and trauma (e.g. community violence) are beyond the ability of individuals to change or avoid. Psychological empowerment is an indicator that individuals are taking collective action to create social and political change. Therefore, psychological empowerment indicates positive and protective developmental processes at the community level that are simultaneously beneficial to the individual participants in those processes. Thus, psychological empowerment can be considered an especially relevant process and outcome variable for groups with less relative power, including women (Harcourt, 2010), young people (Kohfeldt Chhun, Grace & Langout, 2011), and minority groups including racial/ethnic minorities (Becker et al., 2002), sexual minorities (Russell et al., 2009), and those experiencing mental distress (Nelson, Lord and Ochocka, 2001).

Empowerment theory provides both a value orientation for practice and a conceptual frame for studying community and organizational processes and outcomes (Rappaport, 1987). Empowerment has been theorized at different levels (i.e. psychological empowerment, organizational empowerment, community empowerment), and most empowerment theories have insisted that processes and outcomes at these different levels of analysis are interconnected. In other words, empowerment processes take shape in the transactions between individuals and their contexts. Since psychological and community empowerment are mutually dependent on each other, identifying and evaluating empowerment processes should involve ‘the study of the changing relations among psychological and environmental aspects of holistic unities’ (Altman, 1987). Too often, however, studies of psychological empowerment neglect community-level processes. Conversely, community development, which has been attentive to empowerment at the community level, has not been consistently attentive to psychological processes and outcomes among people affected by community development projects (Goldsworthy, 2002). Attending to both psychological and community-level processes – and

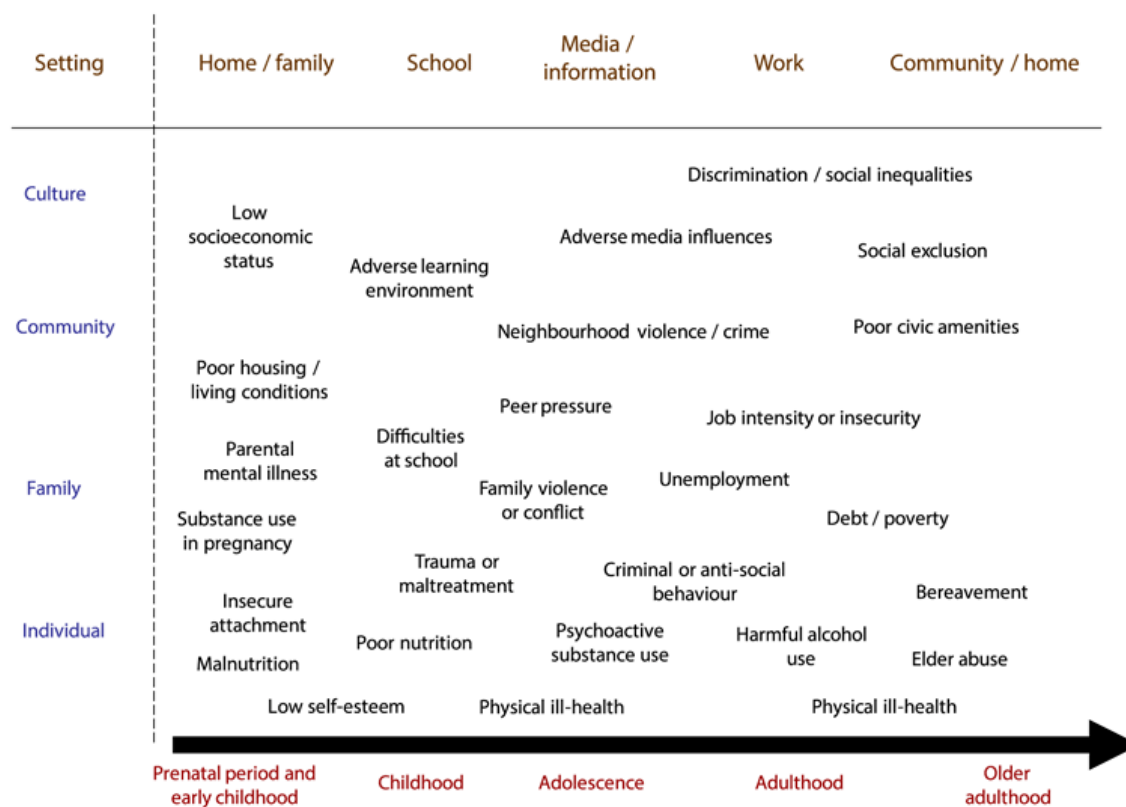


the transactions between them – holds promise for resolving important dilemmas in community development practice.

Progress has been made in addressing shortcomings of participatory development theory and practice. The common premise that community development practice should universally have material well-being as a final goal therefore limits the degree to which development processes can be truly participatory and transformative (Christens and Speer, 2006). If participatory development processes are considered as empowering processes, it becomes clear that they should involve local residents in selecting not only the means to achieve predetermined ends, but also the focal issues and final goals of development processes. An approach to understanding and evaluating such shifts in practice would be to assess gains in psychological empowerment among local participants in development projects. Identifying, sustaining, and proliferating the types of processes that most effectively enhance the psychological empowerment of participating community members would better position community development to affect well-being not only through economic development, but also through transactional processes that promote wellness, resilience, and sustainable community power (Christens & Peterson, 2012).

Wilson (2012) states that the widely known and universally accepted definition of Community Development (CD) is that of the United Nations Department of Economic and Social Affairs of 1963 which define CD as the process by which the efforts of the people themselves are united with those of governmental authorities to improve the economic, social and cultural conditions of communities, to integrate these communities into the life of the nation, and to enable them to contribute fully to national progress. According to the WHO (2013: 27), mental health is defined as a state of well-being whereby every individual person realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to have a positive contribution to his or her community. Mental health is influenced by a variety of individual attributes, environmental factors, and social and economic circumstances. As a result, people differ in their emotional resilience which means that individuals experience symptoms of mental distress at varying levels in the face of stress and trauma (Green & Haines, 2015). There are a number of risk factors that negatively impact and affect mental health at both the individual as well as community levels, which have crucial implications across the life course of any individual.

## Overview of Risks to Mental Health over the Life Course

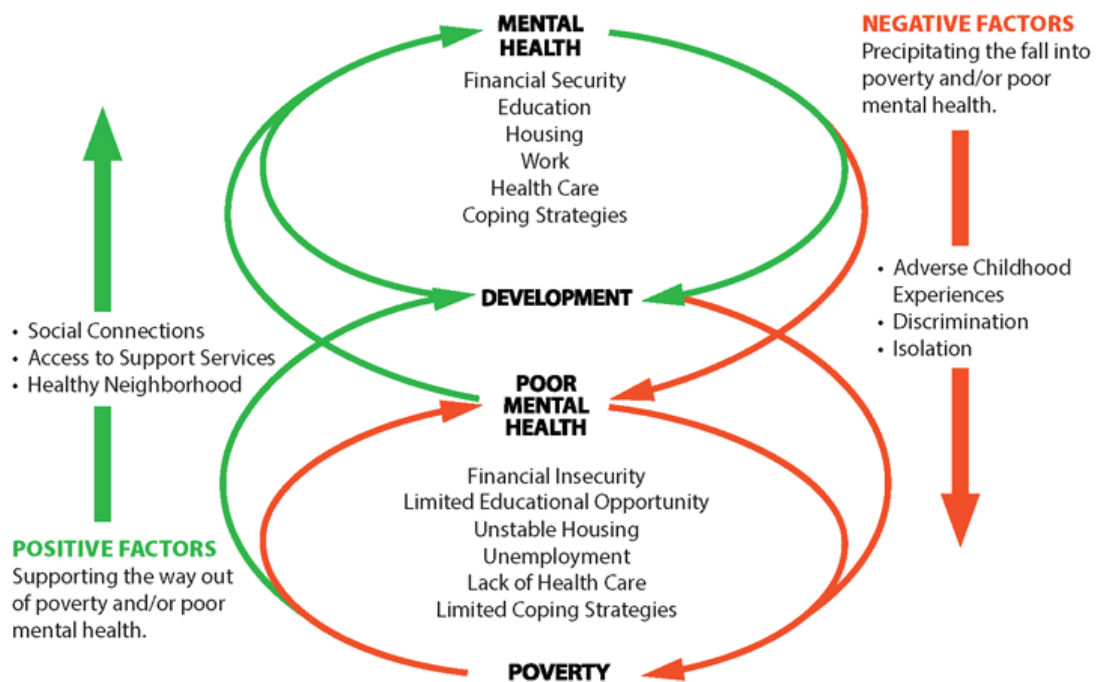


**Source:** World Health Organization, “Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors,” August 27, 2012.

Community development as a discipline has a crucial role to play in influencing health at the population level by supporting the physical, social, and civic infrastructure that makes health possible and easily accessible for all communities (Green & Haines, 2015). Achieving population-level mental health, consistent with the WHO definition, is a necessary component of achieving broader population health, and it requires approaches that go beyond a focus on individual-level clinical treatment for those struggling with mental health challenges (Fieldhouse, 2012). Community development and Psychology can have a multidisciplinary approach to tackling the issue of mental illness. Research shows that community development-

related issues such as unstable housing and unemployment are connected in a complex negative cycle with poor mental health. There is a growing awareness of the need to explicitly address the mental health needs of low-income populations, recognizing that they are more likely to face negative risk factors such as adverse childhood experiences, social isolation and loneliness, discrimination and detachment from academic or work achievement (Maura & Weisman de Mamani, 2017). These negative experiences can diminish a person’s sense of control, self-efficacy, connectedness, and hope, all of which are important elements for resilience and mental health promotion. People in poverty are also less likely to have protective factors that promote mental health, including many of the things that community development works to provide, such as stable housing, supportive community networks, and financial security (Rose & Thompson, 2012). Low-income children and adults also face barriers to accessing mental health services as such services are usually not available in poorer communities and are thus costly to access in the more affluent communities in which such services are usually found (Olesen et al., 2013).

### Positive and Negative Factors that Influence Mental Health



Source: Adapted from World Health Organization

Mental health promotion across the life course is critical for supporting the economic resilience and mobility of low-income people, a key aim of community development efforts. For example, there is clear evidence that poor mental health is associated with reductions in labour force participation and employment (Chatterju, Alegria & Takeuchi, 2011). It is also both a consequence of and risk factor for unemployment (Olesen et al., 2013). Mental health problems among children have a severe negative impact on educational outcomes, which can limit future economic wellbeing. Reflecting on these drivers of poor mental health, it becomes clear that the community development discipline has a very critical role to play in addressing these root causes of mental ill health (Maura & Weisman de Mamani, 2017). The community development discipline, as well as the discipline of Psychology, have a crucial opportunity to work together and leverage each other's strengths and principles to support the mental health of low-income communities.

## **2.10 Conclusion**

This chapter provided the study's literature review which discussed the topic of mental illness reviewing studies from South Africa as well as other African countries.

## **CHAPTER THREE**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 Introduction**

The previous chapter has reviewed literature surrounding the topic of mental illness. The chapter also provided the theoretical/conceptual framework of the study. All research conducted has underlying ideological assumptions that motivate the rationality of that study and which research method is appropriate to be utilized for the development of knowledge in that study (Popkewitz, 2012). This chapter will distinctively provide an overview of the study methodology adopted to guide in the process of data collection and analysis. This chapter will discuss the research design used in this study including the data collection tools, the process of analysing data and finally, to ensure trustworthiness between the researcher and participants this chapter will provide four important criterions. The chapter will close with the limitations of the study.

