

**THE CULTURAL BELIEFS OF FAMILIES AFFECTED BY MENTAL
ILLNESS: THE PERSPECTIVES OF CAREGIVERS**

by

LEBOGANG MILLICENT MATLALA

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Supervisor: Mrs NJ Bila

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DECLARATION

FULL NAME: _____

STUDENT NUMBER: _____

I declare that this mini dissertation: “The cultural beliefs of families affected by mental illness: The perspectives of caregivers” is my own, original work. All secondary material used has been carefully acknowledged and referenced by means of complete references in accordance with the University’s requirements. This dissertation was not previously submitted by me for a degree at another university.

I understand what plagiarism is and I am aware of the University’s policy and its implications in this regard.

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complained about the challenges I faced during my studies. Your encouragement and support mean a lot to me. I thank you all sincerely.

ACRONYMS

DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International Classification of Disease
DG	Disability grant
CSG	Child support grant

TERMS AND DEFINITIONS

Ntwane	Small village in Kwarrielaagte, Dennilton where the study was conducted
Bantwane	People of Ntwane village
Sentwane	Common language spoken in the small village of Ntwane, also referred to as Northern Sotho

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ABSTRACT

THE CULTURAL BELIEFS OF FAMILIES AFFECTED BY MENTAL ILLNESS: THE PERSPECTIVES OF CAREGIVERS

BY

LEBOGANG MILLICENT MATLALA

SUPERVISOR: MRS. N. J. BILA
DEPARTMENT: SOCIAL WORK AND CRIMINOLOGY
DEGREE: MSW SOCIAL WORK IN HEALTH CARE

The community of Ntwane lives in a small village unknown to many people. Like most communities, its people are faced with challenges which require the intervention of a multidisciplinary team in order to enhance their quality of life. The prevalence of mental illness, as reported by community members, is high and knowledge in this regard is minimal. This study, which explored the cultural beliefs of families affected by mental illness, was informed by the prevalence of mental illness, as well as a concern regarding the lack of education and knowledge on mental illness. The community members fail to recognise the influence of culture on their beliefs regarding mental illness. Mental illness is viewed as being caused by elements such as witchcraft and supernatural forces, yet culture is not seen as influencing this belief.

The goal of this study was to explore and describe caregivers' perspectives on the cultural beliefs regarding mental illness of families affected in the small village of Ntwane. The cultural beliefs of families affected by mental illness were explored using snowball sampling. The research approach utilised in this study is qualitative as it sought to gain an understanding through rich, insightful information. A total of twelve participants were drawn from this community with the caregiver representing the family.

The findings of the study indicated that there were cultural influences on the view of mental illness in the study community. Witchcraft, punishment for failing to appease

the ancestors, as well as supernatural forces and the abnormal movement of blood were perceived to be the causes of mental illness in the community.

The study concludes that culture does in fact inform views of mental illness in the study community. The study proposes the need for community education in order to enhance the mental wellness of community members. An education system catering to the needs of individuals with a mental illness is also needed. Specialised mental health services within the reach of community members is also seen as vital and needed in this community.

KEY WORDS

Mental illness

Mental health

Ecological systems theory

Traditional healers

Western doctors

Cultural beliefs

CHAPTER ONE

GENERAL INTRODUCTION OF THE STUDY

1.1 INTRODUCTION

Mental illness is a worldwide problem affecting individuals across all walks of life. It is a neglected problems with Burns (2014:7) asserting that 75% of people with common mental disorders in South Africa do not receive any treatment. Burns (2014:6) asserts that mental disorders are common and responsible for a reduction in life expectancy, where there is collective and individual suffering, loss of social as well as occupational functioning and productivity, and extensive disability. Mental illnesses are the cause of major burdens on those affected, such as caregivers and other family members in contact with a person with a mental illness. Burns (2014:6) states that “mental and neurological disorders are responsible for 14% of the global burden of disease and 30% of disability-adjusted life-years.” It is also anticipated to increase over the next few decades with low- as well as middle-income countries being most likely to experience a disproportionate increase in burden due to mental illnesses as they pass through the epidemiological transition (Burns, 2014:6). Asuni, Schoenberg and Swift (1994 in Quinn, 2007:175) support this statement and state that mental illness is widespread with low-income countries being challenged the most by it.

Different cultural beliefs can have an impact on the manner in which mental health is experienced by individuals. This is evident in many countries globally, as stated by James and Peltzer, (2012:94). In Malaysia, the belief that one’s mental illness is caused by supernatural forces has resulted in greater use of traditional healers and less compliance with the medication provided by Western biomedical sciences. Sharif and Ogunbanjo (2003:11) assert that a similar pattern is also found to exist in South Africa where psychiatric patients who believe that their illness is due to supernatural forces, are more likely to seek spiritual and herbal healing as their treatment method. Quinn (2007:175) believes that there are many debates on how different cultures and traditions define mental illness. Subudhi ([sa]:136) supports this notion and alludes to the fact that “every society has its own culture and this

culture regulates an individual's perception and treatment procedure of mental illness”.

In this study, the focus was on the cultural beliefs of families affected by mental illness, with the main focus being on the caregivers who are part of the family system. A literature review will be conducted in order to gain more insight on the topic and identify gaps which exist within the research field. The study was conducted in the rural community of Ntwane. Ntwane is a rural area in Kwarrielaagte, where the Bantwane settled in the Moutse area around 1903 following their decision to purchase a number of farms that were available in the area. Kwarrielaagte is also referred to as Moutse and the name Ntwane emerged because the inhabitants of the area are called the Bantwane.

Magubane (2001:8-12) indicates that the Bantwane originated from present-day Botswana. They moved to their current home in South Africa's Mpumalanga Province (recently incorporated into Limpopo Province) after a series of relocations that probably began around the 18th century. The language they speak today attests to the influence of northern Sotho groups, notably the baPedi, at some stage in their history.

1.2 DEFINITION OF KEY CONCEPTS

1.2.1 Culture

Kazarian and Evans (2001:65) state that the definition of culture, which usually focuses only on objective traits that include geographical region, race, language and religion, should also focus on subjective features such as shared beliefs, values and ideas. They argue that by switching focus to subjective aspects, the definition of culture becomes more pliable and adaptable to many different groups. They believe that in order to meet the criteria of a cultural group, there need to be shared experiences in that group that are passed along to other members of the group. “Culture refers to a mixture of behaviour and cognition arising from shared patterns of belief, feeling and adaptation which people carry in their minds” (Fernando, 2010:7).

Tseng and Streltzer (2010:1) define culture as “unique behavioural patterns and lifestyles that are shared by a certain group of individuals which differentiates them from other groups. It may be expressed in various ways that regulate life, such as through customs, etiquette, taboos, or rituals. It is said to be characterised by a set of views, beliefs, values and attitudes towards life that are passed on from generation to generation.”

1.2.2 Cultural beliefs

Cultural beliefs are defined as “beliefs that come from a place in a person that is not just learned behaviour. They are said to include a mixture of traditions, behaviour and practices that have been created by a person’s culture. Such cultural beliefs can have such an influence on a person’s life that they can even influence their access to health care, such as believing that as a Jehovah’s witness, certain types of medical procedures cannot be accepted” (Bravewell, 2014:1).

1.2.3 Family

Benokraitis (2005:5) refers to a family as “a unit that is made up of two or more people who are either related by blood, marriage or adoption, living together to form an economic unit as well as bear and raise children together.” Debates do exist around the definitions as other diverse groups, such as childless couples, cohabiting couples, elderly siblings living together, gay and lesbian couples and foster parents, should not be excluded because they are also a family (Benokraitis, 2005:5).

1.2.4 Caregiver

Pierson and Thomas (2010:65) define the caregiver as a person responsible for looking after another person who cannot look after himself or herself in some or all respects. The caregiver can be either a family member or not. In this research study, the caregiver is defined as a family member. Pierson and Thomas (2010:65) are of the opinion that the most demanding role of a caregiver is likely to be for a person with conditions such as dementia or those with serious mental health problems.

1.2.5 Mental illness

The World Health Organization (WHO) (1992 in Karban, 2012:31) states that mental illness is “clinically recognisable patterns of psychological symptoms or behaviour causing acute or chronic ill health, personal distress or distress to others.” Nies and Ewen (2007:469) similarly define mental illness as a maladaptive response to distress as well as the inability to mobilise resources. A person suffering from mental illness is faced with challenges such as low self-esteem and difficulty in forming interpersonal relationships. It poses challenges in thinking abilities, mood, behaviour and challenges everyday functioning.

1.2.6 Mental health

“Mental health is the emotional and spiritual resilience which enables us to enjoy life and survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others’ dignity and worth” (Health Education Authority, 1997 in Karban, 2012:31). Eby and Brown (2005:24) define the term mental health as the ability to interpret reality accurately and achieve a sense of meaning in life. It is further described as the ability to be able to demonstrate productivity as well as creativity, to have control over one’s own behaviour and to have the ability to adapt to change as well as conflict. Mental health can therefore be summed up by the researcher as the ability to function effectively in everyday life and circumstances.

1.3 THEORETICAL FRAMEWORK

The study was based on the ecological systems theoretical approach. This theory, which guided the study, is central to the metaphor of the interrelatedness of a person and an environment. The community being studied deems that the beliefs that they have, balance their mental health and wellness. Any transgression of these environmental factors will cause mental imbalance. This resonates with the philosophical framework of the ecological systems theory as quoted by Bonfenbrenner (1973 in Gray & Webb, 2013:175), which states that people are active participants in their development and the way in which they perceive their environments is often as important as the way they actually experience their

environmental contexts. The community of Ntwane's perceptions of what mental illness is, as well as the causes of mental illness, has become a reality for them. Their perception is mental illness is what it is and they have always believed it to be caused by factors such as witchcraft.

Bronfenbrenner makes reference of an ecological model of human development where he divides the ecological environment into four nested systems, namely: microsystem, mesosystem, exosystem and macrosystem, in order to allow us to go beyond the setting which is being immediately experienced (Gardiner & Kosmitzki, 2011:25). The fifth system of the ecological model is the chronosystem and will seldom be referred to by the researcher. The systems are summarized as follows based on Bronfenbrenner's ecological theory model as cited by Gardiner and Kosmitzki (2011:25-26).

The microsystem is the first system and is the closest to the focal individual as it has direct contact with him/her. The next system is the mesosystem, which recognizes the interrelatedness of systems and provides a connection between them. The third system is the exosystem, which refers to the social setting beyond the immediate environment of the focal individual yet in some way influences the individual's development. The fourth system is the macrosystem, which considers the influence of values and customs held to be of high importance by the focal individual. These systems of Bronfenbrenner's ecological systems theory model of human development will be further discussed and elaborated on in chapter 2 of the study under section 2.2.

1.4 RATIONALE AND PROBLEM STATEMENT

In this study, the researcher intends to explore the cultural beliefs of families affected by mental illness with the caregiver being a family member representing the family. Cultural beliefs seem to influence views on mental illness, with traditional remedies being given preference without the consideration of Western medication in the study community. The researcher observed that in the study community, culture not only affects how the community views mental illness, but also how it affects treatment choices and limits the community's willingness to educate themselves on mental

illness and mental health. Research conducted in previous years shows the rippling effects that mental illness can have on different generations within a family structure, from the parents to the children and more especially on the caregivers who, according to Saunders (2003:175), “suffer from stress, experience moderately high levels of burden, and often receive inadequate assistance from health professionals,” as a result of dealing with mental illness within the family.

Starting from the parents in dealing with mental illness “the caregiver responsibilities often fall on the mentally-ill parent’s spouse or partners, if they have, and/or extended family members, including children’s grandparents and older children. This puts enormous stress on the family physically as well as psychologically” (Reupert & Maybery, 2007:365). These authors (2007:362) also report that “the child of a parent with mental illness may experience a home environment that is different from many other children as they live with the symptoms, behaviours and expressions of mental illness.”

The researcher observed that in the community of Ntwane, many families are experiencing mental illness within the family structure, but are not educated on mental illness. Their cultural beliefs and the way in which they were raised to view mental illness affects their judgement of the true nature of the illness and hence affects their willingness to consult professionals in the field of mental health for assistance. Traditional remedies were seen by the researcher to be given preference over Western treatment and limit the community in educating themselves on other potential causes of mental illness. It was often seen either as punishment from ancestors or as witchcraft, even without the existence of proof in this regard. As stated by Magubane (2001:8-12), the inhabitants of this small rural community in Limpopo believe in God, the existence of ancestors, traditional healers and inanimate objects and plants. This forms part of their cultural beliefs on which they place great value. The influence of their cultural beliefs is evident in how they handle issues affecting them. In the study community, the researcher observed that assistance is often sought from traditional healers before medical doctors are consulted. Hence, the motivation arose to explore this further through research, rather than relying on own observation and making judgements which have not been proven. This resonates with the statistics provided by WHO (2010:1), which indicate

that “approximately 80% of Africans habitually consult experts on traditional medicine – ‘healers’, ‘herbalists’, ‘doctors’ to treat their sicknesses.”

Through consultation of sources, the researcher identified that little research has been done in the Ntwane community. Literature on the background of this small rural community is almost non-existent as Magubane (2001) is one of the very few researchers who have studied the community and even classifies its inhabitants as “Africa’s undiscovered people”. Coetzee (1977) and Stoffberg (1967) are the only two other researchers identified by the researcher to have conducted studies on the culture of this specific community. Hence this motivated the researcher to focus her research on this ‘unknown’ community in the hope that it would enhance their quality of life and motivate community education in the form of mental illness/health awareness programmes by social workers in the community.

Through conducting a literature study on the cultural beliefs of families affected by mental illness, the researcher was able to identify and possibly refer to ample research on mental illness as well as culture, and mental illness and its effects on the family. However, research, which focuses specifically on the effects of cultural beliefs on mental illness, is not abundant. The researcher views mental illness and culture as integrated entities as this resonates with the researcher’s theoretical framework which indicates that the individual is part of the whole community in which he/she lives and therefore cannot be separated from it (Gray & Webb, 2013:176). The researcher also considered the body, mind and spirit of the participants in the study.

The research question which guided the study was:

- What are the perspectives of caregivers regarding cultural beliefs of families affected by mental illness?

The sub-questions which assisted the researcher in answering the research question are as follows:

- How do these cultural beliefs influence the manner in which mental illness is viewed?
- How will these cultural beliefs influence the choice regarding treatment options?

1.5 GOAL AND OBJECTIVES OF THE STUDY

The research goal and objectives of the study are as follows:

1.5.1 Goal of the study

The goal of this study was to explore and describe the cultural beliefs of families affected by mental illness and the perspective of the caregivers.

1.5.2 Objectives of the study

The objectives are as follows:

- To describe culture and mental illness from an ecological systems perspective;
- To explore the cultural beliefs regarding the mental illness of families affected;
- To explore how the choice of treatment of mental illness is affected by these cultural beliefs; and
- To find out how services that are provided to families affected by mental illness can be improved.

1.6 RESEARCH DESIGN AND METHODOLOGY

A brief overview of the research methodology which was utilised in the study will be discussed. It should be noted, however, that a more detailed discussion of the methodology utilised as well as the research approach and research design will be discussed in greater detail in chapter 3 of the research. Measures of ensuring trustworthiness and ethical considerations will also be discussed in depth in chapter 3 of the study.

The study is based on the qualitative research approach. The research study made use of applied research that was exploratory in nature as it aimed to gain insight into the cultural views of families regarding mental illness (Fouché & De Vos, 2011:95).

The collective case study was employed by the researcher as a qualitative research design suitable for the study conducted.

The sampling method employed was snowball sampling. The researcher made use of semi-structured one-to-one interviews as a data collection method in order to gain a detailed picture of the participants' cultural beliefs about mental illness (Greef, 2011:351). The ethical considerations of the study will also be discussed in chapter three.

1.7 LIMITATIONS OF THE STUDY

Although the study succeeded in reaching its objectives as set out, challenges arose that required sudden changes to be made. In the planning stages of the study, there was supposed to be an *imbizo*, in which the community leader would inform the community of the research study and during which community members would be asked to volunteer as participants in the study.

However, this proved impossible to make happen as the researcher had to rely on the community leader to ensure that the *imbizo* took place. Due to his busy schedule, changes had to be made in order to ensure that the study went ahead as planned. With the permission of the community leader, the researcher was able to obtain participants through the snowball sampling technique which involved approaching a single case with a family member with mental illness for interviewing (Strydom & Delport, 2011:393). Information on similar cases was sought from that one individual until the researcher was able to reach her target of participants.

1.8 DIVISION OF RESEARCH REPORT

The research report consists of four chapters. **Chapter one** focuses on the introduction and general orientation of the study, including a brief discussion of the theoretical framework relevant to the study, rationale and problem statement of the

study, the goal and objectives, limitations to the study, as well as a brief overview of the study's research methodology.

Chapter two provides an in-depth literature review. A more comprehensive in-depth discussion of the theoretical framework guiding this study will be discussed. An overview of mental illness, mental health and culture both locally and globally will also be discussed in depth. Cultural beliefs about the causes of mental illness will also be discussed, as well as the functioning of families with a member with mental illness.

Chapter three outlines the research methodology employed for the study. It includes a detailed explanation of the research approach, type of research, research design, study population, sampling, data collection, data analysis, trustworthiness of the data, pilot study, as well as the ethical considerations of the study. Moreover, the empirical findings of the research study are also presented and discussed in this chapter.

Chapter four forms the final chapter of the report. It outlines how the goal and objectives of guiding the study were achieved by the researcher. The key research findings of the study from which conclusions were drawn will be discussed and the recommendations from the study presented.

To follow is a literature review on culture and mental illness. The theoretical framework which guided the study will also be discussed in **chapter two** of the study.

CHAPTER 2

MENTAL ILLNESS AND CULTURE

2.1 INTRODUCTION

In this chapter, the researcher consulted a range of literature relating to the research topic in order to gain a deeper understanding of the complexity of mental illness, its impact on different cultures and how they view it, the treatment options sought, as well as the different cultural beliefs about mental illness and mental health. There is a paucity of literature that speaks directly about the cultural beliefs of families affected by mental illness. Hence, the researcher focused more on literature that speaks of the link between culture and mental illness as well as the literature that discusses how mental health is viewed globally and locally. A few sources consulted by the researcher are rather dated, but nevertheless are relevant and provide an insight that increases understanding of mental illness in a variety of families, communities and well as countries.