#### **3.2 Research Paradigm**

Many scholars within research have wrestled the term paradigm as it has a different meaning to different scholars. A paradigm is defined by scholars as an arrangement of basic convictions and theoretical frameworks, shared amongst them with the assumptions about (1) ontology (defining reality) (2) epistemology (explaining a phenomenon) (3) methodology (proving the phenomena exist) and methods (Neuman, 2000, Creswell, 2013 and Rehman & Alharthi, 2016). It is noteworthy that a research paradigm gives direction to the researcher as to which research method should be employed in the study to acquire knowledge. There are a number of taxonomies that distinguish a paradigm; Mackenzie and Knipe (2006) classify them accordingly, as follows: positivist, transformative, interpretivist, critical, pragmatist and de-constructivist, post-positivist. However, in social science research only 3 paradigms are dominant, they are listed as follows: the positivist, the interpretive and the critical paradigms (Myers and Avison, 2002)

##### **3.2.1 Interpretivism Paradigm**

This is a qualitative research study and the underlying research philosophy guiding this study is the interpretivism paradigm. This paradigm enables researchers to understand the construction of the world through the views and perception of the participants of the study (Thanh and Thanh, 2015). Hence, the study used qualitative methods to collect data, (Creswell,

2013 and Thanh & Thanh, 2015). According to Rehman and Alharthi (2016) the interpretive paradigm lies on the foundation that in a societal setting there are multiple realities that exist. The scholars further assert that interpretive ontology is anti-foundationalist, meaning it denounce the idea to adopt any permanent, unvarying (or foundational) standard by which truth can be universally known (Lincoln, Lynham & Guba 2011). Interpretive research values subjectivity as it studies human behaviour (Willis, 2007), it seeks to “understand the interpretations of individuals about the social phenomena they interact with” (Rehman and Alharthi 2016:55). Hammersley (2013) assert that since humans have diverse ways of viewing and seeing the world in different societal settings with different cultural beliefs in order to avoid bias study.

**Table 1: Interpretivism paradigm**

<b>Paradigm</b>	<b>Ontology</b>	<b>Epistemology</b>	<b>Theoretical perspective</b>	<b>Methodology</b>	<b>Method</b>
	What is reality?	How can I know reality?	Which approach you use to know something	How do you go about finding out?	What techniques do you use to find out?
Interpretive	There is no single reality or truth. Reality is created by individuals in groups.  Anti-foundationalist	Therefore, reality needs to be interpreted. It is used to discover the underlying meaning of events and activities.  Subjective	Interpretivism (reality needs to be interpreted)  Phenomenology  Symbolic Interaction  Critical Inquiry  Feminism	Ethnography  Grounded Theory  Phenomenological research  Action research  Analysis	Usually qualitative, could include: Qualitative literature, Observation, participant and case study.

Source: Thanh & Thanh, 2015 and Rehman and Alharthi, 2016.

### 3.3 Research Design

Research design can be considered the structure of research. According to Akhthar (2016), a research design is the arrangement of conditions for the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy and procedure. Research design is the plan, structure and strategy used to search a question (Mustafa, 2010). Leedy and Ormrod (2005) defines research design as a plan for a study, providing the overall framework for collecting data. MacMillan and Schumacher (2001) define it as a plan for selecting subjects, research sites, and data collection procedures to answer the research questions. They further indicate that the goal of a sound research design is to provide results that are judged to be credible. Durrheim and Reingold (2010), argues that research design is a strategic framework for action that serves as a bridge between research questions and the execution, or implementation of the research strategy.

There are four types of research design namely: Exploratory, Descriptive, Explanatory and Experimental. Exploratory research is the primary stage of research and the purpose of this research is to achieve new insights into a phenomenon. This research is one which has the purposes of formulating a problem for more accurate investigating a problem for more accurate investigation or for developing a hypothesis. This is applied when there are few or no earlier research/studies to which references can be made for information (Stebbins, 2001). Exploratory studies are usually more appropriate in case of problem about which little research knowledge is available (Swedberg, 2020). Descriptive research is also known as statistical research, this describes phenomena as they exist. It is used to identify and obtain information on characteristic of a particular issue like community, group or people. This type of research describes social events, social structure, social situations. The observer observes and describes what he or she found. Descriptive research answers the questions, what, who, where, how and when (Forman & Damscroder, 2007).

Explanatory research is when the purpose of the study is to explore a new universe, one that has not been studied earlier. the research is mainly concerned with causes or answering the ‘why’ question about some phenomenon. The research purpose in this case is to gain familiarity in unknown areas. Often explanatory research design is used to formulate a problem for specific investigations, or aim at formulating research design thus, often when the universe of study is an unidentified community, this design forms the first step of research, after which other types of research designs can be used (Sandelowski, 2000). Experimental research is the design that

is used to test a Research Design of causal relationship under controlled situation. An experiment is an observation under controlled conditions or in other words, it is a design in which some of the variables being studied are manipulated or controlled or which seeks to control the condition within which persons are observed. Controlling of conditions means that the phenomenon or the condition should not be allowed to change while the experimentation is going on (DeMarrais & Lapan, 2003). This study adopted the exploratory research design as this was the most suitable design in meeting the objectives of this study. The exploratory design is most suitable as little is known about the community attitudes towards people living with mental illness in the community of Inanda.

Research studies can be classified in various ways (Bless et al., 2013). In theoretical research, there are two leading research methodology that serve as research designs in a study. These are quantitative research, which relies on measuring, comparing and analysing variable, and in contrast qualitative research, records the aspects of the world by using words (Bless et al., 2013: 56). The researcher utilized the qualitative research which will present an exploratory qualitative study. Qualitative research was largely influenced by Wilhelm Dilthey in his work of 'science of the spirit' (Erickson, 2011:44 cited in Mills & Birks, 2014). As a philosopher in social sciences, he's work was aimed to "understand human experience, as opposed to gathering proof for the purpose of prediction and ultimately generalization" (Mills & Birks, 2014). Bless et al. (2013) defines qualitative research as "research conducted using a range of methods which use qualifying words and descriptions to record and investigate aspect of social reality" (Bless et al., 2013: 394). In one's understanding, qualitative research allows the researcher to gain more information from the people being studied. The overall aim of conducting a qualitative research is to examine the impact of a phenomena in a given cultural or social setting (Mills & Birks, 2014). The researcher aimed at exploring the different attitudes community members have towards people living with mental illnesses in the community of Inanda; KwaZulu Natal. The exploratory qualitative design was mostly suitable for this study. This research design allowed the study to gain an in-depth understanding of the proposed research problem, by directly collecting information and opinions from individuals that have been exposed to living with people living with mental illnesses.

### **3.4 Data Collection Instruments**

Schwandt cited in (Mills & Birks, 2014) described methodology as "a particular social scientific discourse that occupies a middle ground between discussions of method and



discussions of issues in the philosophy of social science” (Mills & Birks, 2014). A methodology is strongly linked to the desired objectives that a researcher seeks to achieve hence a methodology gives the researcher a direction on how to achieve the set objectives (Mills & Birks, 2014). The qualitative research approach, according to Creswell (2013), begins with assumptions and study’s the research problem to gain an understanding of individuals meaning to a human or social problem. Similarly, Bless et al. (2013) defines qualitative research as "research conducted using a range of methods which use qualifying words and descriptions to record and investigate an aspect of social reality" (Bless et al., 2013: 394). In a qualitative study, the researcher’s essential role or rather task, is to describe people’s social reality as constructed in their minds and further more; utilize scientific concepts of a particular discipline to increase understanding of that construction (Crang and Cook, 2007). To make sense of a certain phenomenon the researcher needs a “commonplace evidence” derivate from peoples shared experience with life; hence qualitative research requires experimental or practical knowledge (Heron, 1992 and Hamel et al., 1993 cited in Cropley, 2019). There are a number of alternative data collection techniques in qualitative research to reveal lived experiences of people’s lives such as “the physical form of data, using existing data, second-hand data, virtual data and non-verbal data” (Cropley, 2019).

### **3.4.1 Critiques of Qualitative Methodologies:**

There are a few critiques tainted to qualitative methodologies, of which are important to consider when planning which research design to utilize in one’s study (Mills & Birks, 2014). Below is a table outlining casual analysis by Hammersley (2008) of the main disadvantages of utilizing some qualitative methodologies: 1. Failing to rigorously operationalize concepts and thereby to document measurable differences. 2. Not ruling out rival explanations through physical and statistical control. 3. Failing to produce generalizable finding.

Morse (2011) adds to the above critiques stating that qualitative methods do not give answers to the phenomena being researched but rather raises more questions. Morse further suggest a methodology that will both represent physical and statistical data to increase generalizable findings. This study made use of focus groups, interviews and direct observations as methods for collecting information which will lead to addressing the research question of this study. Focus groups, interviews and direct observations techniques are commonly utilized in qualitative research methodologies to gain groups or individuals viewpoint (Bless et al, 2013). Data collection is defined as the process through which needed information is gathered to

address a research problem (Polit & Beck 2004). Taylor (2005:240) also explained that data collection tools in qualitative studies are specific processes followed by the researcher to obtain information from the targeted participants using techniques such as interviews and observations. Data collection techniques are fact-finding strategies, which can be used as tools for data collection (Annum, 2017:1).

For this study, in-depth interviews were used as the data collection tool. In-depth interview refers to a process whereby a researcher actively engages participants in conversation. In-depth interviews are useful in gathering rich data and information from questions that are mostly open ended. It is also useful when conducting research with few participants unlike survey research (Guion et al, 2011). The focus of these in-depth interviews were on perceptions, attitudes and participants' understanding of mental illnesses and their causes. Aral et al. (2007:449:452), confirms that in-depth interviews provide researchers with detailed information about people's experiences. It also gives participants the opportunity to express themselves based on their own words. One-on-one interview techniques that were used in this study are among the methods commonly applied in qualitative research of few participants in the field of mental health. This is also due to the sensitivity of the research questions. To ensure that sensitivity and privacy was respected, participants were interviewed individually in a private room, and interviews were audio-taped and transcribed to ensure accuracy.

The interviews were one-on-one and they were semi structured in order for respondents to talk freely about the subject of interest and leave open space for new ideas to arise during the interview process (Bless et al, 2013). In qualitative research, interviews are the commonly used form of research method by an estimated 90% of social scientists (Briggs, 1986 cited in Cropley 2019 & Mason, 2002). Interviewing can be structured and unstructured; on the one hand, structured interviews are thoroughly prepared questions and process on interviewing each interviewee. On the other hand, unstructured interviews could be defined as a "free-flowing conversation" (Hancock et al., 2009). During the process of interviews, the interviewer has a fundamental task of obtaining unobstructed access to information as to what the interviewee knows and also creating a pertinent environment (Cropley, 2019). The interviewer should always ensure that the respondents feel that their views are taken; hence the interviewer should always listen attentively, avoid judgmental facial expressions and most importantly ensure they have respectful and alert behavioural and body language (Hancock et al. 2009). Cropley (2019) advises that the 'why' and 'what do you mean?' questions should be avoided by the interviewer because these questions indicate a sense of disagreement; he further suggests that the

interviewer uses encouraging questions such as ‘what, where, where and how?’, as such questions encourage the respondent to express their views more.

### **3.5 SAMPLING METHOD**

Sampling refers to selecting a small portion that will represent the entire population in the interest of defining certain features of the target population (Mouton, 2009 & Bless et al 2013). A sample, as defined by Bless et al, (2013) “is the subset of the whole population” that the researcher plans to study for generalizing about the target population. Neuman and Robson (2014) defines population as “the abstract idea of a large group of many cases from which a researcher draws a sample and to which results from a sample are generalized” (Neuman & Robson, 2014, 247). Mouton (2009) states that the chosen representative group should be accurate and unbiased sample. To ensure this, Mouton listed the process of sampling as follows, “clear definition of the population, systematic drawing of the sample, drawing probability rather than non-probability samples and observing the advantages of multi-stage verses simple random sampling” (Mouton, 2009). In qualitative studies; when we sample, we select cases/units, the chosen cases/units therefore represent the larger population of cases/units (Neuman & Robson, 2014). In any qualitative research, the aim is to develop theoretically and empirically grounded argument, thus it is essential for the researcher to choose an unbiased representative sample that will allow the researcher to access data in order to achieve the aforementioned aim in qualitative researcher (Mason, 2002). Choy (2014) argued that sampling in qualitative research allows us to have an in-depth understanding of complex social issues. The sampling criteria which was employed for this study is as follows: thirteen (13) participants from the younger generation and thirteen (13) participants from older generation South Africans residing in Inanda, Kwa-Zulu Natal. These were adults between the age of 18 years to 35 years in the younger generation and 36 years and above in the older generation who all voluntarily participated in the study. The study chose to include the two different age groups in order to discover whether there were opposing or similar views and perceptions regarding mental illness between the two age groups. Participants in both these age groups were asked about their understanding, experience, perception and attitudes regarding the issue of mental illness. The interviews took place in the comfort of each participants home to ensure that the participants were comfortable enough and to avoid travel costs. The duration of the interviews was approximately seventy-five minutes each. In addition, ways through which the views and perceptions of community members towards those living with mental illnesses can be improved were also explored from both the younger and older generation. The inclusion of both these

groups was important because it provided the study with unbiased and rich information, which presented the voices of both the younger as well as the older generation.

The nature of a qualitative research is to explore, describe, and understand human experience through the collection of intense, full accounts of the issues to be studied. Participants of qualitative research are therefore selected through snowballing and purposive sampling where the participants are chosen and allocated due to the situation they went through in the field of the study, because of their ability to add to and enrich the structure and character of what is being or to be studied (Polkinghorne, 2005). Therefore, those individuals who can provide the most insight into an experience are able to provide rich information.

This study made use of the snowballing sampling method. Snowball sampling is a non-probability sampling technique that yields a study sample through referral made among people who share or know of others who possess some characteristics that are of interest to the research. This method is well suited for the research purposes and is particularly applicable when the focus of the study is on sensitive issues such as mental illness, possibly concerning a relatively sensitive matter and thus requires the knowledge of insiders to locate people for the study. In other words, snowball sampling is also a tool used by the researcher to collect data on the few targeted populations who went through the situation and do not want others to know their social status, then asks those individuals to provide information needed to locate other potential participants (Gentles, Charles, Ploeg, & McKibbin, 2015). Participants may not be comfortable to openly raise their personal views about mental illnesses as they may not want to come across as cruel to those living with mental illnesses around them.

#### 3.5.1 INCLUSION CRITERIA:

- Thirteen community members between the age of 18-35.
- Thirteen community members between the age of 36-65.
- People residing in Inanda KwaZulu-Natal.

#### 3.5.2 EXCLUSION CRITERIA:

- Family members of people living with mental illnesses.
- Minor people who are below the age of 18.
- People not residing in Inanda KwaZulu-Natal.

### **3.6 Data Analysis Technique**

Analysis of data also includes the creation of data categories and placing data into appropriate columns or categories to identify links contained by columns of information to take better informed decisions (Bless, 2013). Data analysis is the process of systematically searching and arranging the interview transcript, field notes and other material that can be accumulated to increase understanding and to enable the researcher to present what s/he have discovered to others (Creswell, 2013). In this research, data was analysed using thematic analysis in this study as a qualitative content analysis. In thematic analysis, the researcher tabulates data using Microsoft Word to develop themes and thematically analyse qualitative interviews (Leedy and Ormrod, 2014). Thematic analysis allowed the researcher to organize the data collected from individual interviews in developing themes that fulfil the research aims and objectives. Tables and graphs were used to generalize data to the whole population through percentages or bar graphs.

According to Streubert and Carpenter (2008:60), data analysis can also be defined as a mechanism for reducing and organizing data to produce findings that require interpretation by the researcher. In this qualitative study, thematic analysis will used to analyse the data. Neumann (2008: 61), defined thematic analysis as the categorization of data into meaningful themes. It is a data analysis approach which focuses attention on identifying patterned meaning across a data set (Frost, 2008:2). It is used widely in various disciplines, such as the behavioural, social, health and educational sciences. Since this is an interpretive study, it can be assumed that the attitudes, understandings, meanings and perceptions of the participants are derived from their own experiences and that reality is subjective rather than objective. This has important implications for research analysis. Thematic content analysis was therefore used. Five steps outlined by Terre Blanche et al (2006) were primarily used for analysis in this study, with some reference to other authors where applicable, and NVIVO 8 computer software was used to stored and analyse the data.

The first step of data analysis was to read and develop an intimate relationship with the data. This involved becoming familiar and immersing oneself in the content to be analysed. This step began long before textual analysis was undertaken; it commenced right from when interviews were planned, and participants identified. This means that by the time that data analysis began, the researcher already had a preliminary understanding about the phenomena being explored (Terre Blanche et al, 2006). Then, immersion again occurs in reading and

rereading texts or transcripts of interviews and looking for emerging themes and developing tentative explanations. This step also involved noting the quality of the transcripts, including the portrayed neutrality in asking questions and responding to participants' answers, and the richness of detail in the field notes (Ulin et al, 2002).

Secondly, themes were identified. This was done using the same words, style, or terms used by the participants themselves. These were then used to establish connections and infer general rules or classes from specific occurrences. Themes then emerged from the text, rather than the researcher beginning with predetermined themes and fitting text to these themes. The identification of themes was more than simply summarizing content; it occurred with consideration given to processes, functions, tensions, and contradictions (Terre Blanche et al, 2006). Subsequently, the information relevant to these themes were displayed in detail, and then reduced to its essential points. Next, each theme was then carefully examined to discover the underlying core meanings and feelings of the participants, and then finally an overall evaluation and interpretation was done, assessing the emergent themes and how they related to each other (Ulin et al, 2002).

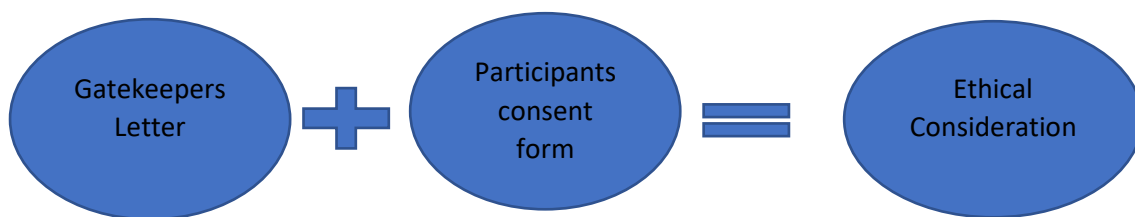
The third step in data analysis according to Terre Blanche et al (2006), is coding. Data was marked at relevant instances as pertaining to one or more themes – these can be phrases, lines, sentences, or even whole paragraphs. NVIVO 8 was useful for this as data can be efficiently stored, coded, and grouped. These were then easy to store and retrieve as and when needed. The fourth thing was for elaboration to occur. As data was broken down into themes and coded, events and discussions were no longer appearing linearly. Common topics, some of which were expressed in several ways, were grouped together under a single theme. Elaboration then occurred as each theme was studied and considered in more detail. This allowed for the subtler nuances to be seen. (Terre Blanche et al, 2006).

The last step in data analysis according to Terre Blanche et al (2006) is putting together the interpretation of the data and checking it. This is the written account, seen in subsequent chapters of this thesis, and was presented under the themes used for analysis. This interpretation reviewed and identified weaknesses that were attended to. The researcher's personal role in the entire process was once again reviewed and considered.

### **3.7 Ethical Considerations**

Ethics is the board of knowledge that comprises of customs and norms that help to describe the difference concerning acceptable and unacceptable conducts (Smythe and Murray, 2000).

Ethics is a major aspect of the Ethics Committee of the College of Humanities, Ethical clearance was acquired from University of KwaZulu-Natal on the 12<sup>th</sup> of March 2021 (Protocol reference no: HSSREC/00002452/2021); to make sure that this study confirms to the University's set of accepted rules before going out to collect data. In this study, the researcher ensured that respondents were not subjected to harm and respect for their dignity was taken into consideration while the data was collected. Full involvement consent was obtained from respondents before they participated in this study.



### **3.8 Informed Consent and Voluntary Participation**

To protect the participants from harm, the study employed the method of informed consent, which is the core principle of ethical consideration. The researcher thoroughly explained the study, including the risks and benefits of participating, to the participants and what is expected of them (Creswell, 2013). After, everything was explained, those that wished to continue, were given an informed consent form to sign and they also received a copy.

### **3.9 Confidentiality**

The public disclosure of private information may cause embarrassment, so this study employed the principle of confidentiality in order to avoid embarrassment and to protect the privacy of respondents. The principle of confidentiality refers to a condition in which the researcher tries by all means to protect personal information of research participants from being discovered by others (Creswell, 2013).

### **3.10 Anonymity**

This is another principle that was employed in the study, which is linked to confidentiality. Creswell (2013) asserts that data from participants should not be associated with their names. In this study, the researcher used false names to protect the identity of participants. When direct observation was conducted, photographs were not taken, only audio-recording was done.

## **3.11 TRUSTWORTHINESS**

### **3.11.1 Research Credibility**

One of the four principles utilized to state if there is trustworthiness in research is credibility. According to Bless et al. (2013: 236) this principle seeks to emphasize the truth of the reality of the study. The truth and reality of the study, was represented by the relevance of result format of the research which typically refers to research questions, data collection methods and approaches, and the data analysis that was adopted.

### **3.11.2 Research Dependability**

There is a slight difference between credibility and dependability which is another principle of research trustworthiness. Dependability refers to the level that the research done by different researchers and the results would be consistent. This means that if another person wants to make an exact copy of this research, he or she should have adequate information from this research report. As a result, he or she must attain the same findings as this study did. However, this principle requires the researcher to clearly and thoroughly illustrate the strategy followed by research (Bless et al. 2013: 237). Furthermore, the study would be trusted if the researcher has clearly presented all the necessary steps that was followed during data collection process and has also presented good examples when explaining the process of data collection.

### **3.11.3 Research Transferability.**

Transferability refers to the level at which the results of qualitative research are applicable to other contexts. This principle stresses that the research outcomes can be applicable to other situations and this study made use of thick description to demonstrate research transferability. However, Bless et al. (2013: 237) claims that, the principle ensures that, the researcher clearly provides detailed descriptions of the data collection process. Furthermore, Bless et al. (2013: 237) argues that this principle can be referred to the extent in which the outcomes of study will be generalized or be migrated to another different situation identified by the researcher. Therefore, this study provided a clear description of how community participation can be used as an approach to promote behavioural interventions to address the epidemic of HIV/AIDS.

### **3.11.4 Research Confirmability.**

A fourth standard is confirmability, which refers to the quality of the results produced by an inquiry in terms of how well they are supported by informants who are involved in the study



and by events that are independent of the inquirer. Reference to literature and findings by other authors that confirm the inquirer's interpretations was used to strengthen the confirmability of this study in addition to information and interpretations by people other than the inquirer from within the inquiry site itself.