When conducting a literature review, consideration of the theoretical framework guiding the research study is also important. The researcher referred to literature which describes how the functioning of families with a member with mental illness is affected, as well as the impact of cultural beliefs on treatment choices.

WHO (2001:19) asserts that mental disorders differ from physical illness with the most common, which usually cause severe disability, being depressive disorders, substance abuse disorders, schizophrenia, epilepsy, Alzheimer's disease, mental retardation as well as childhood and adolescent disorders. Factors such as poverty, sex, age, conflicts and disasters, major physical diseases, as well as the family and social environment, are seen as being associated with the prevalence, onset and course of mental and behavioural disorders.

Mental illness is seen by the researcher as a global problem with scant awareness of its impact. WHO (2001:19) states that, "one in four families is likely to have at least one member with a behavioural or mental disorder, with around 20% of all patients seen by primary health care professionals having one or more mental disorders".

Individuals, families and communities should familiarise themselves with this phenomenon in order to gain a full understanding of what it entails as well as the services that are available to them. Lack of knowledge and understanding of mental illness is seen by the researcher as the predominant reason why people affected by mental illness do not receive adequate treatment, above the role of culture. Although mental illness and mental health education are important and needed in many communities, one should respect the fact that because cultures vary, people will view mental illness, its causes and treatment in diverse ways.

2.2 THEORETICAL FRAMEWORK FOR THE STUDY

The ecological framework is seen by Algood, Harris and Hong (2013:128) as facilitating the organization of information about people and their environment in order to understand the interrelatedness of those systems. According to the ecological systems approach, people are seen as requiring environmental support and coping skills in order to adapt to continually changing environments and transitions in life (Algood et al., 2013:128). Germain (1973 in Gray & Webb, 2013:175) proposes that in order to fully enhance the well-being of individuals, both the physical and social environment of those individuals must be assessed alongside each other. In other words, people from the same physical environment will often uphold the same beliefs and value systems due to their socialisation throughout their development.

Bronfenbrenner (1977 in Gray & Webb, 2013:175) theorised five types of systems which are nested together and continually interact with each other; throughout this continuous interaction, they shape human development. These five interconnected systems which continually impact on the individual are described as the microsystem, mesosystem, exosystem, macrosystem and chronosystem. Bronfenbrenner suggests that these five systems are nested around a focal individual like a set of Russian dolls (Neal & Neal, 2013:723). The researcher was guided by the definitions provided by Neal and Neal (2013:724) as well as Algood et al. (2013:128-132) in describing the five systems. Algood et al. (2013) define the systems according to Bronfenbrenner's (1977) ecological framework, as presented in the following sections.

2.2.1 Microsystem

The microsystem is described as a setting in which a set of people engage in social interactions that include the main individual (Neal & Neal, 2013:724). Bronfenbrenner (1977 in Algood et al., 2013:128) describes the microsystem as “a pattern of activities, social roles, and interpersonal relations experienced by the individual or a group of individuals in a direct setting.” In this study the microsystem includes the family and other structures such as schools and churches, which has direct impact on behaviours and held beliefs. Individuals in the study community interact with one another socially and have also developed shared beliefs which are guided by their cultural beliefs and practices.

2.2.2 Mesosystem

A mesosystem is seen as comprising interactions between two or more microsystems which can affect the individual (Bronfenbrenner, 1977 in Algood et al., 2013:129). Neal and Neal (2013:724) describe the mesosystem as “a social interaction between participants in different settings that both include the focal individual.” In this study, the mesosystems, which could include different families, churches, schools and other structures, interact with each other through their connections and influence behaviours and beliefs. The belief in witchcraft and other supernatural forces is a belief held by most individuals in this community because they were raised in an environment that held those beliefs highly. Through their interaction with these mesosystems the same values and beliefs are developed.

2.2.3 Exosystem

The exosystem is described by Neal and Neal (2013:724) as “a setting with a set of people engaged in social interaction that does not include the focal individual but who interact directly or indirectly with the focal individual.” The exosystem is described by Mutumba and Harper (2015:56) as comprising contexts which do not directly involve the developing individual. However, these contexts have an influence on the behaviour and development of that individual. Many different structures exist within the study community and although they may not have direct interaction with each other, the interaction between one or more structure within the individuals

microsystem seems to have had a significant influence on the individual's development and belief systems. Even though individuals in the study community have not had personal experience of witchcraft, they still believe in its existence due to the fact that they were raised in a community that believes in such. Even though individuals outside a family structure may not have direct contact with an individual, through interactions with other family members and other individuals within the same community, similar beliefs develop.

2.2.4 Macrosystem

The macrosystem as described according to Bronfenbrenner's (1977) ecological framework as cited in Algood et al. (2013:130) is the culture in which the individual is rooted. Neal and Neal describe it as the social patterns which direct the creation, as well as the termination, of social interactions between individuals. Each community has its own culture. This culture is guided by shared beliefs, values and customs. Ntwane is a community which is guided by their culture. They engage in cultural practices which are considered important by the community members. Their culture also determines the beliefs they hold regarding issues such as those held regarding mental illness.

2.2.5 Chronosystem

The chronosystem is depicted by Neal and Neal (2013:724) as "the observation that patterns of social interactions between individuals change over time, and that such changes impact the focal individual, both directly and by altering the configuration of ecological systems around him/her." The chronosystem believes that individuals change with time and experience things differently depending on their developmental stage. However, in the study community, similar beliefs are held and seem to be mostly influenced by culture.

2.2.6 Relationship between systems

Neal and Neal (2013:723) demonstrate that although the ecological systems theory is widely acknowledged for highlighting the importance of interdependent and

multilevel systems on individual development, the exact relationship which exists between systems remains hard to pin down. Bronfenbrenner (1977) in Neal and Neal (2013:723) originally described the different levels of ecological systems as being nested within each other, which gave rise to the ecological system theory's classic portrayal as "a set of concentric circles". Neal and Neal (2013:723), however, argue that the systems should rather be conceptualized as being networked together because the term "nested" conceals the relationship between them. When referring to systems as networked, each system is then defined in terms of social interactions surrounding the main individual. This is when the different systems are said to be related to each other in a way that is overlapping rather than nested. Bronfenbrenner's (1945) earlier descriptions did recognize the role of social networks in shaping the development of individuals.

In the context of this study, the ecological systems theory focuses specifically on the interrelatedness of a person's environment and culture to the perceptions they hold about certain issues, such as mental illness in this case. Germain (1973 in Gray & Webb, 2013:175) suggests that in order for a person to fully embrace human well-being, the physical and social environments of an individual need to be assessed at the same time. In this study, it is vital for the researcher to assess the relationship between the environment, the inhabitants' behaviour as well as their culture. This standpoint guided the researcher in terms of explaining certain behaviour as expressed and experienced by the inhabitants of the study population. With the ecological systems theory as a guide in the study, the researcher was able to have an open mind with regards to the influence of the environment on the inhabitants' beliefs and behaviours. Human beings live in communities and those communities are their environment. The study population has its own beliefs and those beliefs include the existence of God, ancestors, traditional healers as well as inanimate objects and plants. These form part of their cultural beliefs and values and are inseparable from their environment. The environment in which people develop, grows them to be the individuals that they become in life. It is this environment which basically guides the way certain issues are seen and interpreted.

The ecological systems theory forms part of the general systems theory, which conceptualises the way each system functions and interacts with other systems. The

family is seen as a system that comprises several subsystems, such as the spousal, parental and sibling subsystems. This means that each system is part of a larger system (Ross & Deverell, 2010:305). People adapt to their constantly changing environment in order to cope and survive in that environment as well as to compete for necessary resources. Ross and Deverell propose that “In order to adapt to their environment, communities would manipulate stressful environments by performing cultural rituals, which help in alleviating the environmental stressors” (2010:305). The researcher believes this to be the logic behind the belief in preferring to seek assistance from traditional healers rather than Western doctors for mental illness. Seeking assistance from traditional healers and performing rituals aimed at dealing with the mental illness, gives inhabitants comfort in the knowledge that they have done something to assist the individual with mental illness by either appeasing the ancestors, or getting herbs to heal the person.

The researcher therefore believes that the ecological systems theory fits well with this study as she has attempted to explore how culture affects mental health. This theory, according to the researcher, resonates well with the focus of the study, which seeks to explore the cultural beliefs of families affected by mental illnesses. Furthermore, this theory is appropriate in that it highlights the interrelatedness of the environment with the system and its functioning. The individual cannot function apart from his/her environment and this study will clarify why and how cultural beliefs have an impact on mental illnesses, community education on mental illnesses, as well as the type of treatment that is sought for them within the community. The fact that individuals in one community often hold similar beliefs about issues, such as mental health and mental illness, shows the extent to which the environment to which a person belongs impacts on their belief system and views of the world and its issues.

The ecological systems theory, which believes in the metaphor of person-in-environment, clearly suggests that a person adapts to his/her environment and cannot function apart from this environment. This concept supports the researcher’s notion of the existence of a relationship between the environment of the study population and their culture which in turn affects their behaviour and beliefs about issues affecting them, such as mental illness within the family structure. There are

four main ideas common to the ecological system's thinking, described in the following section (Gray & Webb, 2013:178).

2.2.6.1 *Part of the whole*

The first key idea common to the ecological systems' thinking is the belief that it is impossible to fully understand the intricacy of the human situation by simply looking at it in a linear way. It is vital to also consider how individual parts fit and function within the larger whole, which is part of the interrelatedness of systems. This basically refers to the fact that the part cannot be separated from the whole. The individual is part of his/her environment and can therefore not be separated from his/her environment. Individuals in the study are part of a community. They have shared beliefs, values and customs which guide their daily experiences. In order to fully understand the views of the individuals in the community, the researcher needed to understand their culture as well as what they hold highly and as important.

2.2.6.2 *Stability*

The second key idea of the ecological systems' thinking is the belief that systems strive for stability. When communities seek a certain balance, they achieve it through beliefs which result in cultural balance according to their values. The whole, which has been formed from parts, causes equilibrium or balance. Systems are seen as always striving to maintain symmetry. In order to achieve balance, community members in the study have developed common beliefs which they use to explain phenomena which may cause an imbalance for them. These beliefs include the belief in witchcraft and supernatural forces. In order to make sense of anything misunderstood, bewitchment and other supernatural forces are viewed as being responsible.

2.2.6.3 *Methods*

The third key idea of the ecological systems' thinking is the belief that systems have within them methods which allow them to handle and adjust to continuously changing environments. Individuals learn to adapt to their environment in order to find a balance and cope. Due to the continually changing environments, individuals

adapt to these changes in order to maintain equilibrium. Beliefs held in the study community may not be the same beliefs held many years ago. They changed with time and in order to find balance and cope, the individuals had to adjust to these changes.

2.2.6.4 *View of environment*

The fourth and final key idea is the belief that the ecological systems approach has a narrow understanding of the environment. The environment is seen as a fixed social setting, with attention being focused on the individual's ability to change and to accommodate environmental conditions that might hinder their progress. The final key idea of the ecological systems approach is seen as being unrealistic by the researcher as the environment cannot be fixed. There are many changes which arise with time and these were not considered by this view.

The ecological systems theory supports the researcher's belief that the existence of a relationship between the environment of the study population and its culture in turn can affect the population's behaviour and beliefs about certain issues, such as mental illness. The person, who is the focal point, is part of many systems which are networked together or, according to Bronfenbrenner (1979), nested within one another (Neal & Neal, 2013:723). In essence, when talking about the ecological systems theory, one first needs to understand the functioning of the general systems theory in order to properly comprehend the meaning of the ecological systems theory. This theory believes that culture is shaped by the interactions between structures which develop shared beliefs, values and customs. The individual is seen as being part of a system of structures which interact together socially and develops shared beliefs, values and customs. Culture determines what is viewed as acceptable or unacceptable behaviour in the study community. The shared beliefs which exist in the study community are guided by the cultural background in the community.

2.3 MENTAL ILLNESS

Busfield (2011:1) is of the opinion that the term mental illness encompasses a large number of conditions, from illnesses such as brain diseases, namely Alzheimer-type

dementia and schizophrenia, to more common disorders like anxiety, depression, alcohol use/abuse and dependency, as well as various other personality disorders. “Mental illness often refers to a wide range of psychiatric symptoms that persist over time and are functionally disabling in living skills, social interaction, family relationships, jobs, and/or education” (Johnson, 1997 in Reupert, 2007:362).

Crawford (2006:262) believes that a minority of people suffer from long-term mental illness from which most of those who suffer can make a full recovery with the correct treatment. Mental illness has been identified by McCubbin and Finley (1983 in Saunders, 2003:177) as a catastrophic stressor for the family, which entails stressors that strike the family suddenly and overwhelmingly, making it difficult to cope. Woolf (2006:237) asserts that witchcraft is seen as one of many causes of mental illness. Quinn (2007:178) mentions that in many parts of Africa, people with mental illness often lose social support and are found shackled, begging, stealing or wandering the streets alone.

Golightley (2012:2) states that WHO held a conference in January 2005 for European ministers where the focus was on starting the process of drawing up a framework for comprehensive action and political commitment to mental health. Three important areas for improvement were highlighted and these include the facts that:

- Mental illness affects every fourth citizen in Europe and can lead to suicide, which is a cause of a significant number of deaths.
- Mental illnesses are seen to cause a significant amount of loss and burden on the economic, social, educational, criminal as well as the justice systems.
- Finally, the existence of stigmatisation, discrimination and lack of respect for the human rights and dignity of those individuals suffering from mental illness challenges core European values.

Mental illness is clearly a global problem affecting all people, across all cultures. More time and resources should be dedicated to those suffering from a mental illness.

2.3.1 Classification of different mental illnesses

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (APA, DSM) is one of two international psychiatric classifications that seek to provide universal standards and definitions for identifying different mental illnesses. DSM V being the latest version available. The second classification is referred to as International Classification of Disease (ICD).

The researcher was unable to predict which mental illness would be the focus of the study as most families do not know the diagnosis of their loved ones and merely refer to them as having a mental illness. Hence the researcher has highlighted only some of the many mental illnesses which have been documented for the purpose of clarity on the range of mental disorders. With the DSM in mind, having to compile a list of the great number of documented mental illnesses would give rise to a rather long list. The researcher will be focusing on a more refined list as a summary of a few of many disorders which exists.

2.3.1.1 *Dementia*

Dementia, which usually occurs in the elderly, refers to the deterioration of one's brain functioning and is usually identified by loss of memory. It is also regarded as a condition which many people are aware of and refer to as literally being "out of one's mind" (Busfield, 2011:28).

2.3.1.2 *Schizophrenia*

"Schizophrenia usually stands in the public's and professional's perception as a paradigmatic madness, which involves from a western, Enlightenment view the loss of reason" (Foucault, 1976 in Busfield, 2011:29). "The word schizophrenia does not mean split personality despite being used in this way in the media. It usually means being split off from reality so that unusual thoughts, feelings and experiences become a person's reality, and the more humdrum day-to-day concerns become less important" (Ramsay et al., 2006:17). Symptoms of schizophrenia as cited by Busfield (2011:26) include, but are not limited to, hallucinations, delusions, disorganised speech and behaviour. (DSM V:2013) however emphasizes the relevancy for an

individual to at least have on of these three symptoms in order to be diagnosed as having schizophrenia; delusions, hallucination and disorganised speech.

2.3.1.3 *Bipolar disorder*

Bipolar disorder is defined as a manic-depressive insanity which is characterized by a cyclic shift between states of mania and depression (Busfield, 2011:32). The DSM V. (2013) emphasise change in activity and energy as well as changes in mood as measures to consider before diagnosing bipolar disorder. Ramsay et al. (2006: 30) define bipolar, which is also known as manic depressive psychosis, as “a form of mental illness in which people experience big changes in their mood. At one extreme, people experience mania, and feel high or elated. At another extreme they experience severe depression and feel very low or depressed. These mood swings are more extreme than the normal ups and downs most people experience, maybe as a result of some happy or sad event.” The causes of bipolar disorder have been viewed as being rooted in family history with inheritance and genetics being seen as playing a role in the development thereof. The appearance of bipolar disorder should, however, not be viewed as inevitable to appear in other family members if one family member has it (Ramsay et al., 2006:31).

2.3.1.4 *Depressive disorders*

“Here a person’s mood is sad or down. This lowness of mood is persistent and does not change even when good things happen” (Ramsay et al., 2006:31). Different types of depression have been outlined by the DSM-III (Busfield, 2011:33). They include major depressive disorder, dysthymic disorder and atypical depression and will be discussed briefly according to symptoms.

Major depressive disorder is characterised by Busfield (2011:33) cited from APA (2000) as follows:

- depressed mood;
- loss of interest in nearly all activities;
- changes in appetite or weight, sleep patterns;

- changes in psychomotor activity or decrease of energy;
- feelings of worthlessness and guilt;
- difficulty thinking, concentrating or making decisions;
- recurrent thoughts of death or suicidal ideation, plans, or attempts; and
- symptoms accompanied by clinically significant distress or impairment in social, occupational or other areas of functions.

“Symptoms must not result from bereavement unless they last for more than two months or are characterised by functional impairment, morbidity, preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation” (Busfield, 2011:33).

Dysthymic depression is viewed as being based in personality dynamics and must have lasted for a period of at least two years (Busfield, 2011:35).

Atypical depression, also referred to as depressive disorder NOS, “is a category for those with depressive symptoms of at least two weeks’ duration that do not fully meet the criteria for the other two depressive disorders or for other disorders where depressed mood is included as a component, like adjustment disorder with depressed mood” (Busfield, 2011:35).

Episodes of depression are viewed as very stressful on the family and friends of the affected individual. After episodes of mania (depression), caregivers are left feeling exhausted and powerless to help. There is also the worry of the possibility of self-harm by the depressed individual while lack of knowledge makes coping difficult (Ramsay et al., 2006:36).

2.3.1.5 *Alcohol disorder*

Alcohol disorder occurs if an individual abuses alcohol and, as a result, develops dependence on it. Socially unacceptable behaviour displayed after excessive alcohol consumption is viewed as a mental illness (Busfield, 2011:36). “About 1.7 million men and 0.6 million women in the UK are drinking in a harmful way, with one in 13 men and one in 50 women admitting to some dependence on alcohol” (Ramsay et

al., 2006:112). Furthermore, Ramsay et al. (2006:114) highlight the effects that the abuse of alcohol has on the family structure. For example, the way in which the abuser of alcohol interacts with the rest of the family is altered thereby changing the family atmosphere and the climate of trust.

2.3.1.6 *Antisocial personality disorders*

These disorders are described as “a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood” (APA, 2000 in Busfield, 2011:37) Other personality disorders which can be found in the DSM and the ICD are listed as follows with their diagnostic features by Pilgrim (2010:32):

- *Paranoid personality disorder* includes symptoms such as suspicion, mistrust, resentment, jealousy and bearing of grudges;
- *Schizoid personal disorder* refers to a person bearing the following symptoms: emotionally cold and detached, as well as lacking enjoyment;
- *Schizotypal personality disorder* has the following symptoms: social anxiety, eccentricity, oddness of thought and perception;
- *Borderline/emotionally unstable* individuals usually portray symptoms that include repeated suicide and self-harm attempts accompanied by persistent feelings of emptiness, fear of abandonment and unbalanced mood conditions;
- *Disocial/anti-social personality disorder* includes impulsiveness, lack of guilt and remorse as well as irresponsibility as symptoms;
- *Obsessive compulsive personality disorder* includes the display of the following symptoms in individuals: preoccupation with rules and small details, inflexibility and stubbornness and well as being perfectionists.
- *Histrionic personality disorders* can be identified by symptoms which include shallowness, attention-seeking behaviour and over-concern with physical attractiveness.
- *Anxious avoidant* individuals usually have a fear of being criticized or humiliated and are fearfully avoidant of others.

- *Dependent personality disorder* is seen in an individual who lets others take responsibility, has a fear of being left to care for self, and needs excessive help from others in making decisions.

Through the consultation of literature on what is meant by mental illness, as well as consideration of a few of the many different mental illnesses that exist, the researcher was able to increase her knowledge of the different mental disorders even though they cannot all be mentioned. The researcher views knowledge of the different mental disorders as vital because most family members of individuals with a mental illness have no knowledge of their loved one's diagnosis. Research in a specific field requires some knowledge of that field, which can be obtained through consulting the literature. In order to go into the field equipped with knowledge on mental illness, the researcher deemed it necessary to study the different types of mental disorder as described in the literature.

2.3.2 Causes and conceptualisation of mental illness

Different authors make use of a variety of theories to explain the causes of mental illness. The researcher has noted the causes of mental illness as summarised by Pilgrim (2010) as well as Srivastava (2002 in Subudhi, [sa]). Pilgrim makes reference to three causation theories, i.e. biological, psychological and social explanations discussed briefly in the following sections (Pilgrim, 2010:47)

2.3.2.1 Bio-determination

Samuel Guze is a North American psychiatrist who strongly advocates for the biological cause of mental illness. Since the 19th century severe mental illness has been argued to have been caused by a genetically programmed disease occurring in the brain. This is seen as being visible in a functional mental illness like schizophrenia.

2.3.2.2 Psychological determinism

Although some psychiatrists and most psychologists have stressed the psychological causes of mental illness, much debate and disagreement exists about what the

psychological causes of mental illness mean. Intra-psychic conflict, attachment problems, trauma, operant and classical conditioning, distorted cognitions and existential challenges have been highlighted as psychological causes of mental illness by different psychological researchers and therapists.

2.3.2.3 *Social causation*

Mental health researchers from different backgrounds, for example, psychiatry, psychology and sociology, argue that the social causes of mental illness are the most vital to look into and trace as they can lead to interventions for improving the condition of patients with a mental illness. The social causation model is said to emphasize social stressors alone or in combination as factors leading to a mental illness (Pilgrim, 2010:173). It is also noted by Pilgrim (2010:81) that in the past 20 years, numerous critical professionals and sympathetic individuals have pointed out that removing people from the social context in which their mental illness emerged and then allowing them to return to the very same situation which is seen as having caused the mental illness, is not a helpful way of managing the illness.

2.3.2.4 *Biopsychosocial determinism*

“This model does not challenge the basic validity of psychiatric diagnosis but does argue that the patient’s particular biographical picture should be privileged when understanding why they are presenting with these particular symptoms at this time in their life. Thus the emphasis in the model is upon multi-factorial aetiology and patient-centredness” (Pilgrim, 2010:48).

Srivastava (2002 in Subudhi, [sa]:136–137), however, makes mention of three different theories of causation of mental illness namely; the supernatural theory, the shock theory as well as the biochemical theory.

2.3.2.5 *Supernatural causation theory*

Being possessed by malevolent evil is said to cause a change in the mental state of a person. This change in the person’s mental state then marks that person as having a mental illness. People believing in the supernatural cause of mental illness consult

faith healers for the treatment or removal of evil which caused the mental illness (Subhudi, [sa]:136).

2.3.2.6 *Shock theory of causation*

This theory views the causes of mental illness as resulting from sudden change in the individual's environment which causes an imbalance. The individual's inability to cope with the change leads to mental illness (Subhudi, [sa]:137).

2.3.2.7 *Biochemical theory of causation*

A chemical imbalance which occurs in the brain is seen as responsible for the onset of a mental illness. People who believe in the biochemical causes of mental illness are knowledgeable about modern medicines and seek medical interventions for mental illnesses (Subhudi, [sa]:137).

The theories of causation which are seen by the researcher to be relevant to this study include the supernatural theory of causation by Subudhi [sa] as well as the biological and social explanations for the causes of mental illness by Pilgrim (2010). The supernatural theory seems to be the most favoured, with witchcraft and the ancestors being presumed as the cause for mental illness in an individual. The supernatural theory of causation is viewed by the researcher as going hand in hand with the belief of the ecological systems theory that the environment influences an individual's views and perceptions of reality. Through conducting this study, the researcher should be able to determine which theory of causation is most prevalent in the study community rather than relying on assumptions.

2.4 MENTAL HEALTH

The World Health Report (2001:3) contends that mental health is not rated as being of such high importance as physical health. The report states that more than 40% of countries in the world have no mental health policy and over 30% have no programme for mental health; over 90% of countries do not have a mental health policy which includes a policy for children and adolescents. Scrutiny of mental health care across different countries and cultures is vital as this would enhance

understanding of the diverse ways in which mental health issues are perceived by people of different cultural beliefs. Quinn (2007:176) mentions that within a traditional context, attitudes towards the mental status of people are more negative than in Western contexts.

In Ghana, biomedical forms of mental health care have been adopted by the government and, as a result, mental health care is provided by both biomedical as well as traditional healthcare providers. There is an estimated staggering amount of about 45,000 traditional medical practitioners in contrast to the minimal number of only 15 psychiatrists and 150 community psychiatric nurses for a population of 17 million people (Mullings, 1984; Roberts, 2001 in Quinn, 2007:178). In the study conducted by Quinn (2007:185), findings indicate that in urban areas of Ghana, there is a greater belief in a biomedical understanding of mental illness while in rural areas people are more inclined to believe that there are spiritual factors contributing to mental illnesses: “In rural areas, there seemed clear evidence that traditional village life is more intact and traditional beliefs about mental illness are prevalent. The growth of spiritual churches also seems to have had a significant influence on the adoption of spiritual beliefs about illness” (Quinn, 2007:186).

Cauce Cauce; Domenech-Rodriguez; Paradise; Cochran; Shea; Srebnik & Baydar (2002:46) allude to the fact that the way in which families respond to mental health problems is guided by the larger social environment and determines whether or not they gravitate towards or away from services available to them. This statement corresponds with the view of the ecological system’s theory which is guiding this study. It believes in the influence of the surrounding environment on the well-being of individuals as each individual is seen as not being separate from the environment which guides their way of life based on set beliefs and shared values (Gray & Webb, 2013:179).

2.5 MENTAL HEALTH AND MENTAL ILLNESS GLOBALLY

As much as it is important to consider the meaning of mental health according to our diverse local communities, it is also just as vital to take a glance at how mental illness and mental health are viewed globally in order to understand the dynamics

surrounding this phenomenon affecting individuals and families across the world. Karban (2012:2) makes reference to the slogan that “mental health is everyone’s business” in order to emphasise the fact that mental health is a major global concern affecting everyone. Karban (2012:2) further refers to figures from the WHO (2008) which show that in 2004, over 150 million people worldwide experienced depression; 26 million people were diagnosed with schizophrenia; 40 million people suffered from epilepsy; 24 million people suffered from Alzheimer’s disease and dementia and 125 million people were affected by alcohol-use disorders. In the United Kingdom 8.65 million people experienced mental health problems in 2007, a figure that was projected to rise to 9.88 million by the year 2026.

The WHO (2001:19) states that mental and behavioural disorders are common in communities, affecting more than 25% of all people at some point during their lives. “Within Australia, 22% of women and 18% of men reported a mental health issue during the year 2006 (Australian Bureau of Statistics, 2009 in Cohen et al., 2011:109). The WHO (2001:19) believes that these mental and behavioural disorders are universal and affect people of all countries and societies, individuals of all ages, gender and economic status, from rural or urban environments. They also have an economic impact on societies as well as on the quality of life of families and individuals.

The WHO (2005:11 in Karban, 2012:2) recognises that there is “no health without mental health”. It recognises that there is a two-way relationship between mental disorders and other health conditions. Mental health difficulties are seen to increase the risk for other health conditions while the presence of ill health is seen to increase the chance of mental illness. Mental illness is clearly a global problem affecting all people, across all cultures. More time should be dedicated to mental illness and mental health.

2.6 CULTURE

South Africa is a country of great diversity with many different cultures, meaning that people have different values, belief systems and traditions. Culture is seen by the researcher as an important part of human existence. We are all born into a specific

culture and that culture grooms us to be the individuals that we are and define who we are. Fernando (2010:9) defines culture as “a sort of explanation of the way people live and when applied to an individual refers to a mixture of behaviour and cognition arising from shared beliefs, feelings and adaptations which people carry in their minds.” The research was conducted in a community that has shared values and a shared belief system in order to determine whether having the same culture means a condition such as a mental illness is viewed in the same way by all in the community. Cauce et al. (2002:45) state that “social scientists have come to acknowledge that every individual exists within a complex set of environmental systems and that these systems affect his or her psychological well-being at a fundamental level”.

Pirutinsky, Rosmarin and Pargament, (2009:949) states that, with the many diverse cultures in today’s reality, it is vital to recognise the influence that culture has on the many aspects of mental health, including stressors confronting individuals, the way they cope and the social supports available to them as well as how they express symptoms. Kleinman (1988 in Pirutinsky et al., 2009:950) states that “Culture may impart unique explanatory models, or beliefs and attitudes concerning mental illness”, and it “can determine the motivations, barriers, and pathways to help” (Rogler & Cortes, 1993 in Pirutinsky et al., 2009:950).

Bhugra (2006:17-18) believes that “culture structures the way people define what is abnormal and deviant, how illness is defined and how and where help is sought, as it is the culture that determines what resources are available for managing what kind of distress”. It is for this reason that Bhugra (2006:20) argues that in assessments, it is vital that the world view of the patient as well as that of their caregivers and their cultural aspects of defining what abnormal behaviour entails, are taken into consideration. This is because what may be seen as abnormal in one culture may be regarded as completely normal in another culture. Bhugra (2006:20) is of the opinion that cultures can stigmatize or de-stigmatize mental illness, depending on what they view as normal and what they see as abnormal. In contexts where trance and possession are known to commonly occur as part of religious and healing cults and practices, dissociation, which is also a mental illness, “may communicate a message about one’s distress, lack of control and culpability by showing that the person is

somehow controlled by or speaking for an ‘other’” (Kirmayer & Santhanam, 2001 in Kirmayer & Bhugra, 2009:10). Kirmayer and Bhugra (2009:10) believe that this ‘other’ refers to a god, spirit or ancestor in many cultures, while in Western societies it is mostly understood as a fragment of a person’s imagination or personal history.

Tseng and Streltzer (2010:75) believe that “culture has a significant influence on thought, emotion, behaviour, and illness-related behaviour. It strongly influences how people experience and manifest emotional problems, present psychiatric symptoms, and seek professional help.” Tseng and Streltzer (2010:79) further state that they believe that in order for a clinician to properly understand and treat a mental disorder, detailed facts such as how the problem started, how the patient copes with it, as well as information on the patient’s personal life, family, personality and behaviour patterns need to be explored. The patient’s beliefs, perceptions, as well as his/her interpretation and understanding of what he/she observes, are all factors which are influenced by the cultural background and thus need to be evaluated according to the patient’s understanding and motivation. Fernando (2010:82) is of the opinion that, “certain values come down through traditions to underpin the way mental health is seen and services are organised; and these values determine what is held to be normal or abnormal in thinking, believing and feeling.”

Because of differences in culture and individual belief systems, a variety of methods can be used to assist individuals of different cultures. “Different types of psychosocial therapies can be culture specific or culture bound with psychoanalytic therapy being more embedded in western egocentric traditions and less likely to be successful across cultures” (Bhugra, 2006:21). It is therefore vital to consider all aspects of a culture when deciding on the management of mental illness. Some people might prefer Western or traditional norms or the other way around. In managing mental illness, Bhugra (2006:22) recommends that the client’s explanation of the symptoms she or he is experiencing be seen as the starting point.

Chen and Mak (2008:442) conducted a study where they mention that among Chinese and Chinese Americans, cultural values may conflict with expectations in counselling. Traditional Chinese culture is known to place more value on self-restraint as opposed to emotional expression with the expectation to control and

suppress emotional problems by placing little importance on them. For this reason, the researcher believes that the relativist approach to mental illness is applicable as it takes cognisance of cultural beliefs in the treatment of mental illness. The counsellor assisting individuals with such beliefs would have to be creative in terms of accommodating their beliefs yet with the goal of assisting them pursue the correct treatment.

Quinn (2002:46) believes that differences noted from different cultures are not simply a matter of personal or family decision, nor are they a mere reflection of cultural differences. Quinn (2002:46) states that these differences are as a result of dynamic interactions between individual and family choice, cultural values and belief systems, social networks available for referrals as well as other factors such as the availability of services within the community. However, the researcher is of the opinion that differences in culture could be the reason for the different reactions to the same situation. Culture encompasses all of the factors mentioned by Quinn and is defined by Fernando (2010:9) as “a way of life common to a group which may or may not be defined as a ‘community’”. Fabrega et al. (1993) and Sue (1994 in Cauce et al., 2002:47) mention that although not investigated, there have been many assumptions that ethnic and cultural groups differ on questions as basic as what is perceived to be a mental health problem.

2.7 CULTURE AND MENTAL ILLNESS

Subudhi ([sa]:135) believes that mental illness and culture cannot be isolated from each other. Culture is seen as being influential in how mental illness is perceived. “Cultural relativists emphasise that concepts are socially constructed and vary across cultures. Mental illness is a social construct. Hence, different cultures have their own beliefs to find the aetiology of mental illness, as well as treatment and intervention processes” (Subudhi, [sa]:135). Subudhi ([sa]:132) further states that, with time and changes in culture, concepts of mental illness are also changing. Every culture has its own way of explaining mental illness which is based on its own belief systems and practices. Bhugra (2006:20) is of the view that in assessing the general risk of chronic severe mental illness, it is vital to understand the worldview of patients

and their caregivers, and also the cultural aspect of their definition of what is normal or abnormal behaviour.

Draguns and Tanaka-Matsumi (2003:765) are of the view that different mental disorders are experienced differently across cultures. They explain that although a hallucination is one of the symptoms which define schizophrenia, “cultural concepts of reality are related to the attitudes toward hallucination and their thresholds of acceptability and those hallucinations trigger different social responses across cultures” (Draguns & Tanaka-Matsumi, 2003:765). They further state that “whether a hallucinatory experience is construed as supernatural or pathological is again influenced by the prevailing cultural beliefs”.

“In the Democratic Republic of Congo (DRC), illnesses were perceived to be caused by witchcraft, magic or God” (Fernando, 2010:131). Lambo (1969), as quoted by Fernando (2010:132), states that African traditions attribute the cause of illness to both natural and supernatural or spiritual factors, with the difference between them varying across tribes. The treatment of illness is determined by its assumed cause. This statement, according to the researcher, proves that culture determines the type of treatment that will be sought, depending on what is believed to be the cause. In the study community, beliefs in supernatural forces and witchcraft, is believed to be the cause of mental illness, to limit treatment options as well as the community’s willingness to be educated on mental illness.

The two models that are suggested to be primarily responsible for explaining how understandings of mental illness relate to culture are the universalist models, as well as the relativist models, as stated by Swartz (1998 in Quinn, 2007:175). The universalist model, which is also known as the ‘etic’ approach, “sees the classification, measurement and treatment of mental illness as being globally applicable” (Patel, 1998 in Quinn, 2007). The relativist approach, which is in contrast to the universalist approach, argues that the culture-bound aspect of the biomedical model limits its universal applicability. It proposes to evaluate phenomena from within a culture and its context. It also aims to understand its importance as well as its relationship with other facets of a particular culture (Kleinman, 1991 in Quinn, 2007:175). However, Patel (1998) as quoted by Quinn (2007:175) mentions that

many authors recognise weakness in both approaches and have developed other models that integrate their methodological strengths.

After conducting a study in Ghana, Quinn (2007:175) believes that there seems to be a greater reliance on culturally-specific explanations of mental illness in rural areas, which suggests the need for the development of integrated mental health services which will reflect and take into consideration these differing beliefs. Chen and Mak (2008:448) are of the opinion that integrating mental health services with primary care services has the potential to break the resistance of individuals seeking specialized care. This is seen by Chen and Mak (2008:448) as having the potential to reduce the stigma attached to mental illness as people will regard mental health issues as part of their overall health rather than explicitly seeking mental health services. This information can be integrated in the section discussing culture.