### **3.12 Conclusion.**

In the final synopsis, this chapter has outlined the research methodology, design and process of data collection and analysis. The objectives of the study were recapped to demonstrate the synergy with the data collection methods. Upon that, the sampling design and techniques are systematically presented.

## CHAPTER 4

### PRESENTATION AND DISCUSSION OF THE STUDY FINDINGS

#### 4.1. Introduction

The previous chapter discussed the research design as well as the methodology employed by the researcher to conduct the study. This chapter presents and discusses the findings from the interviews conducted with twenty-six participants. Thematic analysis framework will be used to analyze the findings from participants. Key themes are derived from the objectives of the study which are: a) To understand the views and perceptions of community members towards those living with mental illnesses in Inanda. b) To identify the causes of these attitudes and perceptions towards those living with mental illnesses in Inanda. c) To describe how these attitudes affect those suffering from mental illnesses in Inanda. The chapter commences with a presentation of demographic profiles of all the candidates who participated on the study. The participants' demographic profiles are of paramount importance in this study as they demonstrate the different views and opinions of the participants. Theory will be used either to support or refute the empirical findings. The rest of the chapter discusses the study findings under various themes.

#### 4.2 Demographic profiles of participants

The table shows that the participants were between the ages 20 and 60. Ten of the participants were male while the remaining sixteen were female. Of the participants, ten had matric, seven had post matric education while the rest had no matric. Eleven of the participants were unemployed while the remaining fifteen were employed at the time of the study. Seven of the fifteen participants had formal jobs while the remainder had informal jobs.

**Table 2:** Demographics of study participants.

Name	Age	Gender	Educational level	Employment status
MHP1	20	Female	University student	Unemployed
MHP2	24	Female	Matric	Employed

MHP3	21	Male	University student	Unemployed
MHP4	21	Male	University student	Unemployed
MHP5	35	Female	Matric	Employed
MHP6	28	Female	Grade 5	Unemployed
MHP7	23	Male	Degree	Employed
MHP8	26	Female	Diploma	Employed
MHP9	24	Female	Degree	Employed
MHP10	23	Female	Diploma	Employed
MHP11	39	Female	Matric	Unemployed
MHP12	27	Female	Matric	Unemployed
MHP13	42	Female	Grade 9	Employed
MHP14	39	Male	Grade7	Employed
MHP15	25	Male	Matric	Employed
MHP16	44	Male	Matric	Unemployed
MHP17	56	Female	Grade 10	Unemployed
MHP18	48	Female	Grade 4	Employed
MHP19	37	Male	Grade 6	Employed
MHP20	44	Female	Matric	Employed
MHP21	60	Female	Grade 7	Unemployed
MHP22	29	Male	Matric	Employed
MHP23	43	Male	Matric	Unemployed
MHP24	47	Female	Matric	Employed

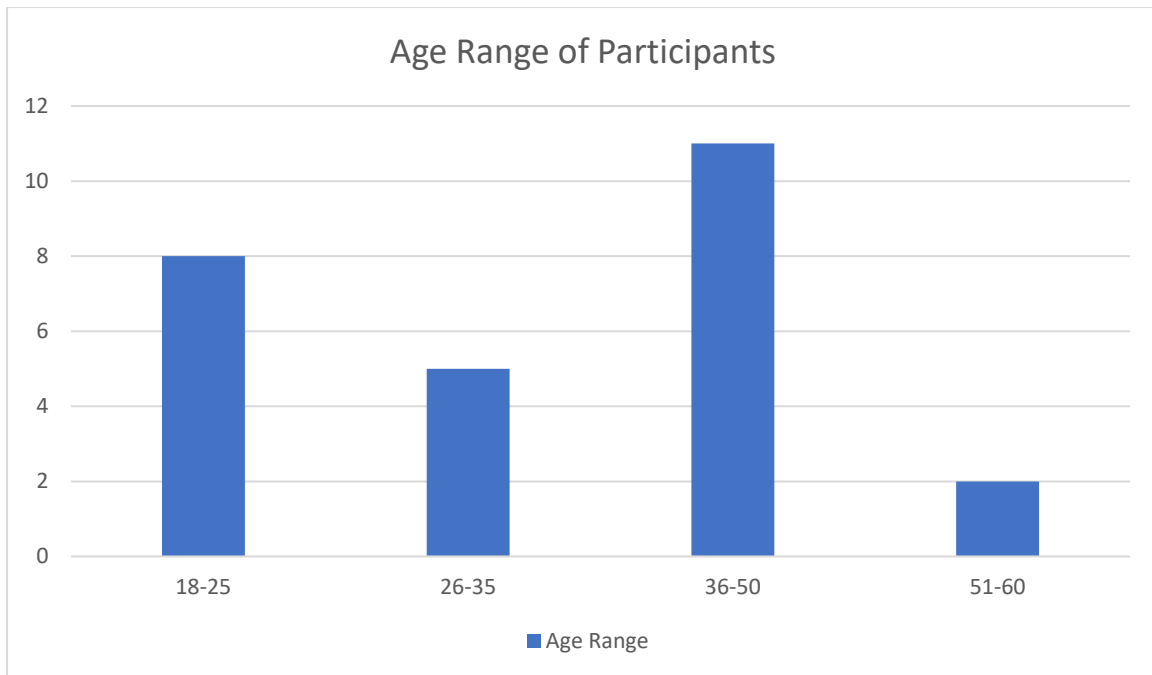
MHP25	42	Female	Grade 9	Employed
MHP26	37	Male	Grade 2	Unemployed

#### 4.2.1 Age distribution

**Table 3:** Age range of participants

Age range	No. of participants
18-25	8
26-35	5
36-50	11
51-60	2
<b>Total Number of Participants: 26</b>	

The above table shows the total number of participants as well as their age distribution. Only participants above the age of 18 were eligible to participate in this study. The participants ranged from the ages of 18 and 60.



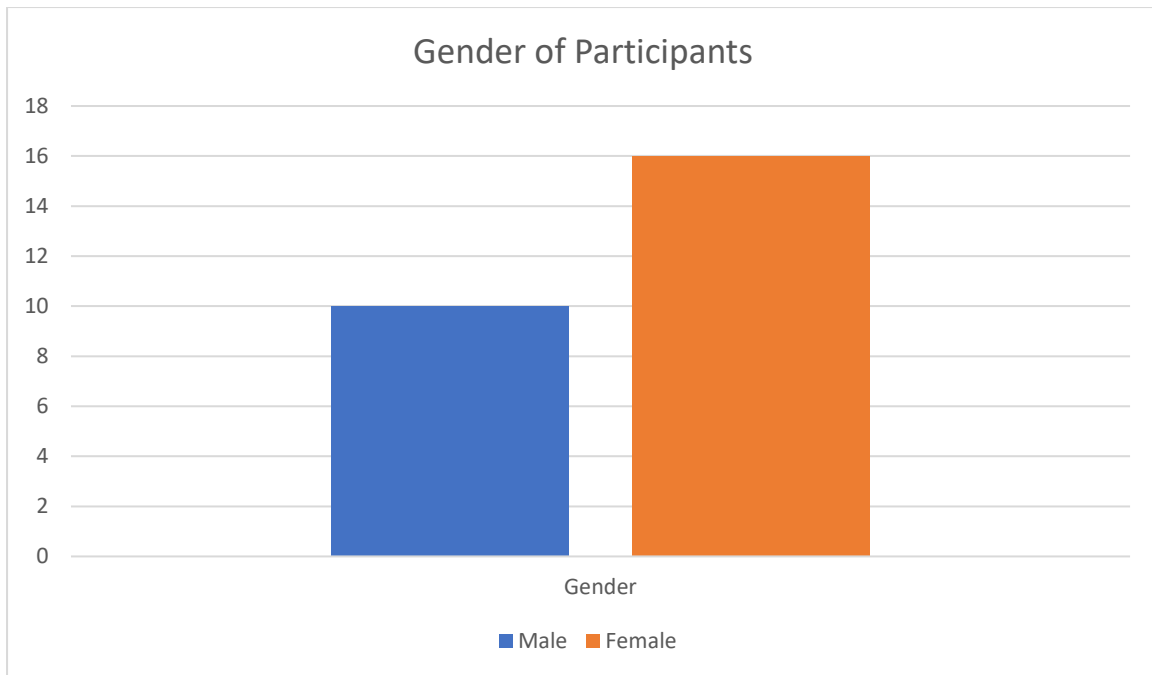
The above graph shows the age distribution of the study participants as well as the number of participants that participated in a particular age group.

#### 4.2.2 Gender

**Table 4:** Gender of participants

Gender	Total number of participants
Female	16
Male	10
<b>Total</b>	<b>26</b>

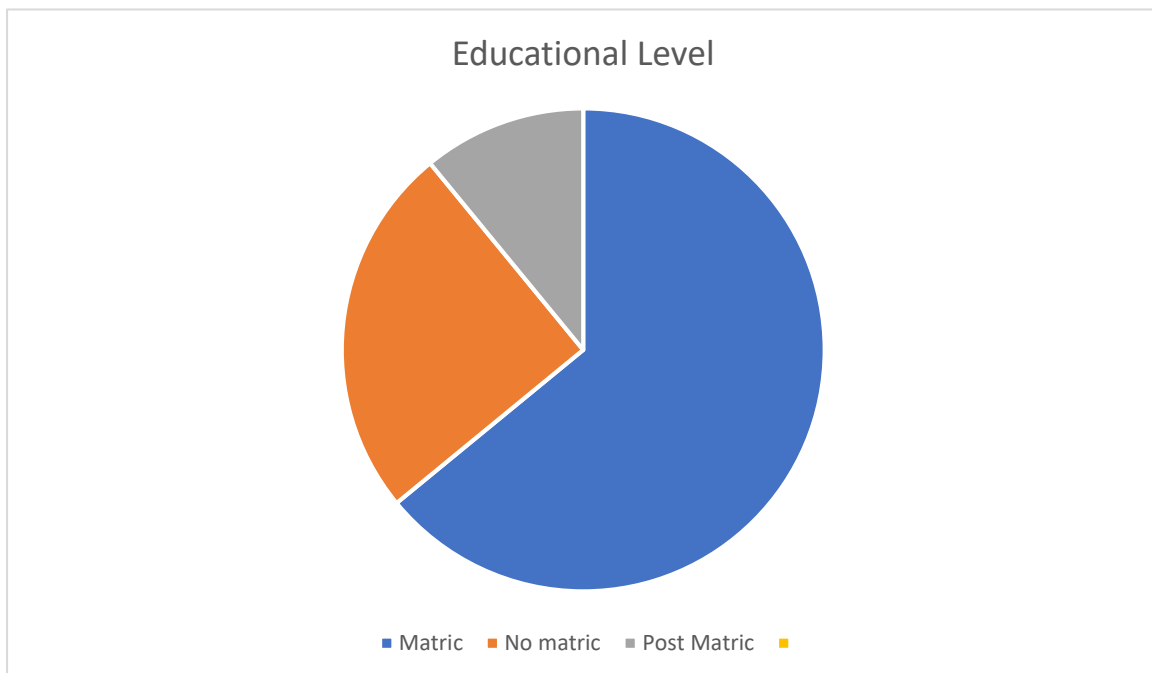
As shown in Table, 26 community members participated in the study. The participants were identified by the researcher through sampling method because it was the most suitable method for the study. Both females and males participated in the study.