Even though mental illnesses are viewed by Herrman et al. (2005 in Subudhi ([sa]:132) as being a common and universal phenomenon, the universalist model is not seen to be applicable by the researcher in addressing mental illnesses. The researcher is of the opinion that the relativist approach is more applicable in our diverse world of numerous cultures and belief systems. This approach recognizes the fact that the differences in cultures define how culture will be viewed as well as the treatment option that will be sought. Therefore, mental illness cannot be viewed as globally applicable. It is important to understand a certain culture in order to understand how those who are part of it will view mental illness. The researcher believes that in order to promote mental health, the treatment of mental illness should be approached with the specific culture and beliefs in mind.

2.7.1 Cultural causes of mental illness

Kirmayer and Bhugra (2009:2) suggest that it is widely recognised that cultural models influence how people interpret the signs and symptoms of illness, including psychiatric disorders. Kirmayer and Bhugra (2009:2) differentiate between two types of systems, namely the biomedical concept of disease, which refers to the patient's subjective experience of illness, as well as the social meanings of sickness. Similarly, Quinn (2007:175) mentions two systems for explaining mental illness; the

first being the biomedical which focuses on diagnosing through symptoms and where treatment is primarily sought through medical interventions. The traditional system attributes the causes of mental illness to factors such as witchcraft, curses or evil spirits and treatment is sought from traditional healers, herbalists or through spiritual means.

Tseng and Streltzer (2010:2) believe that “culture influences health and illness in the ways people conceptualise a given illness, seek help, utilise the healthcare systems, relate to healthcare providers, and accept medical treatment prescriptions.” This seems to be evident in the beliefs of the study population where mental illnesses are perceived to be attributed to supernatural forces such as witchcraft and failure to appease the ancestors. This means that these beliefs hinder families from seeking appropriate medical help as most people opt to seek assistance from traditional healers or simply believe that the mental illness is as a result of some sort of taboo. Golightley (2012:10) believes that the discrimination experienced by people with mental health problems is intensified if that person happens to be from a black and/or minority ethnic community.

Heine et al. (1999 in Kirmayer & Bhugra, 2009:9) is of the opinion that a person’s self-esteem and self-representation are shaped by cultural norms and values and this may contribute to them being more vulnerable or resistant to depression and other anxiety disorders. These researchers point out that “Notions of guilt and shame also vary across religions and cultures, altering the cognitive schemas and specific symptoms associated with depressed moods” (Bhugra, 1996; Bhugra et al., 1997 in Kirmayer & Bhugra, 2009). Karasz (2005 in Kirmayer & Bhugra, 2009:11) reports that in many cultures the psychological symptoms of depression are explained in socio-moral or spiritual terms instead of being recognized as a health problem. Kirmayer and Bhugra (2009:11) suggest that the differences in causal explanation and interpretation of events are seen as having the potential to contribute to worsen the depression and anxiety in individuals. An example is given by Kirmayer and Bhugra (2009:12) of individualistic cultures, where attributing failure to oneself and success to others, can cause or worsen depression in the individual.

Kirmayer and Bhugra (2009:12) also believe that psychotic disorders are influenced by social and cultural contexts where experiences, as well as the explanations of such psychotic disorders, also vary across different cultural groups. Cauce et al. (2002:45) assert that culture is seen as having an influence on every aspect of behavioural and emotional disorders, from defining the disorder to the treatment sought. Research across different cultures has also been extended to varieties of delusions in persons with a mental illness. Stompe (2001 in Draguns and Tanaka-Matsumi, 2003:765) states that in research conducted over more than a century ago, “religious delusions are most frequent in Catholic societies followed by Protestant and Islamic ones, while they are extremely rare in Bhuddhist countries”. More recently, comparisons of religious delusion in Austria and Pakistan confirm that Austrians exceed Pakistanis with regards to the frequency of religious delusions, while secular delusions were also found to be more frequent in Austria as opposed to Pakistan (Draguns & Tanaka-Matsumi, 2003:765).

2.8 DIVERSE CULTURAL VIEWS OF MENTAL ILLNESS

Chen and Mak (2008:443) state that in collectivist cultures such as Asian Americans, people are more likely to attribute mental health problems to internal, personal causes. On the other hand, counsellors influenced by Western psychotherapeutic approaches perceive mental illness as arising from interactions between the person and their environment. Mallinckrodt, Shigeoka and Suzuki (2005) in Chen and Mak (2008:443) consider that cultural differences such as these may influence the perceived efficacy of Western-based psychological treatment for mental illnesses.

After having examined 10 universal and culture-bound psychological and social problems, Luk and Bond (1992 in Chen and Mak, 2008:443) have categorised lay beliefs about mental illness into the environmental/hereditary as well as social-personal causes, as follows: “The environmental/hereditary factor encompasses both physical and somatic sources conducive to psychological problems, such as genetic predisposition, brain and nervous system, working environment and health state.” The socio-personal factor is seen as being related to social and psychological sources, such as, the individual’s quality of life, past experiences, educational background and religious beliefs (Chen & Mak, 2008:443).

Like many African countries, India is culturally diverse with a common belief in spiritual traditions from primeval times. It is known as the home of all religions where culture plays a crucial role in directing, moulding and exhibiting social behaviour at individual and group levels (Subudhi, [sa]:132).

Thompson (2007 in Subudhi [sa]:138) mentions a practice from the Stone Age, where a crude surgery was developed to cure mental illness. In this surgery, people suffering from any form of mental illness had a hole drilled through their skull in order to release the evil spirit thought to be the cause of the mental illness. “These practices called trepanning are evident in fossils of human skulls in South America and Europe” (Subudhi, [sa]:138). Subudhi ([sa]:138) indicates that faith healers in India believe the causes of mental illness to be due to natural and supernatural powers and usually follow ritualistic, as well as religious obligation, processes for the treatment and diagnosis of mental illness.

Subudhi, ([sa]:138) speaks of Ayurdeva, an ancient practice in Indian culture, used to cure a variety of health problems, which is also being used in the mental health field. This ancient tradition is also being promoted by the government who are offering courses on it and who also appoint Ayurdeva practitioners to health centres. Kishore et al. (2011) as well as Nayar and Das (2012 in Subudhi [sa]:138) point out that in tribal regions, there is a preference to visit sorcerers and other faith healers to cure mental illness. There is a belief that places of worship can provide an alternative to psychiatric treatment for people with mental illness.

Subudhi ([sa]:138) concludes by stating that there is a definite and concrete relationship between culture and mental illness in Indian rural areas which stems from ancient times. The same traditional belief about mental illness is still being followed in this twenty-first century. Mental illness continues to be viewed as a shame and taboo, while those affected by it are stigmatized in India. Awareness is seen by Subudhi ([sa]:138) as necessary in order to orient people to follow modern mental health practices. Consequently, Subudhi ([sa]:138) proposes that research based on the effects of culture on mental health or mental illness be given more attention in India. This standpoint is echoed by the researcher, who believes that the

field of culture and mental illness should also be given greater attention in South Africa, more especially in small, rural communities.

In a study conducted in Ghana by Quinn (2007:181) some of the beliefs about mental illness in rural areas include attributors such as witchcraft, curses, bad spirits and other spiritual factors as its cause. “Someone had charmed the cloth, her enemy, and gave it to her. When she wore the cloth it turned her mentality”, is one of many quotations from respondents in the study who seemed to believe in the traditional system as the cause for mental illnesses. Heetham and Rzadkowolski (1980 in Quinn, 2007:176) suggest that attitudes towards mental illness are influenced by culture. When compared to industrial cultures, they found that pastoral societies have fewer illness taboos and are usually more tolerant of people with psychosis: “Some studies suggest that attitudes towards mental illness are more negative within a traditional context”. Gelfand (1964) and Imperato (1977 in Quinn, 2007:177) support this point of view as they mention that there are studies in many parts of Africa which have found that people with mental illness often lose social support and are found shackled, wandering the streets alone begging, or even stealing, to stay alive.

Subudhi ([sa]:137) mentions that there was a prevalent concept in ancient times that attributed mental illness to supernatural power, magical spirits such as witchcraft and demons, or even possession by evil spirits which disrupt the mind. This concept appears to still be prevalent in this modern era, as asserted by Subudhi, ([sa]:137). In rural India, the belief that mental illness is caused by evil spirits, angry that the person with the mental illness had killed a cow during his/her past life, is still prevalent (Magnier, 2013 in Subudhi, [sa]:137).

Thara, Islam and Padmavati (1998 in Subudhi [sa]:137) have identified other reasons believed to be responsible for the onset of mental illness. These include family conflicts as well as relationship problems; financial problems as well as role performance problems; troubled relations with neighbours resulting in violence; self-destructive behaviour, sadness, sleeplessness and alcohol misuse. The researcher believes that this list may vary depending on the difference in cultural beliefs as

culture mostly determines what is believed to be the cause of mental illness as mentioned in the previous paragraph by Subudhi ([sa]:137).

Pirutinsky et al. (2009:949) are of the view that culture may have an influence on the community's attitudes towards mental illness, more especially when the illness itself is shaped by a cultural context. This basically goes back to the notion that "what is seen as normal in one culture might not be seen in that way in another culture". Hence the community's attitudes may be determined by what they believe to be the cause of the mental illness. The researcher is of the opinion that in communities where a mental illness is thought to have been brought about by supernatural forces such as witchcraft, there might be sympathy expressed towards that individual as it is unlikely that self-bewitchment would take place. In contrast, where the mental illness is seen as a result of the individual's own wrongdoings and as a punishment from the ancestors, stigma and a lack of sympathy might be expressed.

2.9 IMPACT OF CULTURAL BELIEFS ON CHOICE OF TREATMENT

Kleinman (1988) and Rogler and Cortes (1993 in Pirutinsky et al., 2009:949-50) believe that "culture may impart unique explanatory models, or beliefs and attitudes concerning mental illness and can determine the motivations, barriers, and pathways to help". Thus, this indicates that it is imperative for mental health professionals to have knowledge of diverse cultures and be culture sensitive in order to be better equipped to assist mentally ill patients. Cultures differ across the world and therapists have their own culture, which could influence them as well. Therefore, another concern in seeking professional help for mental illness as cited by Bhugra (2006:20) indicates that "therapists whose cultural background differs from that of their patients need to be aware of differences according to age and gender and their professional status".

Despite the fact that it is visible through the consultation of different sources that a relationship exists between culture and different mental illnesses, Cauce et al. (2002:45) are of the opinion that only a few studies have focused on the complex interactions between culture and other contexts that often characterize the lives of youth at risk for emotional and behavioural disorders. Culture is clearly seen as

playing a role in determining an individual's likelihood to have some form of mental illness during their lifespan. This is, however, debated by the researcher who believes that culture does indeed have an effect on how mental illness is viewed but disputes the belief that it might affect an individual's chances of suffering from some or any form of mental illness.

Subudhi ([sa]:137) points out that when it is believed that mental illness is caused by spiritual or supernatural forces, preference is given to traditional healing practices to address it: "Up to about 70% to 80% of the population of the mentally ill belong to rural areas and first visit religious places and consult with the indigenous practitioner for their treatment" (Thara et al., in Subudhi, [sa]:137; Trivedi & Sethi, 1979). Thara et al. (1998 in Subudhi, [sa]:137) also mention that eight out of ten mentally-ill patients seek assistance at religious centres for their condition.

Among the many differing beliefs about mental illness, in India "some rural populations have a common belief that the spirit cannot get out because there is no exit point in the body; so they get sticks and puncture the eardrums on both sides in order to remove this spirit" (Magnier, 2013 in Subudhi [sa]:137). This is a practice that makes sense to them based on their cultural beliefs. As frightening as this might sound to someone of another cultural belief, it is important to understand the origin of such a belief in order to find a treatment option that works specifically for that culture. Considering the fact that there is the belief of puncturing the eardrums as a treatment option for this cultural group, having someone suggest that counselling and maybe medically recognised medication would be a better treatment option would probably sound ridiculous based on what the person believes to be the cause of the mental illness.

Chen and Mak (2008:448) are of the view that consideration of the importance of lay beliefs and how this affects the search for help, "educating the general public about causes of mental illness and correcting their misconceptions may be important in promoting professional services". The researcher supports this view and believes that community education on mental illness is vital in order to promote mental well-being. Although one does not want to undermine traditional treatment options for mental illness or disrespect cultural beliefs, the researcher is of the view that a

community with a clear understanding of what mental illness entails and the different types and causes of mental illness, would be better equipped to make informed choices with regards to the mental well-being of family members and fellow community members.

In support of this approach, Chen and Mak (2008:448-9) argue that “With increasing cultural knowledge and cultural competence, counsellors and therapists can design treatment plans and adapt their counselling styles accordingly to accommodate the special needs of culturally diverse groups”. This is important in ensuring that those seeking help do not feel that they are being misunderstood or judged, as the counsellor will have a clear understanding of their background based on familiarity with their culture and beliefs on mental illness. Hence, the researcher believes that by employing counsellors who are culture sensitive and aware of the differing views from diverse cultures with regards to mental illness, mental health promotion could be achieved with fewer challenges. Bernal and Saez-Santiago (2006 in Pirutinsky et al., 2009:950) believes that there is a need for research which incorporates cultural factors in order to develop an empirically-based and culturally-sensitive community education, services and interventions.

2.10 FUNCTIONING OF FAMILIES WITH A MEMBER WITH MENTAL ILLNESS

Mental illness in any family member has profound psychosocial effects on the family as a whole with the family’s ability to function being greatly impaired as a result of the burden of caring for a family member with mental illness (Robson & Gingell, 2012:166). Having a family member with any form of mental illness, whether it is a child, parent or adult does have an effect on the functioning of the family as a whole. A person without any experience in dealing with the mental illness of a family member can only wonder and speculate on the effects of such on the functioning of the family; however, research conducted with affected families reveals the real truth of the matter. In a study conducted with families affected by mental illness, some of the results have shown that “efforts to deal with a family member with a mental illness aroused strong emotions due to the fact that severe mental illness created threats to the order and coherence of daily family functioning” (Saunders, 2003:184). For example, it has been suggested that there is a link between the poor mental

health of a parent and the persistence of emotional disorders in children (Parry-Langdom, 2008 in Robson & Gingell, 2012:167).

Saunders (2003:176) is of the opinion that dealing with any mental illness is as stressful for the patient as much as for the family members of that individual. The family member who takes the role of caregiver suffers from a significant amount of stress, experiences some level of burden and often does not receive enough assistance from mental health professionals. Families with a parent that has a mental illness are among the most vulnerable in any community. These families are more likely to be isolated socially, suffer financial hardship and experience marital discord, with increased risks for children, genetically, psychologically and environmentally (Beardslee, Versage & Gladstone, 1998 in Reupert & Maybery, 2007:362). Angold (1998 in Robson & Gingell, 2012:167) found that “the level of burden perceived by parents in caring for a child with mental illness was associated with a significant increase in the use of mental health care services”.

Saunders (2003:189) states that families living with a family member with severe mental illness constantly have to adapt to changes associated with the mental illness, as well as changes that occur within the family as a result of having to adjust to the illness. Marsh (1992 in Saunders, 2003:189) asserts that “severe mental illness affects all aspects of family functioning, and all family relationships and roles are altered, sometimes permanently.” These alterations, according to Saunders (2003:189), include financial aspects, employment, social life and family relationships, including marital relationships, physical health as a result of exhaustion from the care-giving role, as well as changes in daily household activities. The family identity as a whole has also been documented as experiencing change as a result of dealing with mental illness within the family. Reupert & Mayberry (2007:362) mention that a child with a parent that has a mental illness may experience a home environment which is different to that of an average child. Those children are believed to be living with the symptoms, behaviours and expressions of mental illness.

Research conducted by Henderson and Vandenberg (1992) as well as Gray (2002 in Altieri & von Kluge, 2009:84), demonstrates that social support is a vital part for

coping in families with a child that has a mental illness such as autism. With little likelihood of being able to engage in social activities due to the mental illness of a family member, there is social isolation and hence higher stress levels than in typical families. Saunders (2003:184) further found results showing that inadequate social support for the caregiver of a family member with mental illness was a powerful predictor of depression and fatigue, documented as a common experience among caregivers. This researcher states that “as families have assumed more of the caregiver role for family members with severe mental illness, high levels of psychological distress among caregivers have been documented” Saunders (2003:181). Having access to more mental health services was documented as reducing the level of psychological distress experienced by family members taking care of a person with mental illness within the family (Saunders, 2003:182). Caregiver education on how to deal with a family member with mental illness, together with coping strategies, are seen as important factors in addressing the psychological and physical needs of caregivers, as stated by Reupert and Maybery (2007:365).

2.11 ROLE OF SOCIAL WORKER IN ASSISTING FAMILIES AFFECTED BY MENTAL ILLNESS

Pilgrim (2010:92) refers to the social worker as being part of a group of “mental health professionals” having a role to play in the assisting individuals with mental illness. Being a social worker, with experience in the field, the researcher also believes that social workers do indeed have a vital role to play in assisting families with mental illness. Support services to the families affected are just as important as community education on mental illness. “A social work approach to mental health need would address problems of living for individuals, families and/or communities by seeking to understand how social forces have both contributed to mental health distress as well as how mental health difficulties affect service users’ social circumstances and relationships” (Archambeault, 2009:20). Archambeault (2009:20) further mentions that in mental health, social work practitioners offer help at individual and systematic levels. When dealing with issues of mental illness within the family structure, the social worker needs to be aware that it affects the family as a whole rather than the individual with mental illness alone. The functioning of the family is affected and the family therefore needs the intervention from the social worker as a whole.

2.12 SUMMARY

Through the consultation of different literature sources, the researcher was able to see that mental illness affects people across all walks of life, irrespective of their economic or social status. Education is essential and the belief that supernatural forces are responsible for certain mental illnesses is confined to not only one area but rather is the belief of many communities worldwide. Alternative remedies, as opposed to Western medicines, are sought as treatment for such mental illnesses. The research population in the proposed study shares some of the beliefs of other communities in the literature consulted as it also believes in inanimate objects and places great value on ancestry. This community usually prefers to seek the assistance of traditional healers as opposed to Western medicine for their ailments.

Appreciation needs to be afforded to the diversity of this beautiful world we live in. Without this diversity, valued by our vast and different cultural groups, the researcher is of the view that we would live in a rather bland world with little to learn or appreciate. Hence, it is important to take into consideration our diversity in order to develop a mental health resolution programme which encompasses the diversity of our world in its attempt to address mental illness, determine suitable treatment options and educate our different communities in order to promote mental wellness.