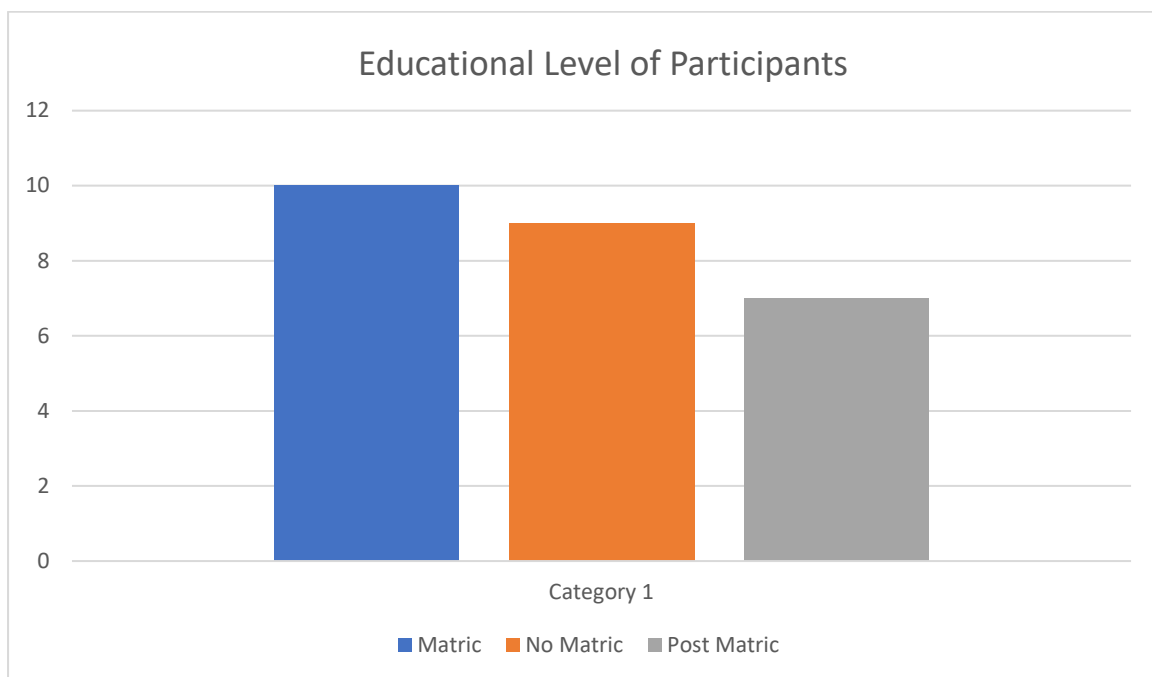
The above graph represents the number of participants that participated in the study according to their gender.

#### 4.2.3 Education Level

**Figure 1: Educational level**



The above pie chart shows the educational level of participants. Category Matric only comprises of participants that have a matric certificate as their highest level of education. Category No matric only includes participants that do not have a matric certificate who dropped out before passing matric. Category Post matric only contains participants that have matriculated and have furthered or are furthering their studies at institutions of higher learning such as at colleges and universities. Such information is vital for the researcher when analysing data; to grasp the effect of the educational level of participants in terms of understanding mental illnesses.



This graph represents the educational level of participants from those having matric to those without matric as well as those who are studying towards and those in possession of post-matric qualifications.

### 4.3 Presentation of Data

#### 4.3.1 Participants' perception of Mental Illness

##### 4.3.1.1 Participants' definition of Mental Illness

The study findings suggest that majority of the participants have a correlating definition of mental illnesses. It is also evident that although these understandings correlate, they differ for

the younger participants in comparison to the older participants. The study found that the younger participants understanding of mental illnesses is that they are illnesses that affect how a person thinks, feels, behaves and also how they interact with other people. One of the participants said:

*“Mental illnesses are illnesses that affect the way that people think, the way they behave or feel or even how they engage with others and they differ. These can be depression, obsessive compulsive disorder and other mental illnesses that are known”* (MHP1).

Another participant said:

*“My understanding of mental illnesses is that they are very serious conditions as it affects how a person thinks. Thus, if a person’s thoughts are disturbed, it also makes how they act and conduct themselves difficult and it makes it hard for the person to cope with life as they feel hopeless, confused and may experience mood swings thus leading to them believing that certain things are true while they are not”* (MHP2).

The study also uncovered that the younger participants’ understanding of mental illnesses is that some of things illnesses are acquired from birth while some are a result of accidents. One participant shared that:

*“My understanding is that people are born with some mental illnesses while some are acquired as life goes on due to some tragic accidents and some mental illnesses are curable while some cannot be cured. Some of these illnesses are age dependent. For instance, there are mental illnesses that affect older people and they lead to memory loss. Thus, I believe there are a lot of mental illnesses out there which may be caused by a lot of things”* (MHP3)

However, one younger participant had a similar understanding of mental illnesses as the participants who were older. The participant shared that,

*“I view mental illnesses as a case whereby a person unintentionally does something that is against facts, normality and morality. For example, a person who goes around picking up and eating litter which is totally against what is normal”*



The study findings suggest that the older participants are of the belief that mental illnesses are illnesses that cause people to act contrary to societal norms and that people are either born with them or they are a result of witchcraft. One participant said:

*“I think mental illnesses are illnesses that one is either born with or one gets as a result of witchcraft or punishment by the ancestors for wrongdoing” (MHP5).*

Another participant had similar sentiments and said:

*“Mental illnesses are illnesses that affect people’s minds and they make people act out of character such as doing what any other normal person wouldn’t do. This is usually a result of witchcraft or punishment for doing something wrong” (MHP6).*

#### **4.3.1.2 Perceptions of what constitutes Mental Illness**

Asked to name different types of mental illnesses they know it was evident that the younger generation of participants were able to correctly identify and name mental illnesses according to their medical terms. It was however not the case with the participants who were older as they simply identified mental illnesses as being mentally disturbed without correctly identifying the various types of mental illnesses. One participant said:

*“I know there is bipolar, there’s anxiety disorder, there’s depression as well as psychotic disorders. I think that’s it because schizophrenia is a psychotic disorder. There’s also dementia which affects elderly people” (MHP1).*

One participant added that:

*“There are a variety of mental illnesses that are out there. Some are normal to a lot of people and some are not categorized as mental illnesses by the black community, for example, depression. Most people are aware that there is a condition known as depression, they however regard this mental illness that is for and only affects white people. Black communities fail to acknowledge that depression is a disorder that affects a person’s mental health and can affect anyone and everyone irrespective of their race or culture. We also have bipolar disorder, dementia, there’s also autism disorder and hallucinations which is when people see things that do not exist in the real world but only exist in their mind. There are also some eating disorders such as anorexia and bulimia nervosa. I believe these are mental illnesses as those who are affected by these conditions have a certain image about themselves and their*

*bodies which may not be necessarily the same image other people have about them”*  
(MHP8).

However, one participant from the younger generation failed to identify or name even one type of mental illness. He was of the view and belief that members of the LGBTQI family were suffering from some sort of mental illness simply because he considered their sexual preferences as not normal and immoral. The participant said:

*“I don’t know any mental illnesses. I am of the belief that the whole LGBTQI group is suffering from some sort of mental illness”* (MHP4).

Upon further probing, the participant said:

*“the whole LGBTQI group was doing something that is against what is deemed normal and that their actions are against nature as predestined by God”* (MHP4).

Having posed the same questions to the older participants, the results were different from what the researcher collected from the younger participants. One participant answered:

*“I do not know mental illnesses by name. I can just see when a person has some sort of mental illness based on their behavior or actions”* (MHP21).

Another participant failed to name even just one type of mental illness they know or that they’ve heard of. He said that:

*“I do not know these conditions by their medical terms but what I do know is that people who have them lose their minds and they often do unimaginable things. Also, in most cases mental illnesses are caused by witchcraft or the ancestors and therefore they do not have names like modern medicine gives them names”*  
(MHP16).

However, two of the participants from the older generation of participants managed to identify depression as a form of mental illness. One of these participants said that:

*“I know there’s depression because I heard on TV that the famous musician HHP committed suicide because of depression. That’s when I was alarmed because I had never heard of anyone having depression and even dying from it. I had always thought that I was a condition that affected white people or those extremely rich people”* (MHP25).

These findings are in line with the literature that shows that people still fail to identify different types of mental illnesses as well as the symptoms associated with them (Henderson, Evans-Lacko & Thornicroft, 2013). Although people know that there are mental illnesses, most of them cannot identify these mental illnesses by their names and they cannot differentiate between minor and severe forms of mental illnesses. This leads to the stigma of regarding all mental illnesses and everyone living with a mental illness as dangerous and unstable (Henderson, Evans-Lacko & Thornicroft 2013).

There are a lot of myths and controversies around the topic of mental illness. These usually hinder help seeking behavior and often perpetuate the stigmas surrounding people living with mental illnesses. People living with mental illnesses are often perceived as unstable and thus a danger to society. This in most cases, is a result of the myths and misinformation people have regarding mental illnesses and the people living with these illnesses. The study asked the participants to share any of these things that they have heard being said about mental illnesses and those living with them which they believed not to be true. One participant shared that:

*“I have heard that most people living with mental illnesses were bewitched and that there is nothing that can be done to help them as the muti is usually irreversible”* (MHP15).

Another participant shared that she has had that people living with mental illnesses are violent and dangerous although she did not believe this to be entirely true as she believed that mental illnesses can be managed with proper treatment. She said that:

*“One myth I have heard is that people living with mental illnesses are crazy. Another myth is that these people are violent and dangerous. I do not believe this as not everyone living with a mental illness is violent”* (MHP8).

Another participant had this to share that:

*“I believe it is a myth that people can be bewitched and made to lose their minds by doing something wrong such as committing a theft. I believe that mental illnesses are a result of problems that may occur in one’s brain. I do not believe that another human is capable of tempering with another person’s mental health”* (MHP3).

Participant nine mentioned hearing that some people suffer from mental illnesses as a result of demonic and satanic possessions. She mentioned that:

*“I have heard people say that people living with mental illnesses are like that as a result of demonic or satanic possessions. I however do not believe this theory as evidence suggests that mental illnesses are caused by various medical difficulties and proper medication is able to treat and manage such illnesses which would not be possible if mental illnesses were a result of supernatural powers” (MHP9).*

Majority of the participants attested to having heard more or less the same myths while a minority shared that they have never heard of any myths around the topic of mental illness. This can be as a result of the fact that some participants are of the belief that mental illnesses are caused by witchcraft and supernatural powers as above findings have mentioned. Also, some participants are of the belief that people living with mental illnesses are unstable and violent and thus pose a danger to society.

This argument is consistent with Szasz (2013) who found that myths regarding mental illnesses and those living with them are one of the leading factors that hinders help seeking behavior and leads to the abuse and the violation of those living with mental illnesses. As a result of myths that paint people living with mental illnesses as violent, dangerous and unstable, people living with mental illnesses are often attacked and abused or excluded from others. This dehumanizes them and violates their right to a quality life.

#### **4.3.1.3 Perception of what causes mental illness**

In this section, participants were asked to describe and share what they thought and knew to be the causes of mental illnesses, the question yielded mixed and opposing answers from both the groups of participants. The majority of them highlighted witchcraft, a punishment from the ancestors for a wrongdoing or a calling to become a sangoma as the causes of mental illnesses while few mentioned that mental illnesses are as a result of traumatic experiences, stress as well as aging. Some mentioned that mental illnesses may be a result of traumatic experiences that a person has went through in life. One said that:

*“I believe that the causes of mental illnesses are traumatic experiences that one goes through in life as they grow. So, a person’s internal and external environment plays a part in their mental health status. These traumatic experiences can be rape, physical or emotional abuse and growing up in unfavorable conditions. So, if there were no traumatic experiences that we went through while growing up, we wouldn’t experience any mental illness” (MHP10).*

Answering the same question, one participant said that:

*“it may be stress, life experiences, family history, childhood abuse or traumatic experiences. The reason I say this may be because of pressure, not getting help or support from people around you as well as how the person experiencing the stress thinks. Whether positively or negatively” (MHP2).*

Other participants mentioned age, traumatic experiences as well as genetics as all having a role to play in leading to mental illnesses. One participant indicated that:

*“I think what causes mental illnesses is maybe, it’s just a change of environment or maybe it could be family history like your genes if for example, someone in the family had some sort of mental illness and then it is passed down to you. Also, it can be a result of child abuse that could traumatize the brain or just some sort of brain injury” (MHP1).*

Participant three shared that:

*“The one thing that causes mental illnesses is aging and I know this for a fact because I know that as people grow older their nerve tissues start wearing away and this leads to mental illnesses. Another cause may be something like a car accident. For example, if your head is hit hard during an accident, some parts of the brain may be impaired as a result of that. So that would lead to the brain not functioning well either temporarily or permanently. Some mental illnesses are inherited from other family members from birth while some people are just born with mental illnesses as a result of complications either during pregnancy or while giving birth” (MHP3).*

Another participant shared that:

*“Mental illnesses can be caused by many factors. For one, it can be a result of past events or experiences that were so severe that they led to a shift in a person’s mind and if that shift is not attended to by consulting a professional such as a psychologist or therapist. For example, if one has experienced any form of abuse. Another factor could be that you were born with a certain mental illness. This may be a result of a combination of certain genes that would lead to some sort of mental illness. For example, Attention Deficit Hyperactivity Disorder (ADHD). So generally mental*

*illnesses can also be caused by traumatic experiences such as emotional abuse and bullying” (MHP8).*

The answers to the posed question showed correlation as most of the participants shared similar knowledge when it comes to the factors that may lead to mental illnesses such as genetic impairments, trauma as well as abuse. However, it also emerged that some participants were of the notion that mental illnesses are caused by witchcraft, some sort of divine intervention in the form of a punishment for a wrongdoing or simply caused by ancestors in their call for someone to be a sangoma. One participant shared that:

*“Mental illnesses are usually caused by witchcraft as a result of jealousy. For example, someone would be very intelligent and excel at university when all of a sudden, they lose their mind. This can be a result of someone who is jealous and they may decide to bewitch the person so that they never amount to anything. Mental illnesses can also be caused by ones’ ancestors if the person has a calling to be a sangoma. So, if the person fails to answer the call from their ancestors, they may permanently lose their mind when in actual fact they were born perfectly normal” (MHP24).*

Another participant said that:

*“I think mental illnesses are caused by a number of things such as when one loses a family member to death, when they are being punished for wrongdoing such as stealing or murdering someone. The person they stole from or the family of the person they killed may decide to use black magic (muti) so that the person is never sane again. Mental illnesses may also be a result of your ancestors if they want you to become a sangoma” (MHP6).*

This is consistent with Stefanovics et al. (2016) who found that people still have opposing views and opinions when it comes to the origin as well as the causes of mental illnesses. Some people are of the belief that mental illnesses are a result of black magic, ancestors or some Supernatural force or being. On the other hand, others believe that mental illnesses are caused by biological as well as medical conditions and thus should be treated using modern medicine.

Another participant shared similar sentiments and mentioned that:

*“I think they are caused by witchcraft or are a result of a punishment from the ancestors for some sort of wrongdoing. Some children are born with mental illnesses as a result of a punishment to their parents for marrying relatives” (MHP17).*

#### **4.3.1.4 Perception on access to availability of Mental Illness Care Services**

It emerged from the study findings that about 90% of the participants had no access to mental health care services as there is not even one mental health care centre in the community of Inanda. This is alarming as mental health care services are of paramount importance in terms of raising awareness regarding mental illnesses as well as the importance of mental health. Such services would also play a vital role in fighting the stigma against people living with mental illnesses as well as in terms of breaking the barriers to seeking professional help in relation to mental illnesses. Asked if they knew of any mental health care services available to the community, one participant shared that:

*“Unfortunately, no. There is no mental health facility in our community. At least not as far as I know. We just have ordinary clinics which do not cater to the needs of mental illness as much as needed” (MHP11).*

Another participant attested to the very same issue of not having access to mental health facilities in the area. She added that:

*“There are no mental health facilities in our area. Even the topic itself is not something that is openly discussed in our community let alone having a designated facility to help people with such issues” (MHP17).*

One participant mentioned that although there are no facilities catering to the topic of mental illness in the community of Inanda, she mentioned knowing of other programs and facilities that help such as SADAG. She said that:

*“There are no mental health facilities in our community but I know that there is SADAG which helps people dealing with depression”” (MHP2).*

A minority of participants mentioned that although they do not have any access to mental health care facilities in and around the community, they however had some access to such facilities in their places of work and in Tertiary institutions. The participant said:

*“I do not know of any facilities in my community but I do have access to such a facility as it is available at my place of work” (MHP8).*

Another participant shared:

*“We have no mental health facilities in our community. However, I know that such services are provided at my university as most of my friends have accessed them when they went through challenges”* (MHP9).

The researcher found that the community of Inanda had no designated facility that deals with mental illnesses. The participants who had access to such facilities had the access and exposure to such facilities because of their external environment which in this case was work or an institution of higher education.

These assertions are in line with Hester (2017) who argued that most communities lack access to mental health facilities. This thus reduces the help seeking behavior of those living with mental illnesses. It also hinders the general public from accessing the right information regarding mental illnesses, their symptoms as well as how these illnesses can be managed. Mental health facilities can also help in equipping the general public with the necessary skills in order for them to know how to conduct themselves around those living with mental illnesses and how they can play a positive role towards the help seeking behavior (Hester 2017).

#### **4.3.1.5 Participants’ sources of information regarding Mental Illnesses**

The study also explored the sources of information which the participants used to get the information they have regarding mental illnesses. The study found that these sources ranged from social media, to family members, friends, school as well as media such as televisions through movies and other Television (TV) shows. The study found that these sources play a role that is both positive and negative regarding the sensitive topic of mental illness. It also found that these sources play an active role in passing and sharing either the correct information or false information. This is of critical importance as it plays a major role in either supporting or destroying the efforts of different campaigns that seek to raise awareness on the topic of mental illness. Asked where they obtained the information they have regarding mental illnesses, one participant said that:

*“I got a lot of what I know from watching television such as watching documentaries, movies and TV shows. To be specific, there’s a show called “The Doctors” which usually speaks about mental health and those suffering from mental illnesses. I have also had a family member who suffered from an anxiety disorder so I got a lot of information from him as he got to receive help and information first-hand”* (MHP1).



Another participant also shared that they got a lot of what they know from TV and from personal experience as they mentioned having experience mental health difficulties. She said that:

*“I have personally experienced mental illness and this allowed me to know more about these illnesses as I was previously ignorant when it comes to mental illnesses as I believed that I would never go through such. I also get a lot from movies although most movies portray mental illnesses and those living with them in a negative manner as the characters usually portray psychotic people who are usually killers” (MHP2).*

One participant mentioned obtaining the information he has from school. He also mentioned that the topic of mental health is not a topic he usually engages in with other people especially his peers as they usually show lack of interest in the topic. He said that:

*“I learnt everything I know about mental illnesses from school. I have obtained a lot of information from the subjects Natural Sciences and Life Sciences from school. This is not a topic I usually speak about with friends or family as this topic is hardly spoken about” (MHP3).*

However, some participants mentioned that they just knew what they know about mental illnesses and there was no direct source of information. They also mentioned knowing what they know from hearing what other people around them say. One participant said:

*“I just know what I know. I have been around long enough to know and understand these things. I have also had family members and people I know suffer from mental illness as a result of witchcraft or a calling. Also, this is the only justifiable cause of mental illness I believe as most people who seek help from doctors either never fully recover or they simply get worse. This has thus proven to me that mental illnesses hardly have anything to do with modern medicine and they should not be treated using modern medicine” (MHP21).*

Another participant had similar opinions. She said:

*“Well I get what I know from people around me. I have also seen and heard of people who suffer from mental illnesses as a result of witchcraft, muti, when they have suddenly lost a loved one who didn't get sick or when they have a calling to become a sangoma” (MHP24).*

Another participant mentioned that:

*“I would say I got a lot from Life Orientation in High School as we sometimes had topics that discussed mental illnesses though it was not in-depth. Also, growing up in the township exposes*

*you to a lot of things, we usually see and experience things as they happen. We also hear things from word of mouth. You get to hear stories about people from other people because townships are like that. Nothing is private. I also got some information from watching movies” (MHP10).*

One participant mentioned knowing what they know regarding mental illnesses from University as she mentioned taking psychology as a major subject which exposed her to a whole lot of information regarding mental illnesses. She said:

*“I got a lot of information from the University. I took psychology as one of my majors and I therefore, got to learn a lot about mental illnesses from the different mental illnesses to their symptoms. I also get a lot of information from movies. However, I have come to realize that most movies depict mental illnesses and those living with them in a negative light. I believe this is what adds to stigma as most people in townships love and watch movies and tend to believe what they see on TV as true which is not always the case” (MHP9).*

These findings are in accordance with previously conducted studies that have found that media plays a significant role towards the stigma associated with those living with mental illnesses. The media usually depicts people living with mental illnesses as unstable and very aggressive. This is often done through movies and as a result of watching such movies, people tend to have a one-sided picture of mental illnesses and how it affects those living with them. The media tends to depict severe mental illnesses and seldomly programs minor mental illnesses and the help-seeking journey (Betton, Borschmann, Docherty, Coleman, Brown & Henderson 2015).

### **4.3.2 How perceptions affect those living with Mental Illness**

#### **4.3.2.1 Stigma associated with Mental Illness**

People living with mental illnesses continue being marginalized and stigmatized in various communities they live in. The places which are supposed to be safe havens for them end up being the very same places where they are alienated and violated harshly. Stigma moves from the professional health care workers, to family members and ultimately to the community. This hinders help-seeking behavior and also negatively impacts the healing process. The study found that the participants had opposing beliefs when it comes to treating people living with mental illnesses. Some participants were of the belief that those living with mental illnesses should be treated as normal as possible as this helps in their healing process. They believed medical professionals such as psychologists and therapists had the necessary tools and medication to help people manage their illnesses. One participant said that:

*“It is unfortunate that at this day and age people living with mental illnesses are still stigmatized, abused and marginalized simply because they are living with a certain mental condition. Mental illnesses can be managed with the right support and with proper medication. Treating those living with mental illnesses differently from other people makes them hopeless and leads to them not wanting to receive help and some may end up having suicidal thoughts. It is important for people, especially families, friends as well as the immediate community to treat people living with mental illnesses as normal as possible. They should be made to feel wanted and important as this will encourage them to seek help thus improve their chances of living normal lives” (MHP9).*

Another participant shared similar opinions. She said that:

*“People living with mental illnesses should be loved and supported in order to encourage them to seek help so that they can lead normal lives. It is sad that we still see and hear of instances where people living with mental illnesses are ridiculed and stigmatized in our community. This behavior is a problem as it will be inherited by children who will also end up with similar attitudes towards those with mental illnesses” (MHP22).*

Participant seven said that:

*“My brother is living with a mental illness since birth. It pains me to see how people mistreat and ridicule him simply because of his condition. People will make him do hard labor simply because they know that he cannot say no. it is difficult and painful to see him going up and down doing things for other people which we do not make him do as a family. The community is supposed to be the one supporting and protecting him, however, the very same people who know his condition are the ones who exploit and mistreat him. If we dare address the issue, we are seen and treated differently from the rest of the community” (MHP7).*

The researcher also asked the participants to share their experiences in relation to how people living with mental illnesses are treated in the community. One said that:

*“I usually see people laughing and even swearing as people living with mental illnesses. They refer to them as crazy and you’ll find them being insensitive towards them. Others go to the extent of making them work for them maybe by cleaning their*

*yards without paying them or even giving them food. This is sad to watch because they are also human and are thus deserving of being treated with respect and dignity. I can also imagine how frustrating this treatment can be for their families”* (MHP9).