The research methodology and empirical study are presented and discussed in the following chapter of the study.

CHAPTER 3

RESEARCH METHODOLOGY AND EMPIRICAL STUDY

3.1 INTRODUCTION

The following chapter outlines the research methodology utilized in the study. The research approach, type of research, research design and methods and feasibility of the study will be discussed in this section. A discussion of ethical considerations and trustworthiness is also included in this chapter. The findings of the study are discussed and integrated with literature in the final section of the chapter. The goal of the study is to explore and describe caregivers' perspectives on the cultural beliefs regarding mental illness of families affected. The objectives of the research study are as follows:

- To describe culture and mental illness from an ecological system's perspective;
- To explore cultural beliefs regarding mental illness of families affected;
- To explore how the choice of treatment of mental illness is affected by these cultural beliefs; and
- To find out how services that are provided to families affected by mental illness can be improved.

The research question that guided the empirical study is as follows:

- What are the perspectives of caregivers regarding cultural beliefs of families affected by mental illness?

The sub-research questions that informed the main research question are as follows:

- How do these cultural beliefs influence the manner in which mental illness is viewed?
- How will these cultural beliefs influence the choice regarding treatment options?

Because the study is exploratory in nature, the findings cannot be generalized as the cultural beliefs of all people with a mentally-ill member worldwide or even in South Africa. They are particular only to the small community of Ntwane in Kwarrielaagte, Dennilton.

3.2 RESEARCH APPROACH

The researcher followed the qualitative research approach. The logic of the qualitative research approach, as stated by Burns and Grove (2005:52), is based on a world view that is holistic and believes the following: There is no single reality; reality, based on perceptions, is different for each person and changes over time; what we know has meaning only within a given situation or context. This view is also expressed as follows: “The reasoning process used in qualitative research involves perceptually putting pieces together to make wholes. From this process, meaning is produced. Because perceptions vary with the individual, many different meanings are possible” (Munhall, 2001 in Burns & Grove, 2005:52).

In qualitative research, “the researcher tries to gain a first-hand holistic understanding of phenomena of interest by means of a flexible strategy of problem formulation and data collection shaped as the investigation proceeds” (Fouché & Delport, 2005:74). The aim of the research was to explore the cultural beliefs of families affected by mental illness and this was best fulfilled using the qualitative approach which allowed for more in-depth information as it is more concerned with describing and understanding instead of explaining and predicting (Fouché & Delport, 2011:65). Conducting a qualitative research study allowed the researcher more flexibility by asking open-ended questions which elicited rich and useful information in order to explore perceptions. The qualitative research approach allowed an in-depth understanding of the perceptions and beliefs of the community and encouraged participants to go into detail and therefore express themselves more clearly.

The qualitative research approach enabled the researcher to obtain an in-depth understanding on how the participants view mental illness. As much as the research sought patterns in responses, differences were also taken into consideration and

noted where valid and interesting references were made, an approach supported by Braun and Clark (2013:20) in this description: “Qualitative research is exploratory, open-ended and organic, and produces in-depth, rich and detailed data from which to make claims”. The qualitative research approach seeks to understand and to generate rich data and descriptions. Although it tends to seek patterns, it also accommodates and explores differences and divergences within the data collected (Braun & Clarke 2013:4).

3.3 RESEARCH QUESTION OF THE STUDY

- The research question of the study is as follows: What are the perspectives of caregivers regarding cultural beliefs of families affected by mental illness? This research question stems from the research topic and gives a clear indication of “what” the researcher wanted to know by conducting her research study (Fouché & De Vos, 2005:100).

The sub-questions which informed the main research question are as follows:

- How do these cultural beliefs influence the manner in which mental illness is viewed?
- How will these cultural beliefs influence the choice regarding treatment options?

Fouché & De Vos (2005:100) highlight the importance of formulating a research question upon identification of a research topic. This phase of identifying a research question is also referred to as “focusing” by Fouché & De Vos (2005:100) as it answers the question of what the researcher wants to discover by researching a specific topic. The research question is said to be open-ended by Creswell (2013:138), with the aim of reiterating the purpose of the study in more detailed terms by starting with words such as “what” or “how” in order to explore a significant phenomenon. The research question assisted the researcher by guiding the study. It assisted in formulating appropriate questions to ask the participants and also assisted in achieving the goal of the study. The research question did helped the researcher to answer the ‘what’ question in her study.

3.4 TYPE OF RESEARCH

The researcher made use of applied research, exploratory in nature as it sought the answer to a “what” question (Fouché & De Vos, 2011:95). Fouché and De Vos (2005:105) define applied research as “the scientific planning of induced change in a troublesome situation.” Applied research focuses more on a problem in practice. It evaluates the problem and addresses immediate problems facing the professional in practice. The driving force behind applied research is to engage with people” (Jupp, 2006:8). By engaging with the participants through one-to-one semi-structured interviews, the researcher was able to obtain rich and insightful data and was enabled to ask the “what” question which, according to Mouton (2001) in Fouche and De Vos (2011:95), is what an exploratory study constitutes.

This study was applied research as it focused on a problem observed in practice by the researcher. By exploring the relationship between culture and mental health, as well as how it affects families dealing with mental illness, the researcher was be able to make recommendations which might enable the community to make better choices with regards to their mental health, mental health education and the treatment options available to them. The researcher was hoping that this study will contribute to the knowledge-base of the community and encourage open-mindedness within it.

3.5 RESEARCH DESIGN AND METHODS

The research design and methodology employed in the study will be discussed and elaborated on in this section.

3.5.1 Research design

The researcher utilised the case study as a research design. Fouché (2005:272) asserts that, “a case study can be regarded as an exploration or in-depth analysis of a ‘bounded system’ (bounded by time and/or place), or a single or multiple case, over a period of time”. Yin (2009 in Creswell, 2013:97) defines a case study as the study of a case within real life, contemporary context or setting. Schwandt (2001:23 in Botma et al., 2010:191) argues that the case study research design is preferred

when the inquiry seeks to obtain answers to “how” or “when” questions; when the person inquiring has little control over events being studied; when the object of study is a contemporary phenomenon in a real-life context; when boundaries between the phenomenon and context are not clear; and when it is desirable to use multiple sources of evidence. The case study design is suitable for the study as the research sought to explore how cultural beliefs affect mental health and mental illnesses.

In a collective case study design, cases are chosen in such a way as to allow for comparisons between cases in order to extend and validate theories (Fouché & Schurink, 2011:322). The researcher specifically made use of the collective case study design as it aims to further the understanding of the researcher about the population being studied which in this case was the cultural beliefs of families affected by mental illness. The interest in the individual case is secondary to the researcher’s interest in a group of cases” (Fouché, 2005:272). Creswell (2013:99) postulates that “in a collective case study (or multiple case study), the one issue or concern is again selected, but the inquirer selects multiple case studies to illustrate the issue.” The researcher has explored the relationship between culture and mental health in order to gain an understanding of the cultural beliefs of families affected by mental illness.

3.5.2 Study population and sampling method

The research population of the study was all families affected by mental illness from the BaNtwane community of Ntwane in Kwarielaagte, a small village in the district municipality of Sekhukhune in Limpopo (see Appendix 3 for letter of permission from the traditional leader). The caregiver was a family member who represented the family. Strydom (2011:222) defines the population as “a term that sets boundaries on the study units. It refers to individuals in the universe who possess specific characteristics. It is the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned.”

The gender of the caregiver could not be pre-determined as it depended on who the main caregiver of the person with the mental illness in the specific family is. Therefore, the researcher decided to focus on all caregivers within the selected

families, regardless of their gender or age. The researcher was hoping that the population would comprise both genders so as to ensure that the findings of the study are not only based on the opinions of one gender, as gender has been suggested to have an impact on interactions, conversations, performances, interpretations as well as knowledge (Warren & Hackney, 2000:1). Male and female caregivers were represented in the participants although males constituted a far smaller number of the sample compared to females. Findings will be further discussed in narrative form as well as through figures in this chapter.

Unrau, Gabor and Grinbell (2007 in Strydom 2011:223-4) state that “a sample comprises elements or a subset of the population considered for actual inclusion in the study, or it can be viewed as a subset of measurements drawn from a population in which we are interested.” The sampling method applicable to this study was non-probability sampling as it is performed at random (Strydom, 2005:198). It was therefore deduced from the definition that the researcher would make use of non-probability sampling, as the population was not known by name, street address or other form of identification.

Non-probability sampling in qualitative research has many subtypes, as identified by Strydom and Delpont (2011:392-4). However, the researcher made use of the snowball sampling technique. This type of sample is usually used when “there is no knowledge of the sampling frame and limited access to appropriate participants for the intended study” (Strydom & Delpont, 2011:393). Using this sampling technique, one participant was identified matching the requirements of the study and that single participant referred the researcher to other similar cases. This process continued until the target number of 12 participants had been reached (Strydom & Delpont, 2011:393). In the planning stages of the research study, the researcher had intended to make use of the purposive sampling technique but because of the challenges encountered, snowball sampling was considered preferable. Because the researcher could not be introduced to the community and potential participants during an *imbizo*, she had to abort the initial plan of using purposive sampling for snowball sampling. The sample which was selected for the study possessed features that were of interest in that they had first-hand experience of the effects of mental illness and were caregivers of people with mental illness.

The researcher consulted the traditional leader of the Ntwane community in order to obtain permission for the research study (see Appendix 1 for letter of permission). It was intended that an *imbizo* be held where the traditional leader would have introduced the researcher to community members and inform them of the proposed research on mental illness. The goal and research procedure would have been shared with community members at that *imbizo*. However, due to time constraints and unforeseen obligations related to the community leader's schedule, this was not possible. Consequently, the researcher had to introduce herself to participants on the day that data was collected and also change the sampling method from purposive sampling to snowball. Snowball sampling is defined as "A form of non-probability sampling in which the researcher begins by identifying an individual perceived to be an appropriate respondent. This respondent is then asked to identify another potential respondent. The process is repeated until the researcher has collected sufficient data. It is sometimes referred to as 'chain letter' sampling" (Jupp, 2006:281).

The 12 participants were selected according to the following criteria:

- They were the caregiver of a family member living with a mental illness.
- The caregiver could be male or female.
- The caregiver could be of any age.

3.5.3 Data collection method

Cresswell (2013:145) states that "data collection refers to gaining permission, conducting a good qualitative sampling strategy, developing means for recording information both digitally and on paper, storing the data, and anticipating ethical issues that may arise". Preparations for data collection were arranged beforehand by the researcher. Twelve participants formed part of the study and were interviewed in the comfort and privacy of their own homes. Silverman (2001:13) stresses the importance for a researcher to always keep in mind "authenticity" rather than "reliability" as the aim is usually to gather an authentic understanding of people's experiences; open-ended questions ensure that this is achieved effectively.

The researcher had a research assistant who although without experience of conducting interviews, is able to operate technological gadgets and assist with recording interviews through a digital recorder (Greef, 2011:368). He functioned as an assistant facilitator and also assisted with the consent forms which had to be completed and signed by all participants while the researcher focussed her attention on the interviews and took field notes.

The data-gathering method relevant to the researcher's study was a semi-structured one-to-one interview. With semi-structured one-to-one interviews as a data collection method, the researcher had a set of predetermined questions on an interview schedule to guide the interview. Open-ended questions allowed for more in-depth response and elicited rich information from the participant. The participants were able to share more closely and this assisted the researcher in obtaining a more detailed picture of each participant's cultural beliefs regarding mental illness (Greeff, 2005:352). The semi-structured one-to-one interviewing method ensured that a researcher obtains good quality and in-depth understanding of the cultural beliefs regarding mental illness and therefore elicits useful data for the research. A digital recorder was utilised in order to assist the researcher when making verbatim transcriptions. The caregiver of a mentally-ill individual, who is also a family member, represented the family in the interviewing. The interview schedule simply guided the interview, rather than dictating it (Greeff, 2005:296). The researcher was able to make use of open-ended questions which elicited more in-depth information and allowed for probing. Data analysis began during the interviewing process when the researcher made rough notes of what was being said and observed.

3.5.4 Data analysis

"Qualitative data analysis transforms data into findings" according to Schurink, Fouché & De Vos (2011:403). During this time-consuming process, the researcher had to detect significant information and patterns to communicate what was revealed in the data collected through a process called coding of data. The researcher integrated Creswell's process of data analysis with the process, as defined by Schurink et al. (2011:403-19). Creswell (2013:182-188) indicates that the process of

data analysis and data interpretation can be best represented by a spiral image called a data analysis spiral. That means that the researcher moves in analytic circles rather than using a fixed linear approach. The spiral steps are merely a guideline and not a rigid recipe that has to be followed step-by-step. Schurink et al. (2011:403-19) assert that the steps for analysing data in this study are as follows:

“[T]he researcher should plan for the recording of data in a systematic manner that is appropriate to the setting, participants, or both, and that will facilitate analysis, before data collection commences.” Before commencing with data collection, the researcher had to ensure that she had an assistant facilitator and a digital recorder which could be used for the recording of data. The researcher ensured that it was in good condition by testing voice clarity, ensuring there were enough batteries as well as enough memory for storage of all data collected. The assistant facilitator was responsible for recording the interviews (Greef, 2011:368). Prior preparation is essential to avoid interruptions and ensure professionalism. Participants were notified that the interviews were being recorded before commencing with recording and gave their consent (Schurink et al., 2011:404). The recordings were transcribed by the researcher after completion of all twelve interviews as data was collected during the course of one full day.

Data analysis in a qualitative inquiry necessitates a two-fold approach, namely data analysis in the field and data analysis away from the field following a period of data collection (Schurink et al., 2011:405). Commencing with the analysis of data on the same day it was collected allowed the researcher to ponder the data while the interviews were still fresh in her mind and themes could be identified. Taking field notes also assisted the researcher as facial expressions and gestures could also be noted.

Field notes are written accounts of what researchers hear, see, experience and think in the course of collecting and reflecting on the data they gather (Bogdan & Biklen, 2007 in Schurink et al., 2011:406). Field notes collected during interviews were used as an effective method of analysis in the study as they ensured that emerging themes and patterns were noted. The researcher’s thoughts and experiences during the study were also noted in the field notes.

This phase, which is also known as the intense analysis stage, is the first step in data analysis which takes place away from the research site. Schurink et al. (2011:408) establish that “at an early stage in the analysis process, researchers organise their data into file folders, index cards or computer files. The researchers also convert files to appropriate text units for analysis.” The researcher began the process of analysing the voluminous data into transcripts the same day that the interviews had been conducted in order to ensure that what she might have failed to note in her field notes would still be fresh in her mind as she would still be able to visualise what she observed during the interviews.

Schurink et al. (2011:409) note that “After the organisation and conversion of the data, researchers continue analysis by getting a feel for the entire database”. Reading and writing memos and transcripts ensures that the researcher has a better understanding of what was being communicated by the participants. More themes, patterns and categories became evident during this process as the researcher was able to repeatedly read through and interact with the data. Creswell (2013:183-4) indicates that it is important to get a sense of the interview by reading and immersing oneself in the details of that specific interview before breaking it down into different parts. Creswell (2013:183) elaborates on this practice by stating that “Writing notes or memos help in this initial process of exploring a database. These memos are short phrases, ideas or key concepts that occur to the reader”.

Creswell (2013:186) defines categories, which are also known as themes, as broad units of information that consists of several codes aggregated to form a common idea. Grinnell and Unrau (2005 in Schurink et al., 2011:411) describe the primary task of coding to be that of identifying and labelling relevant categories or topics for data. Codes may take different forms, such as abbreviations, key words, coloured dots or numbers. The choice of coding is entirely up to the researcher. The researcher in this study was able to code all data collected after transcribing it by making use of numbers as well as colour coding in order to make data more easily identifiable. Creswell (2013:184) indicates that “the process of coding involves aggregating the text or visual data into small categories of information, seeking evidence for the code from different databases being used in a study, and then assigning a label to the code.”

Part of the phase of testing emergent understanding and searching for alternative explanations includes “evaluating the data for their usefulness and centrality” (Schurink et al., 2011:415). It was vital that the researcher determine which information is important and closely related to what she wanted to explore rather than losing focus with information that is not related to the main aim of the study.

Developing typologies, which can also be referred to as a system for categorising things and/or concepts, is very useful in order to make sense of qualitative material. By categorising concepts, the researcher was able to make conceptual linkages between seemingly different phenomena. A typology may be defined as a conceptual framework in which phenomena are classified in terms of the characteristics that they have in common with other phenomena (Schurink et al., 2011:416).

The researcher had to ensure data gathered is represented in a correct and suitable manner using text, figures and even tabular forms. The findings are represented later in this section of the study and reflect what the researcher found after conducting the study. Bias is absent as views presented are those of the participants and not those of the researcher. Creswell (2013:186) states that in the final stage of the spiral, the researcher represents the data, which refers to packaging in tabular or figure form what was found, in order to create visual images of the information gathered.

3.5.5 Trustworthiness of qualitative data

There are four very important aspects to be taken into consideration in order to ensure the trustworthiness of a study, namely credibility, transferability, dependability and confirmability. The researcher will make reference to the strategies for ensuring trustworthiness proposed by Shenton (2004:64-72), with the focus being on confirmability and credibility as these are applicable to the study.

Credibility, also known as authenticity, deals with the question of how congruent the findings of the study are with reality. Lincoln and Guba (1985 in Shenton, 2004:64) indicate that ensuring credibility is one of the most important factors in establishing

trustworthiness. They suggest that prolonged engagement, persistent observation and triangulation are important activities that make the production of credible findings and interpretations in a study more likely. Prolonged engagement with the community being studied is vital in a researcher's understanding of the culture being studied. Triangulation was insured by ascertaining that all twelve participants were interviewed as a way of obtaining verification from more than one source/person (Lincoln & Guba, 1985 in Shenton, 2004:66). By spending prolonged time in the field interviewing all twelve participants, the researcher was able to develop an in-depth understanding of their views on mental illness; hence the credibility of the study was promoted. Creswell (2014:202) reiterates this stance: "The more experience that a researcher has with participants in their settings, the more accurate or valid will be the findings."