Although some participants had positive views towards people with mental illnesses, some had opposing views as they believed that most people living with mental illnesses deserved what they were going through because it meant they had wronged someone. They also believed that those living with mental illnesses should be removed from society and placed in mental institutions as they posed a danger to the rest of the community. One participant said that:

*“I think people living with mental illnesses should be removed from our communities and must be placed in mental hospitals since they pose a danger to us and our children. You will find these people walking around naked in our communities or they will be carrying dangerous weapons. This is a problem as it poses a danger to our children”* (MHP25).

Another participant shared that:

*“These people should be placed in places of safety as they posed a danger to us. Some of them are very touchy and this is very unsettling and uncomfortable to experience. That is why they should be placed in mental institutions with people who are trained and paid to deal with them”* (MHP11).

Although these incidents and experiences may be true, it is dangerous and unfair to paint everyone living with a mental illness with the same brush. The above-mentioned behaviors are not true for every person living with mental illnesses. Some of them are on medication and thus their conditions are managed and controlled which some of them are not treated and may thus pose a danger or threat to the community.

These findings reiterate the findings made by Henderson et al. (2013) who found that mental illnesses and those living with them are still largely stigmatized and marginalized whether in their families, their communities or by mental health care workers. Mental illness is still associated with high levels of stigmatizing attitude and behavior which ultimately hinders the help seeking behavior of those living with such illnesses as a result of the fear of being stigmatized, marginalized and dehumanized.

### 4.3.3 Other pertinent findings which emerged in the study

#### 4.3.3.1 Relationship between education and awareness of Mental Illnesses

The researcher found that there was a relationship between the participants' level of education as well as the information the participants had regarding mental illness and those living with them. The researcher found that education plays a pivotal role in raising awareness regarding mental illness. The study however also found that although academic institutions such as schools and universities played a vital role in raising awareness on the topic of mental illness, there is however still room for improvement. The study found that the higher the participants' level of education, the higher their knowledge of mental illnesses. These ranged from correctly identifying or naming different types of mental illnesses to suggesting ways in which other people can interact and help someone already living with a form of mental illness. Asked about their source of information when it comes to mental illnesses, one participant said that:

*“I got all the information from school. I took psychology as one of my majors and I, therefore, got to learn a lot about mental illnesses, their causes, treatment and how to relate to those living with them. I also got obtained some knowledge from movies and from reading as this helped enrich my knowledge regarding mental illnesses and those living with them” (MHP9).*

One participant shared that:

*“Well I was introduced to the topic in High School when we used to do Life Orientation as a subject. However, University played a huge role as one of the electives I did covered the topic of mental illnesses and that helped me understand them deeper. It helped me realize that there is still a lot of stigma associated with living with mental illnesses which really should not be the case in our time. Especially depression as it has been proven that it can affect anyone and everyone and has dire consequences as it usually leads to suicide” (MHP10).*

Another participant said that:

I just know what I know. I have lived long enough to know these things. I have also heard a lot of stories from people around me. I have also seen people lose their minds because of witchcraft and because they have a calling to become sangoma's. Some are still out of their minds because they were not attended to by healers or because the spell they got is irreversible (MHP14).

Another participant shared a similar sentiment, she said that:

*“I just know what I am talking about. I have also had family members suffer from mental illnesses and when we took them to traditional healers, we were told that they either had a calling or it was a result of witchcraft. I believe this as this is the only justifiable reason that makes sense. No one can just lose their mind suddenly”* (MHP21).

These statements reiterate Maranzan (2016) argument that the education system should integrate mental health awareness programs to the curriculum as these will help raise the awareness in relation to mental illnesses. As a result of the lack of the necessary skills and information, people resort to whatever readily available information whether it is true or not. This leads to high levels of stigma towards those living with mental illnesses as most of this information is wrong.

#### **4.4 Conclusion**

The findings illustrate that the interviewed participants had a lot of opposing views, beliefs and opinions in relation to the topic of mental health. The study found that participants between the age of 18 and 35 were of the idea that mental illnesses are normal and can affect anyone. They are also a result of many factors such as physical, mental and emotional. The older participants who were between the age of 35 and 60 had opposing views as they believed mental illness to be a result of a wrongdoing, a calling or witchcraft.

The study findings also show that people living with mental illnesses are still marginalized and stigmatized. It is evident that some participants believe that people living with mental illnesses are violent and pose a danger to their community and thus should be institutionalized. The participants had various sources of information regarding mental illnesses. These ranged from TV through watching movies and TV shows, to learning about mental illnesses from High School as well as through institutions of higher learning, as well as through word of mouth as some participants shared that they knew what they knew as a result of what they were told by the people around them.

The study findings also depict that the community of Inanda does not have a mental health facility which can play a role in raising mental health awareness. About 90% of the participants said that they knew nothing about mental health facilities.

## **CHAPTER FIVE**

### **CONCLUSION AND RECOMMENDATIONS**

#### **5.1 Introduction**

The overall aim of this research was to critically explore and understand the different attitudes and perceptions community members have towards those suffering from mental illnesses in Inanda KwaZulu-Natal. The study intended to achieve the following main objectives as articulated in chapter 1:

1. To understand the views and perceptions of community members towards those living with mental illnesses in Inanda.
2. To identify the causes of these attitudes and perceptions towards those living with mental illnesses in Inanda.
3. To describe how these attitudes affect those suffering from mental illnesses in Inanda.

The main focus was to explore the attitudes and perceptions of community members in relation to mental health. This is the last chapter of this study and it focuses on providing the conclusion as well as recommendations for the study. The chapter presents findings from the literature review followed by findings obtained from the primary research. In conclusion, the chapter provides the conclusion based on summaries and it will also present recommendations as well as the overall conclusion of the study.

#### **5.2 Findings from the research**

The study found that the two categories of participants which were the participants between the age of eighteen and thirty-five (18-35) and another group which were participants who were thirty-six years (36) and older had a correlating understanding of what mental illnesses were among each group. The first group of participants understood mental illnesses to be illnesses that affect how a person thinks, feels, behaves as well as how they interact with other people. Other participants in this group understood mental illnesses to being illnesses that people are born with while some forms of mental illnesses may be a result of accidents. The latter group however believed that mental illnesses are illnesses that make people act contrary to what is normal in a society and that these people get these illnesses from birth or as a result of witchcraft.

The study also found that the younger generation of participants were able to correctly identify and name different types of mental illnesses according to their medical terms. This was however not the case with the older generation of participants. The older participants were only able to share and name the different symptoms that are related to mental illnesses. The younger group of participants was able to name mental illnesses such as depression, schizophrenia as well as bipolar disorder. It was also evident that the majority of the young participants knew and named depression as a form of mental illness. The study also found that the younger group of participants believed traumatic experiences as well as abuse to be the causes of mental illnesses. Some shared that they believed mental illnesses to be a result of genetics and that people are therefore born with these illnesses. The older participants believed witchcraft to be the main cause of mental illnesses. Other participants among the older group believed mental illnesses to be a result of a punishment from the ancestors for a wrongdoing.

The study also found that there are still very high levels of stigmatization for both the people living with mental illnesses as well as their families. The study found that people living with mental illnesses are marginalized and stigmatized in the communities they live in. This stigma moves from health care professionals, to family members as well as to the community at large. This is evident to hindering health seeking behavior as well as affecting the healing process. The participants shared that people living with mental illnesses are abused physically as well as emotionally as they are regarded as less humans and thus not deserving of being treated with respect and dignity. The study also found that there was a relationship between the level of education as well as the awareness of mental illnesses. The study revealed that the level of education directly affected the level of awareness in relation to mental illnesses. The study found that the participants with high levels of education such as a matric certificate or post matric education could easily name and identify different kinds of mental illnesses and what caused them. This was not the case with the participants who had little to no education as they shared what they believed and what they have heard which is not always factual.

This study also found that there are a number of myths that are associated with the topic of mental illnesses. These myths hinder help seeking behavior as well as help escalate the stigmatization of those living with mental illnesses. People living with mental illnesses are perceived to be dangerous and unstable. This is a result of myths and wrong information which community members share among each other which unfortunately puts those living with mental illnesses in danger. It was also evident from the study findings that the participants had different sources of information in relation to the topic of mental illnesses. The study found



that these sources range from social media, to the TV through movies and TV shows as well as from friends and family. This needs to be carefully looked at as not all these sources provide people with the correct information regarding mental illnesses. The sharing and distribution of misleading and wrong information by these sources leads to the continual stigmatization and victimization of those living with mental illnesses.

The study found that about 90% of the study participants had no access to mental health care services as there is not even one mental health care service centre available in and around the community. This is troubling as this means that those seeking health care services have no facility available and there is also no facility providing the community with the correct information regarding mental illnesses.

### **5.3 Findings from the literature**

Stigma is a major impediment to accessing appropriate care by individuals with mental illness. It is a recognized barrier to the effective management of mental health disorders in several parts of the world (Conner, Copeland, Grote et al, 2010). It affects the health professionals' readiness to provide wholesome interventions for individuals with psychiatric disorders. Furthermore, stigma promotes discrimination, increases the burden experienced by patients and their caregivers, and places restrictions on social integration (Sartorius, Gaebel, Cleveland et al, 2010). Sadly, stigmatising attitudes towards mental illness are prevalent among health professionals, and in some reports these attitudes have not differed from views expressed by lay persons (De Witt, Smit, Jordaan, Koen, Niehaus, & Botha, 2019). In addition, findings have been variable concerning the effects of educational programs, psychiatry clerkships or courses on changing negative dispositions in various groups of health professionals or trainees (Foster, Usher, Baker et al, 2019).

The stigmatization of mental illness is a serious problem affecting patients and their relatives as well as institutions and health care personnel working with persons with mental illness. The more a mentally ill person feels stigmatized, the lower their self-esteem, social adjustment (Perlick, Rosenheck, Clarkin et al, 2010), and quality of life (Rosenfield, 2017). Stigma can adversely affect family relationships (Lefley, 2018), and lead to employment discrimination (Stuart, 2016) and general social rejection (Corrigan, Morris, Larson, Rafacz, Wassel, Michaels, Wilkniss, Batia, & Rüsck, 2010). Finally, Stigma also influences access to care, because people may be reluctant to seek help despite experiencing mental or emotional problems as this might be seen as an acknowledgment of weakness or failure (Schomerus,

Stolzenburg, Freitag, Speerforck, Janowitz, Evans-Lacko, Muehlan, & Schmidt, 2019). Negative and stigmatizing public attitudes towards mentally ill persons, therefore, have direct implications for the prevention, treatment, rehabilitation, and quality of life of those affected.