By interviewing more than one participant, the researcher ensured that there is authentication as data obtained will be representative of more than one individual's beliefs. Transcribing the data and reading through the interview transcripts ensured that the researcher had captured accurate descriptions as given by the participants of their cultural beliefs regarding mental illness. The researcher ensured that transcripts of all participants' interviews were used for coding and the identification of themes.

Shenton indicates that "The concept of confirmability is the qualitative investigator's comparable concern to objectivity. Here steps must be taken to help ensure as far as possible that the work's findings are the result of experiences and ideas of the informants, rather than the characteristics and preferences of the researcher" (2003:72). In order to avoid investigator bias, triangulation is also important in confirmability. It was important that the researcher be unbiased in reporting on findings. Focus was placed solely on results obtained from the participants' experiences and ideas as recorded and transcribed rather than the researcher's own beliefs and perceptions.

Mouton (2010:277) defines member checking as the practice of going back to the source information, this being the participant, to check the data and interpretation thereof, with the aim of correcting obvious errors and obtaining additional volunteer

information. The researcher made use of member checking by ensuring that the accuracy of responses provided was checked throughout the interviewing process by using clarity-seeking questions and paraphrasing questions. Recordings from interviews were played back to participants in order to confirm whether what was said truly reflected their views. These practices ensured the trustworthiness of data collected. Field notes highlighted expression, as observed by the researcher during the interviews, as at times what is observed quantifies what is being said.

With regard to reflexivity, Holloway and Wheeler (2010:8) point out that “it refers to a form of self-monitoring in relation to the research that is being carried out. It also includes awareness of the interaction between the researcher, the participants and the research itself”. These researchers further mention that the manner in which the research process affects the finding and outcomes of the study should be taken into consideration at all times. As a qualified social worker, the researcher is trained in interviewing through the utilisation of skills such as probing in order to elicit more insightful data. The researcher is also experienced in working with individuals on a one-to-one basis ensuring that the interviews were facilitated in a professional manner at all times. Subjective judgement was kept to a minimum and bias was avoided by ensuring that the researcher did not influence the responses of any participant. Undue influence associated with the researcher’s competence to undertake the study was thereby kept at a minimum.

3.5.6 Pilot study

A pilot study was conducted. It was a one-to-one semi-structured interview at Ntwane village with one participant representing the family in order to explore the cultural beliefs of families affected by mental illness. It formed an integral part of the research process as it helped the researcher identify and avoid pitfalls and errors that may have been costly in the actual study and is intrinsically a worthwhile activity (Brink, 2001:174). Strydom and Delpont (2011:394) assert that “in qualitative research, the pilot study is usually informal, and a few respondents possessing the same characteristics as those of the main investigation can be involved in the study, merely to ascertain certain trends. The purpose is to determine whether the relevant data can be obtained from the respondents”. Brink (2001:174) states that “the

purpose of the pilot study is to investigate the feasibility of the proposed study and to detect possible flaws in the data-collecting instruments.”

Conducting a pilot study ensured that the researcher avoided running into problems that could have interfered with the quality of the research study and also delay the research process. Therefore, one participant who met the criteria of participants identified by the researcher, but who would not form part of the actual study, was interviewed to determine the effectiveness of the interview schedule as a data collection method. The selection criteria for selecting the participant for the pilot study was the same as that of selecting the actual participants for the study (Strydom, 2011:241), with gender being either a male or female of any age, who is a family member that has taken the role of a caregiver to a mentally-ill family member. The pilot study participant was able to understand the questions and the researcher could make a few changes to the biographical details on the interview schedule. The category of “no education” was added to the education level. The item “Number of years caring for loved one” was also categorised differently. Northern Sotho was added to the language selection section as one of the options. The first caregiver in a family caring for a person with a mental illness who was willing to form part of the study was used as the pilot. The caregiver from the pilot study did not form part of the actual study.

3.6 ETHICAL CONSIDERATIONS

The researcher had to consider and be aware of ethical issues which might arise during the study in the planning stages of the research study and formulate a plan to address such issues should they arise (Creswell, 2013:56). The researcher was granted permission by the traditional leader of the Bantwane community to conduct the research with families affected by mental illness in the study community. Permission to conduct the research study was also obtained from the ethics committee of the University of Pretoria after their carefully scrutiny of the proposed study and potential ethical issues which might arise. Creswell (2013:57) emphasises the necessity of obtaining permission from a university’s institutional review board prior to data collection in a study. Babbie and Mouton (2010:520) emphasise the view that the researcher needs to be very much aware of what is proper and

improper in conducting a scientific inquiry. The following are the ethical issues the researcher had to take into consideration when conducting the research study.

3.6.1 Avoidance of harm

Babbie (2005:63) asserts that “social research should never injure the people being studied, regardless of whether they volunteer for the study.” Wagenaar and Babbie (2004:40) state that “this principle pertains primarily to psychological harm which may result from asking people to reveal deviant behaviour, unpopular attitudes, demeaning personal characteristics, and the likes.” The researcher was careful of the type of questions she asked, as probing questions can sometimes injure a fragile self-esteem. The researcher also made sure to avoid incurring harm to any of the participants by avoiding embarrassing questions and always keeping in mind that people differ in their responses to such questions. Strydom (2005: 58) believes that the way in which participants can be harmed is either physically and/or emotionally with emotional harm being accepted as that most likely to occur in studies conducted in social sciences.

In trying to reach the goal of the study, which was to explore the cultural beliefs of families affected by mental illness, the researcher had to ensure no participant suffered harm. This includes any form of discomfort or emotional harm by ensuring that participants did not suffer stress from feeling that they had not acted appropriately in addressing the mental illness of their family member. Strydom emphasizes the fact that “emotional harm to subjects is often more difficult to predict and determine than physical discomfort, and often has more far-reaching consequences for respondents” (2005:58).

To further minimise the risk of harm, the researcher was open in informing the participants of the potential impact of the study as it involved them being frank about an issue which might be of a sensitive nature to them because it affects their loved one. The participants were given an opportunity to withdraw or to participate in the study and then to sign the informed consent forms. The researcher also discussed in detail the goal and objectives of the study in order to make the participants aware of its exact purpose.

The researcher also translated the contents of the letter of permission into the language understood by the participants so that they knew exactly what they were consenting to. The researcher read the letter of permission to participants with no educational background in their preferred language (English or Northern Sotho also known as Sentwane) in order to afford them the same opportunity to consent to participation in it with a full understanding of its purpose. Participants who needed further professional assistance were referred to the Limpopo Social Development social worker based in an area of Ntwane called Sempupuru in Dennilton. No participants were referred for further counselling as there was no need. All participants explained that they were not affected psychologically or emotionally in any way by the study. Some of the participants instead mentioned that they felt relief that someone has shown interest in their loved ones' mental state and the effects it has on their family functioning.

3.6.2 Voluntary participation

Wagenaar and Babbie (2004:40) describe voluntary participation as an important principle because social research often represents an intrusion into people's lives and often requires that participants reveal personal information about themselves to strangers, namely the researchers. In this study, the researcher clarified the aim and objectives of the study so as to allow the potential participants a fair opportunity to decide whether or not they would participate. The provision of sufficient information on the research study and the researcher's role in it, as well as the potential effects of the study, were communicated clearly to the participants.

3.6.3 Informed consent

Strydom (2011:117) states that written consent is a necessary part of a research study. This documentation should therefore be treated with the utmost discretion and stored in the correct manner. Participation in the study should be voluntary with no one being coerced into participation. The researcher should always keep in mind that all participants have the right to decide whether or not to participate. They should be aware of the purpose of the study and decide to participate in it based on full knowledge of its parameters. The researcher did not pressure any of the participants

into signing the consent form and made sure to tell them that they were not forced to sign it (Creswell, 2013:59). The participants were informed that the data obtained from the study would be stored for a period of 15 years at the University of Pretoria and that the interviews would be recorded. An informed consent letter which stipulates the above was signed by all participants

3.6.4 Deception of participants

“Deception involves withholding information or offering incorrect information in order to insure participation of subjects when they would otherwise possibly have refused it” (Strydom, 2005:60). The participants were made fully aware of what they were to expect when being part of the study. By knowing the exact aim and purpose of the research, the participants were able to make an informed decision regarding participation in the study and their decision to participate was not influenced by any deception. Babbie (2005:67) agrees and states that deceiving people is unethical and needs to be justified by compelling scientific or administrative concerns which will also be arguable. There was absolutely no need for the deception of the participants in this study and it would not have benefited the study in any way as the study did not involve having to observe the participants but was merely exploring their cultural beliefs regarding mental illness.

3.6.5 Violation of privacy/confidentiality

Strydom (2005:61) is of the opinion that “the right to privacy is the individual’s right to decide when, where, to whom, and to what extent his or her attitudes, beliefs, and behaviour will be revealed.” Social research studies may sometimes violate the privacy of people. Hence it is important to ensure that participants are well aware of this potential privacy violation before they choose to become part of the study.

Creswell (2014:94) suggests that the privacy and anonymity of participants can be respected by assigning fictitious names or aliases or developing composite profiles of participants. In this connection, Babbie points out that “A research project guarantees confidentiality when the researcher can identify a given person’s responses but essentially promises not to do so publicly” (2005:64-5). The researcher dealt with confidentiality by contracting with the participants and assuring

them of confidentiality, meaning that the information shared between them and the researcher would remain confidential, except for when it is released with the study. The information in the empirical findings of the study is not linked to any of the respondents and no one will know what was said or by whom as an alias will be used instead of real names.

3.6.6 Competence of researcher

Strydom (2005:63) makes the statement that researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation. As a prerequisite to undertaking a research study for the master's degree in Health Care, the researcher was required to complete a module in research methodology in order to increase her knowledge in the phenomenon of research. This, together with the researcher's experience in working in the field as a qualified social worker, made her competent to undertake this research study. Consultation of different sources on conducting a research study also gave the researcher a step-by-step guideline and guidance in conducting the research study. Support from the researcher's supervisor, who is also a qualified professional, also means that the researcher was able to refer to the supervisor to ensure that proper steps were being followed in conducting the study.

3.6.7 Publication of findings

Strydom (2005:65) is of the view that reports compiled should be accurate and objective. Researchers should avoid siding with participants and disclosing only the results which are positive to the study; a researcher should present multiple perspectives, including contrary findings (Creswell, 2013:59). Hence researchers are ethically obliged to ensure at all times that the investigation proceeds correctly and that no one is deceived by the findings. The researcher was careful when compiling the findings as she is aware of the importance of accuracy in this step of the research process. The avoidance of researcher bias ensured that the researcher was neutral when compiling the findings.

3.6.8 Debriefing

McBurney (2001 in Strydom, 2011:122) defines debriefing sessions as “sessions during which subjects get the opportunity, after the study, to work through their experience and its aftermath, and where they can have their questions answered and misconceptions removed.” Due to the potential effects the study might have had on the participants it was vital that the researcher make prior arrangements for debriefing them after the research sessions and allow them to ask any clarity-seeking questions they might have in order to give the researcher the opportunity to clarify anything that the participant might not have understood or simply wished to question. Arrangements were made with the area social worker for the counselling and debriefing of participants should the need arise in planning the research study. However, during the study, the need for debriefing of the participants was obviated as they all seemed content with having the opportunity to ask the researcher any clarity-seeking questions they had and no unresolved emotions were elicited.

3.7 SECTION 1: RESEARCH FINDINGS

In the following section, the empirical findings of the study will be discussed and presented. Firstly, the biographical details of the participants will be presented in a narrative format and, where applicable, will be followed by graphic illustration of the findings. The findings from the semi-structured interviews will be presented in a table format where the themes and sub-themes that emerged will be summarized and discussed. The findings will finally be discussed and integrated with the relevant literature where applicable.

3.7.1 Biographic details

The study is based on the cultural beliefs of families affected by mental illness with the caregiver being representative of the family. The biographical information in this study includes the participant’s age; gender; marital status; home language; education level; number of dependents; institution where treatment was sought for the loved one as well as the number of years caring for a loved one with a mental illness.

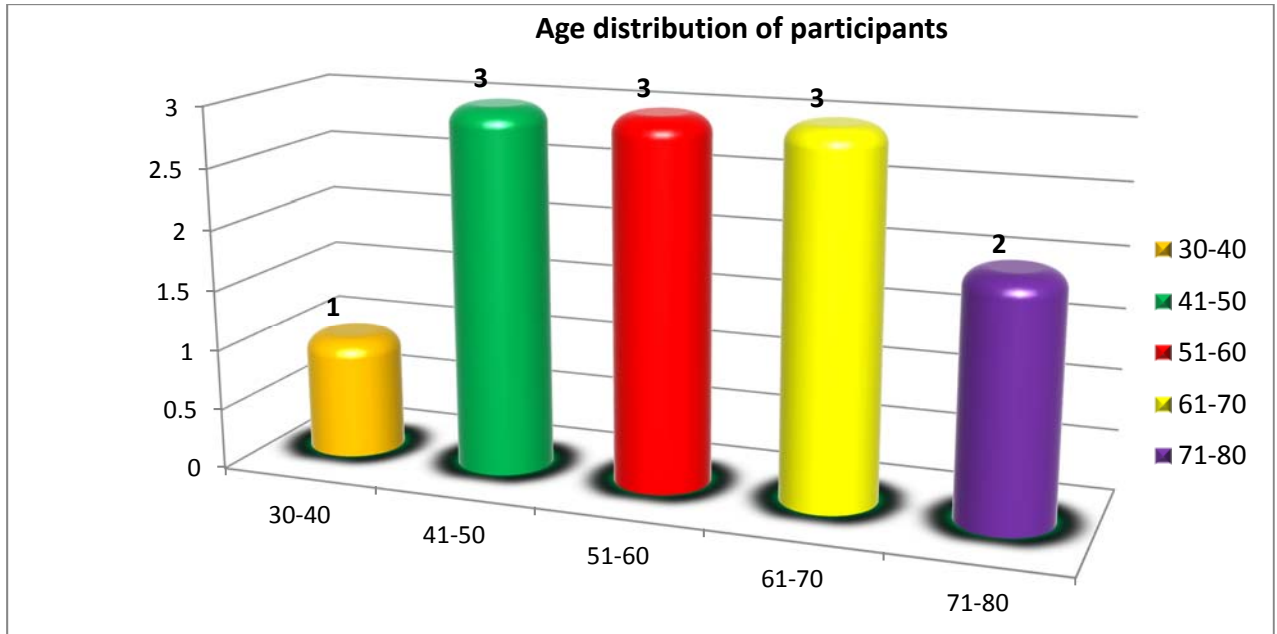


Figure 1: Age categories of participants

In the above figure, the x-axis represents the age groups of the participants as categorized by the researcher. On the y-axis, the number of the participants that fall within a certain age group category is presented. One participant was between the age of 30 and 40; while 3 participants were between the ages of 41 and 50. Another three participants fell under the 51 to 60 age groups; with three more participants falling under the 61 to 70 age group. The last two participants fall under the age group of 71 to 80 years. There were no participants over the age of 80 or above.

3.7.1.1 Gender of participants

The pie chart below illustrates the gender of the participants that took part in the study.

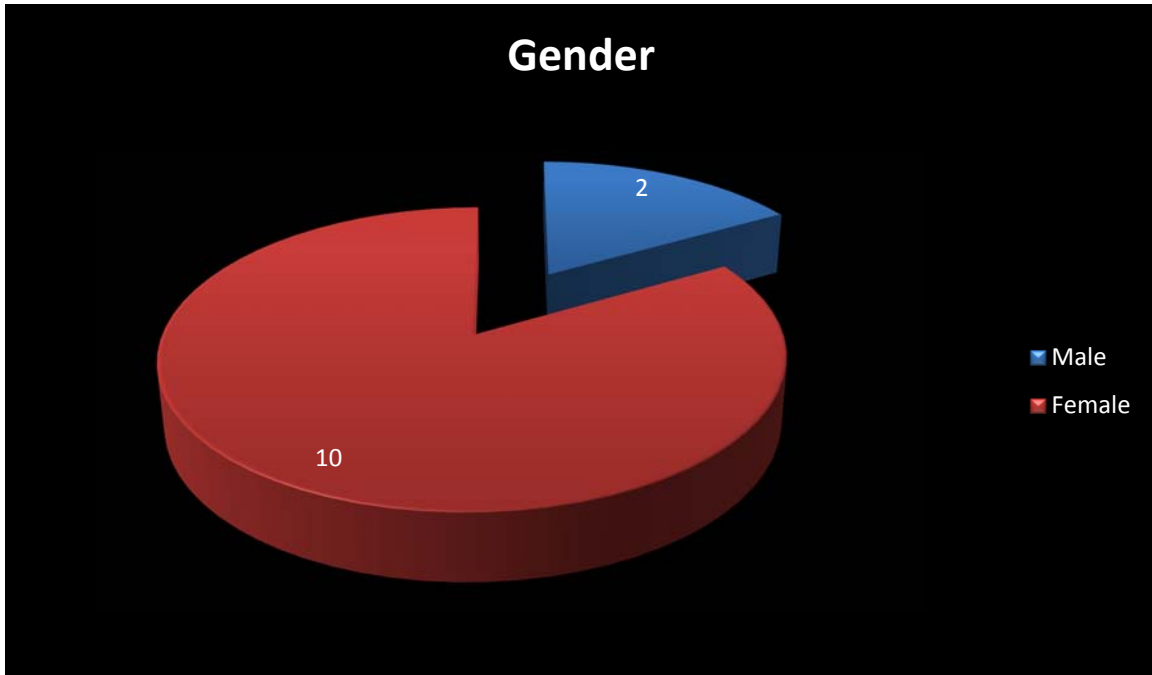


Figure 2: Gender of participants

The findings in figure 2 indicate the gender distribution of participants. Ten out of the twelve participants were female while the other two were male.

3.7.1.2 Marital status of participants

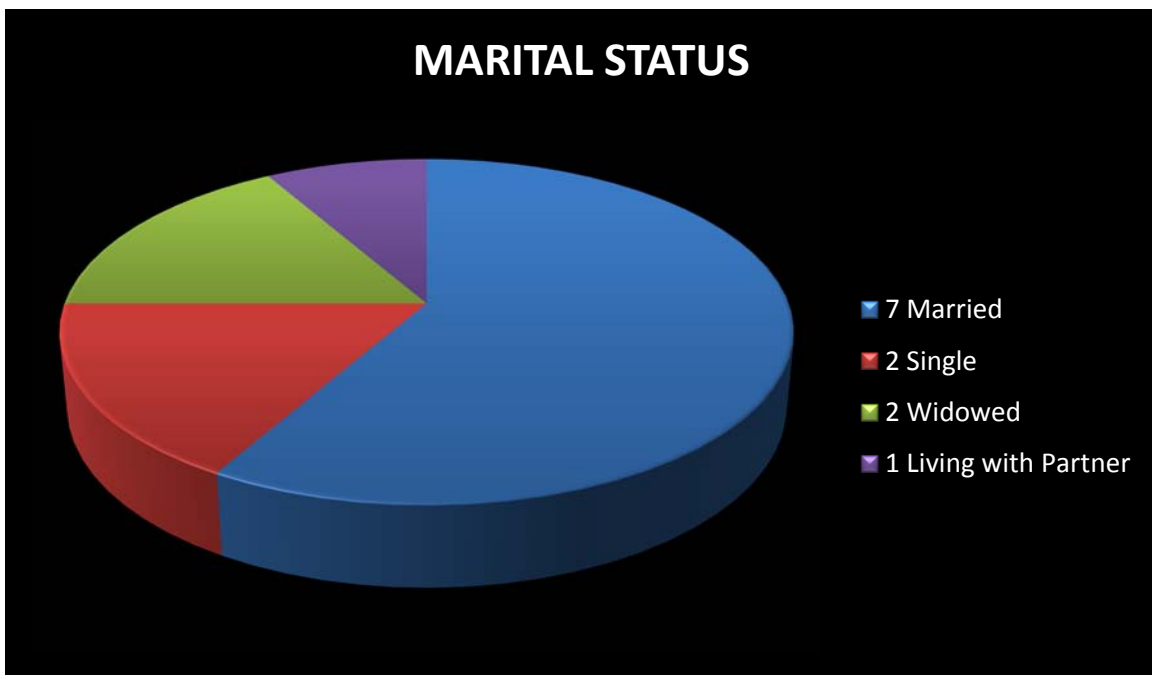


Figure 3: Marital status of participants

The marital status of the participants from the study is illustrated in figure 3. Seven participants are married, two single, two widowed and one participant is living with a partner although they were not married at the time of the study.

3.7.1.3 Home language of participants

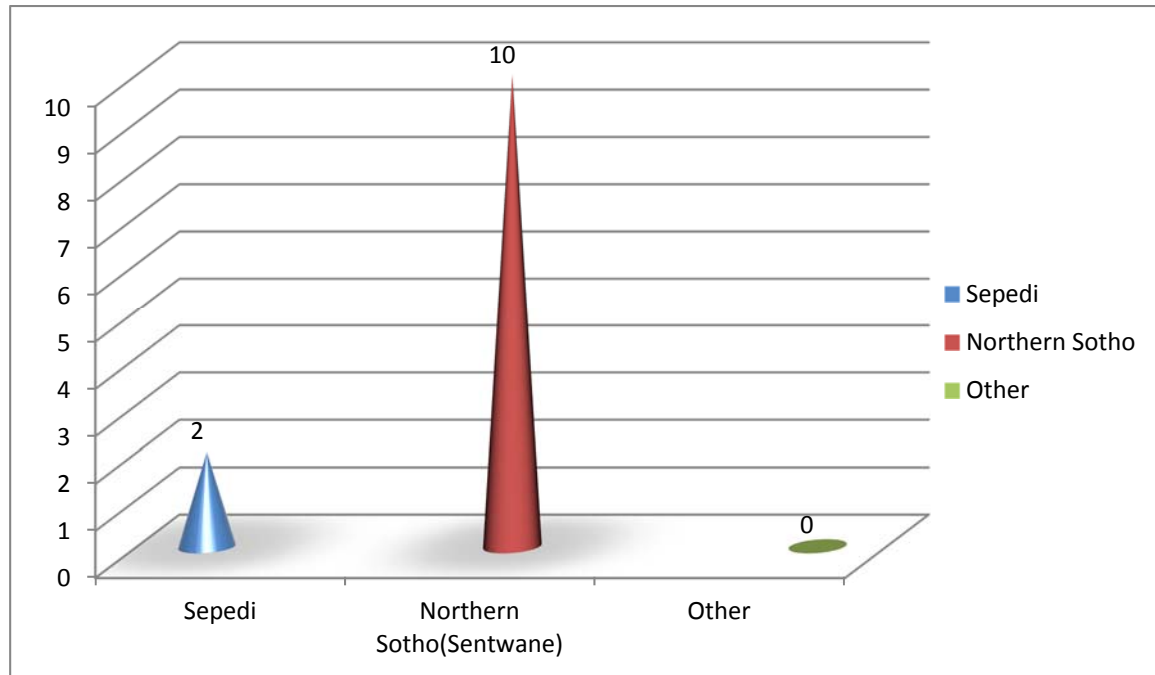


Figure 4: Home language of participants

Of the 12 participants that formed part of the study, 10 use the common and most used language in Ntwane, Northern Sotho, also known as Sentwane by the inhabitants of the area. The other two use Sepedi as their home language although they mentioned that they are familiar with the Ntwane language.

3.7.1.4 Education level of participants

The figure below illustrates the education level of the participants. Four of the twelve participants have not received any education at all in their lives. Five participants had primary education as their highest level achieved, while three of the twelve participants managed to reach secondary education level. None of the participants has gone as far as entering tertiary education as grade 12 is the highest level obtained by one of the participants.

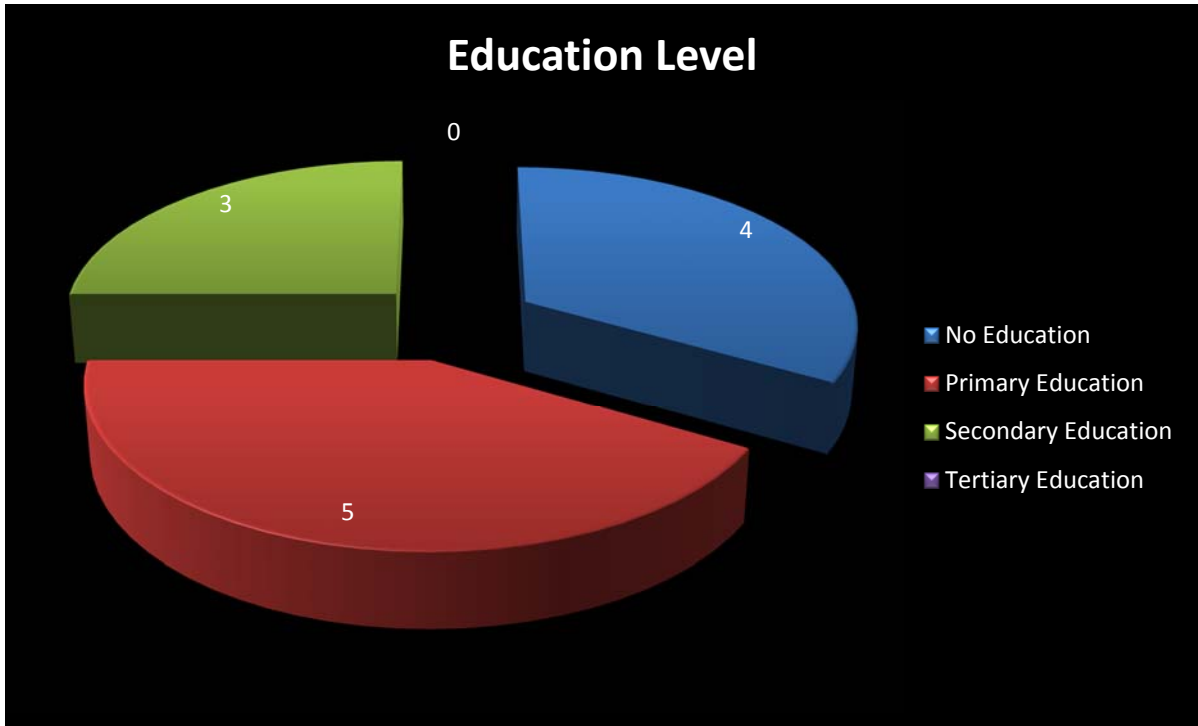


Figure 5: Education levels of participants

3.7.1.5 Number of dependents for the participants

The number of dependents in the participant's household is presented in the following pie chart.

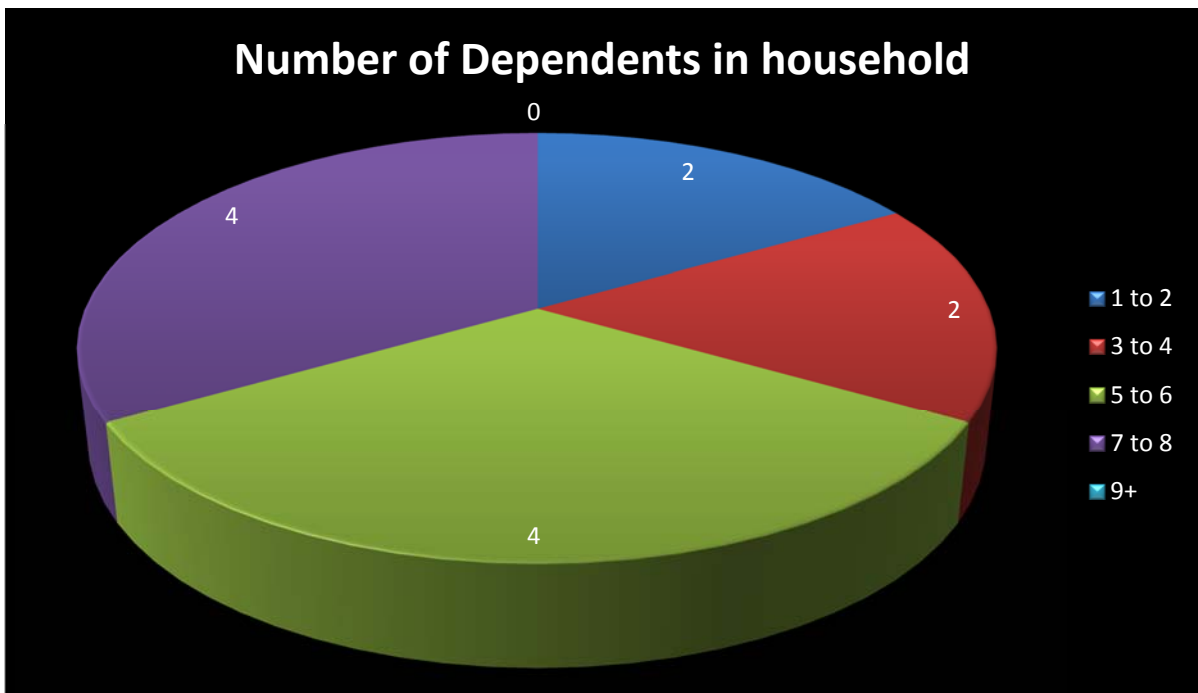


Figure 6: Number of dependents in participant's household

Of the 12 participants that took part in the study, two had between 1 and 2 dependents; another two had between 3 and 4 dependents; four had between 5 and 6 dependents, and another four participants had between 7 to 8 participants. None of the participants had 9 or more dependents.

3.7.1.6 Duration caring for a loved one with mental illness

The following figure represents the number of years during which the participants have been caring for a loved one with a mental illness.

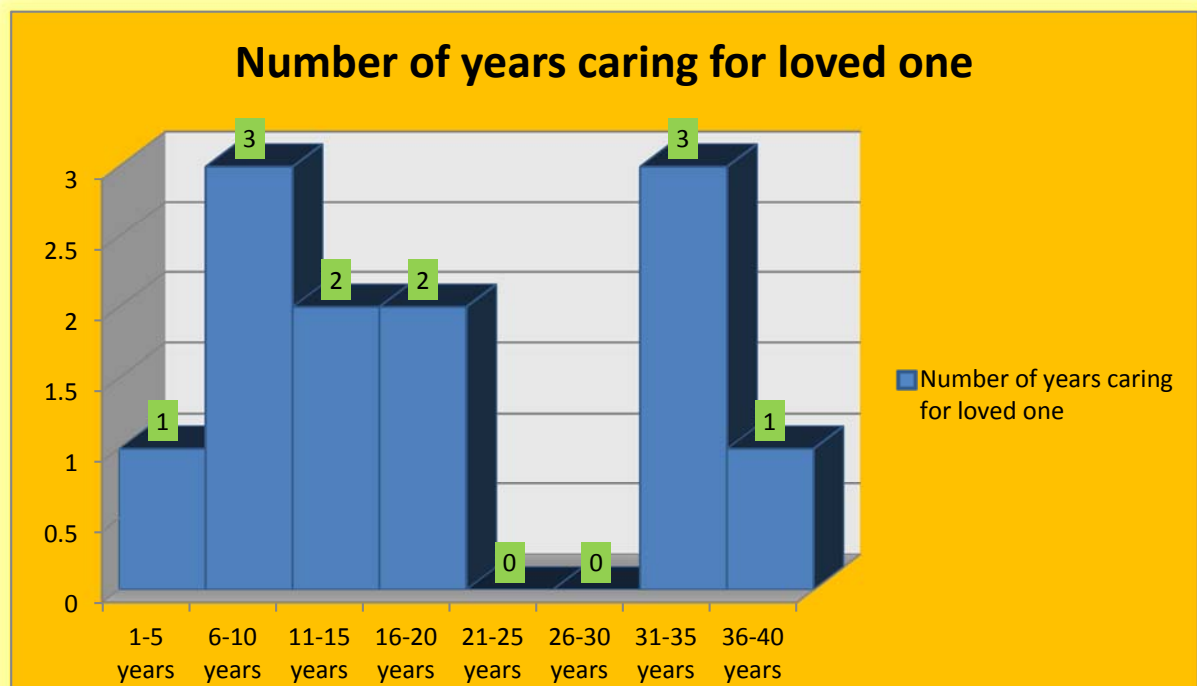


Figure 7: Duration caring for loved one

The findings indicate that most of the participants have been caring for a loved one with a mental illness for long periods ranging from a year to forty years. Of the twelve participants, one had been caring for a loved one for a period of between 1 to 5 years; three participants had been caring for a loved one for a period of between 6 to 10 years; two for a period of between 11 to 15 years and another two for a period of between 16 and 20 years. None of the participants took care of a loved one for the periods ranging from 21 to 25 years as well as 26 to 30 years. Another three of the twelve participants had been caring for a loved one for a period of between 31 to 35

years; while the last one of the twelve participants had been caring for a loved one for a period of between 36 to 40 years.

3.7.1.7 *Institution where loved one is receiving treatment*

Of the 12 participants, 10 were attending Philadelphia Hospital for treatment; while 3 were attending the local Kwarrielaagte Clinic for treatment. One of the 12 participants sought treatment for their loved one from a lengthy distance, at Groethoek Hospital and Thabo Moopo Hospital. The information on the institution where participants sought treatment for their loved ones is presented in table 1.

Table 1: Institution where treatment is received

Name of institute	Number of participants receiving treatment at institution
Philadelphia Hospital	10
Kwarrielaagte Clinic	3
Groethoek Hospital and Thabo Moopo Hospital	1

The findings indicate that most participants sought treatment at institutions that were nearest to them, namely Philadelphia Hospital and Kwarrielaagte Clinic.

3.8 SECTION 2: KEY THEMES FROM EMPIRICAL FINDINGS

During the processing and analysis of data, the following key themes and sub-themes raised by the participants emerged. The findings are supported with direct quotations of the responses given by participants. The integration of literature follows in the discussion of the findings.

A summary of the identified themes and sub-themes from the transcripts and data collected are presented in table 2.

Table 2: Themes and sub-themes

THEMES	SUB-THEMES
Theme 1: General understanding of mental illness	1.1 Knowledge of what mental illness is
Theme 2: Perceived causes of mental illness	2.1 Genetic causes 2.2 Biological/medical causes 2.3 Medical negligence 2.4 Unknown causes
Theme 3: Cultural beliefs about mental illness	3.1 Witchcraft 3.2 Punishment from the ancestors 3.3 Supernatural forces: lightning
Theme 4: Treatment sought regarding mental illness	4.1 Consulting traditional healers 4.2 Consulting medical practitioners 4.3 Consulting both traditional healers and medical practitioners 4.4 Religious perspectives
	5.1 Need for social support system

Theme 5: Strategies to support families affected by mental illness	5.2 Education for the patients with mental illness at government's expense 5.3 Need for specialised mental health services
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3.8.1 Theme 1: General understanding of mental illness

Most of the participants seemed to have a general understanding of what mental illness refers to.

3.8.1.1 Subtheme 1.1: Knowledge of what mental illness is

The participants indicated what their understanding was by explaining mental illness based on their perceptions of what they thought it referred to. This is what they indicated:

- *“Ge ba bolela ka bolwetsi ba hlaologanyo ba bolela ka bolwetsi ba go timella ke monagano.”*

[“The term mental illness refers to an illness where a person loses their mind”]

- *“Ke motho o asa itekanelang”*

[“It refers to a person who is not fully developed mentally.”]

- *“Nna akere ge ke tlare olwala ka hlaologanyo ke monna ka gore ga dire dilo tse dirang ke bana ba bang. Mogopolonyana wa gage o na ikela koo.”*

[“I was able to tell that my child is mentally ill because I could see that he does not do the same things that mentally stable children could do. His mind just wanders.”]

- *“Akere motho ge a lwala ka hlaologanyo ke ge hlogo ya gage e sa tshware gapila. Mara Bjanong oo o tla go tla, kagore ge o bolela naye la utlwana, ga o itsi gore bothata boreng.”*

[“When a person is mentally ill, it is when their mind is not functioning normally. My child, however, astonishes me because when you talk to him he is able to

understand and comprehend everything; I just do not understand what the problem is.”]

- “*Akere bolwetse ba hlaologanyo ke ngwana ge asa kgone go itirela akere. Ene le ge o bolela le ena a sa go kwishishi gore oreng akere.*”

[“Mental illness is when a child is unable to perform everyday functions by himself. When you speak to him he also does not understand what you are saying.”]