Attitude towards mental health are still not on equal terms with those towards physical health. Stigma is recognised as a significant barrier for the early diagnosis and treatment of various mental health conditions (Corrigan, Druss & Perlick, 2014). The World Health Organisation has highlighted the significant role of stigma in influencing mental health prognosis and has identified its reduction as a key target in its 2013–2020 action plan (Rusch, Angermeyer & Corrigan, 2012). Stigma is thought to be more prevalent in illnesses perceived to have uncertain or complex aetiology (Sontag-Padilla, Woodbridge, Mendelsohn, D’Amico, Osilla, Jaycox, Eberhurt, Burnam & Stein, 2016). This may partially explain why stigma towards mental health conditions is much higher than it is to physical health problems (Lincoln, Arens, Berger & Rief, 2018). Research by Rüscher et al., supports the link between poor knowledge and stigma, and showed that increased mental health literacy is associated with a reduction in stigmatising attitudes (Rusch et al., 2012).

Furthermore, poor understanding of mental health conditions has been shown to be associated with public fear and the perception that people experiencing mental health problems are dangerous (Corrigan & Watson, 2020). One of the most significant repercussions of stigma is its effect on help-seeking behaviour. People with mental health problems are less likely to seek help if they feel their condition is stigmatised (Gulliver, Griffiths, Christensen et al., 2012 and Yap, Reavley & Jorm, 2013). Stigmatising attitudes also isolate sufferers and make many societal roles, such as finding a job, harder (Corrigan & Watson, 2020).

## **5.4 Findings from the primary research**

### **5.4.1 Objective 1: To understand the views and perceptions of community members towards those living with mental illnesses in Inanda.**

The study fulfilled this objective because the study found that the views and perceptions of mental illnesses differed between the participants between the age of 18-35 and the participants who between the age of 35-60. The study found that the younger generation of participants believed mental illnesses to be illnesses that affected the functioning of the brain and they believed that this may be a result of trauma, genetics or a result of an accident. They also believed that mental illnesses can be cured or managed using modern medicine. However, the older generation of participants believed mental illnesses to be a result of witchcraft or

punishment from the ancestors as a result of a wrongdoing. They were also of the idea that modern medicine cannot cure mental illness but just perpetuates it. They believed that traditional healers had a better chance of curing mental illness.

#### **5.4.2 Objective 2: To identify the causes of these attitudes and perceptions towards those living with mental illnesses in Inanda.**

The study found that most of the participants obtained the information they have regarding mental illnesses from those around them. The media through movies also had a negative role to play in perpetuating stigma towards those living with mental illnesses as it often depicted them as violent and dangerous. The study also found that there is a relationship between the participants' level of education and their understanding of mental illnesses.

#### **5.4.3 Objective 3: To describe how these attitudes affect those suffering from mental illnesses in Inanda.**

The study met this objective as it found that community members still hold stigmatizing attitudes and perceptions towards those living with mental illnesses. As a result of stigma, those living with mental illnesses are regarded as being unstable, violent and dangerous. This poses a danger to them as well as their families as these attitudes often lead to them being treated in a demeaning and violating way. They are seen as a threat or danger to society which ultimately puts them at the risk of being attacked.

### **5.5 Conclusion**

The aim of this research was met because the study objectives were realized and the research questions were answered. The study successfully explored community attitudes towards those living with mental illnesses in Inanda. The study found that the two groups of participants had opposing views towards mental illnesses. This is directly linked to their sources of information regarding mental illness as well as their level of education. The study also found that the community of Inanda lacked mental health facilities which can play a role in reducing mental health stigma as it could help by administering mental health awareness programs.

### **5.6 Study Recommendations**

#### **5.6.1 Social Media**

Social media has evolved tremendously in the past couple of years. Majority of the South African population has some sort of social media presence. Social media may thus be a great

platform to raise awareness in terms of mental illnesses. Government as well as the Department of Health (DoH) can exploit the fact that social media is readily and easily available to everyone and use this platform as a tool to raise awareness of mental health. This can be done using the different forms of social media. From Facebook, to Instagram and Twitter. The DoH can also collaborate with social media influencers who are able to generate a lot of traffic and can make any topic trend. These social media influencers could begin the topic of mental illness and mental health and engage with millions of South Africans with just one post.

### 5.6.2 Schools

As reported in the previous chapter, the level of education has an impact to the level of understanding and the awareness of mental illnesses and their impact. It is thus crucial for the Department of Education (DoE) to restructure the Life orientation (L.O.) curriculum so that it is inclusive of burning topics such as the topic of mental illness as these topics affect everyone and anyone. L.O. as a subject is essential as it is a subject that equips learners with different ways of responding to social ills and helps learners make sound choices and decisions in relations to these social ills. This subject is thus crucial in raising awareness regarding mental health and in providing learners with the correct information regarding mental illnesses as early as possible. The subject can also help in addressing the myths and misconceptions regarding mental illnesses. It is thus recommended that the DoE restructures and revamps the L.O. curriculum so that it is inclusive of sensitive topics such as mental health.

### 5.6.3 Local Government

Local Government such as the councillors, ward committees, Chiefs (Inkosi) and Izinduna can also play a vital role in raising mental health awareness. These stakeholders are elected by community members and respected by them because they have some sort of influence and they are highly regarded and respected by community members. These public figures can thus play a huge role towards the awareness of mental illnesses. They can introduce public programmes that will be inclusive of all community members and help in combating false information and myths regarding mental illnesses. These figures are also at a better position of accessing funds that can help towards building mental health care facilities in and around communities. This will ensure that community members have access to all kinds of information regarding mental illnesses. This could help improve the help seeking behavior and help with the early detection of mental illnesses thus increasing the chances of survival.

### 5.6.4 Health officials

The DoH needs to ensure that all health officials such as nurses and psychologists treat mental health patients with respect and dignity. This will make it easy for people living with mental illnesses to seek help. The topic of mental health and mental illnesses should be treated with high levels of sensitivity especially by the health officials as what they say and think directly affects those seeking help.

#### 5.6.5 Religious leaders

The church is one of the biggest institutions in our society. Church leaders such as Pastors, Priests and Bishops hold positions of much influence as they are highly regarded and respected by community members. Thus, the topic of mental illness should be an open dialogue in the church as a lot of people are dependent on the church for advice ranging from their health to their personal affairs. Church leaders should be equipped with the necessary skills and information so that they are readily available and properly equipped to deal with matters surrounding the topic of mental health. Pastors already provide counselling programs for their congregants and should therefore be supported and assisted by the DoH to continue with such programs in various communities.

### **5.7 Future Research**

The topic of mental health and illness is complex and therefore further research is required to explore the various factors leading to the much stigma surrounding the topic. The study found that a lot of studies surrounding the topic of mental illnesses are conducted in the disciplines of Psychology and Social Work and not in the Community Development discipline. This study illustrates that a multidisciplinary approach is needed to tackle the topic of mental illness as these issues affect individuals, their families and ultimately the community at large. The studies often conducted in the topic of mental illness usually tackle individual or isolated topics. However, a holistic approach is needed in order to understand the issues surrounding mental illness at an in-depth level. Community Development as a discipline is concerned with transforming systems that leave certain groups and individuals in communities marginalized and stigmatized. Thus, to transform the systems that make those living with mental illnesses prone to abuse, marginalization and violation, a multidisciplinary and holistic approach is needed.

## **5.8 Conclusion**

This chapter presented the major findings from this study in relation to the study aim, objectives as well as the research questions. This chapter also presented recommendations for future research. Overall, the whole study managed to satisfy the aim of this study which was to explore community attitudes towards people living with mental illnesses. the study also succeeded in meeting the objectives of the study and in answering the research questions as shown in chapters 4 and 5.

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## ANNEXURE A

### Interview Questions

1. Demographic data

Age?

Employment?

Education?

How long have you been staying at Inanda for?

Gender?

2. What are the attitudes of community members towards those living with mental illnesses in Inanda?

2.1 What is your understanding of mental illnesses?

2.2 How would you know that someone was experiencing a mental illness?

2.3 Name a few types of mental illnesses that you know of

2.4 What do you think causes mental illnesses? Why do you think this way?

2.5 Do you think mental illnesses can be cured?

2.6 What can a person do to help themselves when they are experiencing a mental illness?

2.7 What can be done by others to help someone experiencing a mental illness?

3. What are the causes of these attitudes towards those living with mental illnesses in Inanda?

3.1 What do people around you say is the cause of mental illnesses? Do you believe that?

3.2 Where did you get the information you have regarding mental illnesses? i.e movies, the news, doctors, family members of people living with mental illnesses or from those around you.

4. How do these attitudes affect those suffering from mental illnesses?
  - 4.1 How should we behave when we know that someone is experiencing a mental illness?
  - 4.2 Please share any myths you may know about people living with mental illnesses.
  - 4.3 What do you think should happen to people experiencing mental illnesses? How should other people treat them?
  - 4.4 Do you have any other thoughts or comments regarding mental illnesses and those living with them?
  
5. Do you know of any mental health services in the area?

## **ANNEXURE B**

### **UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS**

#### **COMMITTEE (HSSREC)**

#### **APPLICATION FOR ETHICS APPROVAL**

#### **FOR RESEARCH WITH HUMAN PARTICIPANTS**

### **CONSENT FORM**

I \_\_\_\_\_ have been informed about the study titled: An exploration of community attitudes towards people living with mental illnesses : a case of Inanda, Kwa-Zulu Natal. I understand the purpose and procedures of the study.

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

I understand that I will not benefit directly from participating in this study.

I understand that all information I will provide will be treated with great confidentiality.

I understand that in any report on the results of this research my identity will remain anonymous. This will be done by changing my name and disguising any detail of my interview which may reveal my identity or the identity of the people I speak about.

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

If I have any further questions/concerns or queries related to this study, I understand that I may contact the researcher on 067 077 2226/084 489 1792 or [216042702@stu.ukzn.ac.za](mailto:216042702@stu.ukzn.ac.za)

If I have any questions or concerns about my rights as a study participant, or if I am concerned about any aspect of the study or the researcher, then I may contact:

**HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban, 4000

Kwa-Zulu Natal, South Africa

Tel: 031 260 4557 – Fax: 031 260 4609

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

Additional consent where applicable

I hereby provide consent to:

Audio- record my interview

YES/NO

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**Signature of Participant**

**Date**

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**Signature of Witness (Where Applicable)**

**Date**

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**Signature of Translator (Where Applicable)**

**Date**



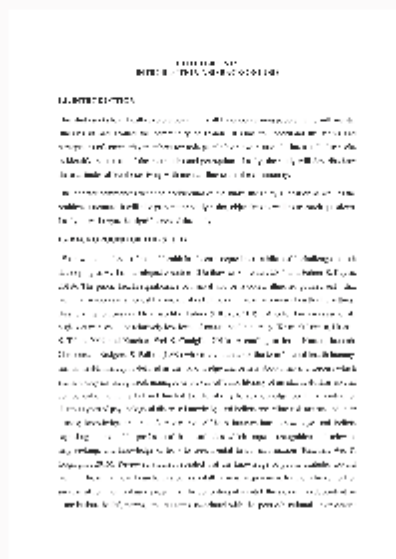


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12 March 2021

Mr Andile Kevin Mthembu (216042702)  
School Of Built Env & Dev Stud  
Howard College

Dear Mr Mthembu,

Protocol reference number: HSSREC/00002452/2021

Project title: An exploration of community attitudes towards people living with mental illnesses: the case of Inanda, Kwazulu Natal.

Degree: Masters

### Approval Notification – Expedited Application

This letter serves to notify you that your application received on 08 February 2021 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 12 March 2022.

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

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#### Humanities and Social Sciences Research Ethics Committee

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