- “*Akere motho olwalang ka hlaologanyo ga tseye gapila akere. Nako engwe wa missa, ommotsa selo nako engwe a utlwe nako engwe eseke a utlwa. Go etsa ena o, ge o bolela le ena okana bolela le ena mara ge o re tate ola ne a reng? A ka se go botse nnete gore go sepetse bjang goa reng nne.*”

[“A person who has a mental illness is mentally unstable. Sometimes they miss certain things. You tell him something and sometimes they will hear and understand you but sometimes they will not. Take my child for instance, you can tell her something now but when you ask her what that man was saying she will not be able to relate the conversation to you.”]

- “*Bareya go lwala ka hlaologanyo*”

[“Mental illness refers to an illness of the mind.”]

The findings indicate that most of the participants interviewed held a common belief of mental illness being an illness resulting from some kind of abnormality in the mind. Busfield (2011:8) suggests that the use of terms such as madness, insanity and lunacy, as well as the belief that an individual can be mad or insane, disturbed or troubled in the mind, are lay beliefs informed by dominant cultural ideas. Busfield (2011:3) asserts that understandings of mental illness do not develop in a vacuum but rather are shaped by social, political and economic change in modern societies. He defines mental illness as encompassing a large number of conditions such as brain diseases, Alzheimer’s type dementia, schizophrenia, the Archetypal madness to the more common disorders such as anxiety and depression. Substance-use disorders as well as various personality disorders are also included in this list (Busfield, 2010:1).

3.8.2 Theme 2: Perceived causes of mental illness

Most participants expressed their views about what they believe is the cause of mental illness in their loved ones. These opinions range from genetic factors to medical and biological factors; they include medical negligence and unknown causes. The causes are discussed below under four sub-themes of the main theme.

3.8.2.1 Subtheme 2.1: Genetic causes

Genetic factors were also considered when addressing the causes of mental illness. The participant was able to identify the link between her loved one's mental state with her late mother's mental state and through that concluded that hereditary factors were the cause of her loved one's mental illness. The following statement was made by the participant:

“Aowa, nna ga ke itsi gapila gore go bakwa ke eng ka go bane obelegwe ntse a le bjago, Ne asegapila, mara kare ge ke nagana gore le mmage ne asena hlaologanyo ya kamo (points to the head) nne. Mara ena ne a sa tshwane le ngwana oo nne, ne a le worse ena.”

[“I do not know exactly what the causes are because my grandchild was born with the mental illness. She has never been okay mentally but then when I thought about it hard enough, I assumed that she must be like this because her mother was also mentally ill. Unlike this child, her mother's mental illness was much worse.”]

One out of twelve participants believed that mental illness is caused by genetic factors. Her belief in this regard was motivated by the fact that the mother of her grandchild, for whom she cares, also had a mental illness even though her symptoms were described as being far worse than those of the child concerned. This statement is supported by Subudhi ([sa]:132), who mentions one of the attributes of mental illness as genetics. These findings indicate that some of the participants do consider the possibility of hereditary factors as a cause for mental illness. Lee et al. (2014:781) have highlighted the view that the “genetic causal explanation of mental illness has been associated with increased perceptions of mental illness as serious and persons with the mental illness are seen as dangerous as opposed to non-genetic attributions.” The genetic causes of mental illness are noted by Uher

(2013:67) as being independent and separate from the psychosocial causes making it a case of nature verses nurture. The ecological system's theory guided the researcher in understanding where the belief in genetic causes could stem from. Being part of a family structure, the participant experienced mental illness within the family before and hence her belief that the cause could be genetic factors.

3.8.2.2 *Subtheme 2.2: Biological/medical causes*

Some of the participants in the study believed that epilepsy, which they refer to as “bolwetsi ba gowa”, was responsible for the onset of mental illness in their loved ones. Their reasoning for this was based on the explanation that before their loved one started having epileptic fits, they were mentally sound. Illness in general is seen by two of the participants as the cause of mental illness as they believe that when a person is ill their brain functioning is affected and this results in mental illness. One participant in particular, believed that the fact that her child had never received the BCG TB immunization, which used to be given to children at birth, is the reason why she has a mental illness and is also physically disabled. Two participants identified stress as the cause of mental illness.

➤ *“Nna ena ga keitsi nne. Nna enobe ele golwala ntho ebakang golwala ka hlaologanyo. Akere ge o lwala go go checherekanya monagano. Golwala ee!”*
[“I do not know. For me I just think it is illness that causes mental illness. When you are ill, that messes your mind. Yes, definitely it's illness!”]

➤ *“Ba bang sebakwa enoba bolwetsi. Ngwana o ogola ale gapila akere, onare mogare ga sebaka ano checherekana bathome bare motho o wa gafa bjang bjang. Malwetsinyana a agogafa ga reitsi gore go bakwa ke eng...ga keitsi.”*
[“With others, the cause is illness. The child grows and develops well, and then all of a sudden they become mentally ill and then they say the person is ‘crazy’, so forth and so forth. I do not know the causes of these illnesses related to being ‘crazy’. I do not know!”]

➤ *“Nna ge ke nagana, mohlomong bo bakwa ke gore, akere bjanong wa wa. Ke motho oawang ele gore owa ka mohuta omong, ga awe gotshwane le bale*

bareng batshwerwe ke malopoOla okamokgwana omong ene go shiana di chika, go shiana dilo tse kamoka mo go ena moo. Bjangong nna kenore go baka ke kamokgo adirang kamokgo. Ke bona mo okareng bo mo tima hlaologonyano.”

[When I think about it I think that the mental illness is caused by the falling (epilepsy). He falls in such a way that it is nothing like people who have the ancestral calling. He shakes all over when he has his epileptic fits which I think is the reason he is unwell mentally.]

- *“Kore o othomile ka gona gowa moo...kegore anothoma ra seke ra itsi gore rereng. Ke gore ne a lekana le ngwana oo (pointing to a child of about 4 years of age playing in the yard)... a no thoma rano bona motho a thoma okare oa hlepha so. Bjanong ile ra no bona gore nthwe ebakileng bjago, akere oa bona go nale bana ba bang ba apesiwang ntho engwe bare selo ke stuip and then o wagago ge a sa se apara ke mokana okeno ke bolwetsi boo. Bjanong oo o tshamikile le bana ba ne ba se apere, ebe e le ge bolwetsi bo medile mo go ena. A fele e re ge kgwedi eya, athoma mola a re ‘hla hla hla hla’ alebella ko dimo kemokana olebella ko fase a we.”*

[“With my child, the mental illness started after she started falling from epileptic fits. When it started we did not know what to say or do. She was about the age of this child (pointing to a child of about 4 years of age playing in the yard). It just started and we saw her looking like she was weak and falling down. We saw the cause of the epilepsy to be due to the fact that, you see there are children who wear this thing called ‘stuip’ and if your child is not wearing it then they get epilepsy. Our child was playing with a child who was wearing this ‘stuip’ and that is how the epilepsy and mental illness started with her. When the attacks start, she goes ‘hla hla hla hla’, looks up and looks down then falls in an epileptic fit.”]

- *“Nna ngwanake kamokgo ile ge atswa sepetlela ba seke bamo enta and then bare ke mo ise ko klinikeng and then go nale hlomolo e ba sa mo hlabang and ko klinikeng ne ele o mohola geke moisa ba fele bare ga e teng thlomolo. And then ka fetsa ke skehle ke mo isa kagore ne ba re ga eteng. Gake itsi ina la thlomolo eo cos ke e ba mo entang ‘mo’ (points to upper arm).”*

["With my child, after giving birth to her she did not receive Immunization injection. I was told to take her to the clinic for the immunization injection but it became such a hassle because every time I went to the clinic for it, I was told that there is no stock for that injection. I ended up giving up and never took her for that injection. I do not know the name of the injection; it is the one that they inject here (pointing to upper arm)."]

- *“Le bolwetsi ba pelo. Go tshwana le ngwana ge akare ale ko lapeng wa kereya le mokgalema, le mo kgalema le topa di kgati le mo iteya ke gore o lahlegela ke hlaologanyo esentse ele omonyane. Akere ka pelo ya gage ore ke gore ga ba nthate nne.”*

["Stress is another cause. Like when a child is at home and you abuse her and you scold her and give her hidings with a stick they lose normal functioning of their mind at a young age. It is because in their heart the child thinks he/she is not loved."]

- *“Bolwetsi ba pelo. Akere okereya nako engwe odutse ole nnoshi ona tshwara ke stress, o no balabala.”*

["Stress is the cause. You find that sometimes you are sitting alone and then you start to stress and are thinking too much."]

The findings based on the above-mentioned statements indicate the existence of some diversity in belief with regards to the perceived causes of mental illness by some of the participants. The findings from one case also indicate that stress resulting from the abuse of a child can lead to the onset of mental illness, as posited by Briere and Runtz (1987 in Pilgrim, 2010:91): “Early childhood abuse is a good predictor of a range of mental health problems in adulthood”. Epilepsy is also presumed to be a popular cause of mental illness by some participants. Ramsay et al. (2006:82) emphasize that “some medically unexplained conditions look like other disorders that have a known physical cause. For example, people diagnosed with non-epileptic seizures have fits that can look very much like epileptic fits. However, investigations show that the brain is not behaving as it does in epilepsy.” The ecological systems theory explains why the participants have the views that they have in that, the social structures around them have influenced their beliefs in this regard.

Three participants concurred with the belief in abnormal blood movement, with too much blood moving to the head/brain as the cause of mental illness. Below is what they had to say regarding abnormal blood movement to the head as the perceived cause of mental illness:

- *“Akere ba bang bare ke ge madi ge a eya ko hlogong. Akere ebe motho anale madi a manchi then a mang aye ko hlogong gomme a mo checherekanye hlaologanyo.”*

[“Others say that mental illness is caused by blood moving to the head. When a person has too much blood, some of that blood moves to the head and then it interferes with the normal functioning of the mind.”]

- *“ke go tshwana le ge motho a nale madi a manchi afelelets aya ko hlogong e ne ago right gore madi a ye ko hlogong. Le ngaka ile ya riyago ya re ke madi a manchi ka ngwana o.”*

[“It is like when a person has a lot of blood. The blood ends up going to the head and it’s not right for blood to go to the head. Even a traditional healer once told me that my son has too much blood.”]

- *“Basotho bare go bakwa ke madi aketsi gore madi ge adirang. Madi agage ke a manchi and di iriwa ke ona. Ga ke itsi le nna.”*

[“Black people say the mental illness is caused by blood, although I do not know how blood causes it. They say his blood is too much and caused the mental illness. I also do not know.”]

The findings indicate that there seems to be a belief in abnormal blood movement being the cause of mental illness among some of the participants. It is believed that if blood moves to the head and maybe comes into contact with the brain, this is a trigger for the onset of mental illness. The reason for blood moving to the head is described as the result of a person having too much blood in the body, some of which moves to the head and affects the mental state of individuals. Viljoen (2006:67) also documented blood movement as the cause of mental illness in a study he conducted where he mentions that “several responses indicated that if blood comes into contact with the brain this translates into mental illness”. These

findings indicate the effect of different systems on the focal individual's perceptions and view of reality. These perceptions are influenced by their cultural background and beliefs. More than one participant mentioned blood movement as the cause of mental illness, indicating this to be a belief which exists within the study community. Gardiner and Kosmitzki (2011:246) believe that "illness at any age and in any ecological system creates considerable stress." Subudhi ([sa]:135) suggests that when looking at mental illness from the perspective of the biomedical model, its origins are considered to be biological in origin. The belief in abnormal blood movement could also be attributed to the cultural background of the participant. The ecological systems theory assisted the researcher understand this as it believes that social structures in the individual's life influence the beliefs they harbour.

3.8.2.3 *Subtheme 2.3: Medical negligence*

Of the twelve participants, one participant believed that medical negligence was the cause of his daughter's mental illness. Although he could not say what happened that he saw as negligence as he is not sure himself, he strongly believes that if his daughter had been delivered correctly without any negligence and complications, she would not be mentally ill. The following are the responses of the participants:

- *"Ngwana o o belegilwe a se right go tloga ko sepetlela. Di taba di tlogetse koo ge ba belegisa mmage ka ena, ga ke itsi gore ba dirile bjang ba dira bjang gore ase belegwe gapila ya ba gona ge a checherekane. Bjanong nka se go botse nnete gore go sepetse bjang goa reng kantle le gore ga ba mo belegisa gapila."*

["After this child was born at the hospital, she was not normal. That's where it all started. During labour, when she was being delivered, I do not know what they did to not deliver her properly but that is when the mental illness began. Therefore I cannot tell you the real story of what happened to her apart from the fact that she was not delivered properly during labour."]

The findings indicate that medical negligence is sometimes viewed as the cause of a mental illness where a mistake which happened during the delivery of a newborn baby declared the child mentally ill due to negligence on the part of the medical

personnel. Medical practitioners, although without proof, are sometimes blamed for certain abnormalities observed in babies immediately after birth. This is evident in the findings above as negligence on the part of doctors is believed to be the cause of mental illness. Maughan (2001: 900) believes that medical negligence can be proved only by another medical practitioner who is skilled in that specific field. In this case, a gynaecologist who is skilled and experienced in his field would have to prove that there was medical negligence which led to the mental illness of the said individual.

3.8.2.4 Subtheme 2.4: Unknown causes

Some of the participants stated that they do not know the causes of the mental illness. The sudden onset of the mental illness in a child that was presumed to be well and observed to be developing well was a shock to the families of those individuals and they mentioned not being able to determine the cause thereof. For some of the individuals, the fact that their loved one was born with a mental illness meant that they do not know how to even begin to explain what the cause might have been as they believed it was God's will. The statements in this regard are noted as follows:

- *“Yoh, Ai ngwanaka ga ke tsebe ga botse gore nkare go bakwa ke eng. Hmmm nkasegobotse nne. Ga keitsi selo ka gore selo se o se arabang tshwanetse ebe selo se o se tsebang...go akanya le gona, aowa.”*

[“Yoh, ai my child I do not know exactly what the causes of mental illness are. Hmmm, I really cannot say hey. I do not know and prefer to answer something that I do know and understand myself...to assume is not right, no!”]

- *“Tjo, nna ena ga re itsi ngwaneso, ga re itsi. Nkase hlaolose ka gore ankere ngwanake obelegwa a le bjago.”*

[“Tjo’, we really do not know the cause, my sister, we do not know. I am unable to explain the cause of the mental illness because with my child, he was born like that.”]

- *“Nna ga ke itsi ngwanaka, ruri ga keitsi. Ka gore motho o ne a itshepelela, ne a thomo sepela, aitlantla mo polelong. Hai goya ge ga memogolo wagage, ne anna le bona. Kege ba mpitsa bare tlaya ngwana ngwana, ge ke fihla mola ke*

fihla ngwana o kore othothomela hlakore le, le nko le leihlwana, le molomo mo, bjanong nna ga keitsi gore ke tlare ke bolwetsi ba mohuta mang bo.”

[“I really do not know the cause my child, really I do not know. Because my child was walking, she had started walking, was even learning to talk. ‘Hai’ until one time, her aunt called me urgently to come see what was happening to the child. When I got there, the child was shaking on one side. Even the nose, eye and mouth were shaking. Hence, I really do not know what kind of illness this is.”]

➤ *“Nna ga keitsi gore go bakwa ke eng. O belegwe ele ngwana ale gapila, ko pele achecherekana.”*

[“I do not know what the causes of mental illness are because my child was born normal like any other child and then as time went by her mind got messed up.”]

The findings indicate that some of the individuals seemed well mentally in their childhood after which suddenly they developed the mental illness and hence causes could not be explained. The others felt that their loved one was born like that hence it is not within their scope to be able to describe the causes as only the Higher Power – God, would know. The same results were obtained by Quinn (2007:181) in a study he conducted in Ghana where he noted a lot of “I don’t know” as answers to causes of mental illness. He saw this as being due to lack of knowledge and understanding of presenting symptoms and the origins thereof. The majority of participants in the study population are illiterate as they have either never been part of an education system or they dropped out of school early during their primary level education. The researcher deems this to be the reason for lack of knowledge on issues of importance in this community. There seems to be a culture which does not emphasize the importance of an education in this community and this in turn affects the well-being of their loved ones.

The theoretical system’s framework guided the researcher in understanding these findings as it emphasises the importance of viewing behaviour within its social setting (Gardiner & Kosmitzki, 2011:12). The researcher was able to understand that the belief that if a mental illness did not develop at birth then its causes cannot be known, apart from bewitchment being the cause. There is a belief in witchcraft being the cause of mental illness in the study community, hence the researcher needed to

have knowledge of the belief systems and values cherished by community members in order to have an understanding of this view. Individuals form part of communities and in these communities they are socialized to hold certain beliefs and norms which guide their development even though they might not interact directly with that individual.

3.8.3 Theme 3: Cultural beliefs about mental illness

Culture seems to have an influence on the views regarding mental illness. This is shown in the views expressed regarding the causes of mental illness. These causes, namely witchcraft; punishment from the ancestors; as well as supernatural forces are discussed below according to the statements made by the participants.

3.8.3.1 Subtheme 3.1: Witchcraft

There seems to be a strong belief among the participants that if a person develops a mental illness during the course of his/her life rather than at birth, then it is because they have been bewitched. In those that are born with mental illness, it is mostly accepted as being God's will and no one is blamed because they were born like that. Here are some of the statements quoted regarding this belief:

- *“Go nale go tswala, gore ngwana a re a hloga ko badimong o humane okare ga a Tshwane le bana ba bang. Ebe e le ge moka a tlo go charakanyetsa. O a lwalang ka hlaologanyo gapila ke o a tshwetseng akere, gomme ge olwala ontse o le o mogolo osepela, ebe ele boloyi.”*

[“There is a child who is born with a mental illness. That is when a child comes from the ancestors and you find that he/she does not look like other children. That is when the mayhem begins. A person who has genuine mental illness is one born with it and then if the mental illness develops later on in life, it is witchcraft.”]

- *“Ngwanake ba mo loketse lefofonyane ka le baka la gore ne ba nagana gore ke monga wa mpja e bolaileng dinku tse pedi tsa monna wako dithabeng. O a lwalang ka hlaologanyo ke o a tswetseng. Akere bjanong o waka bolwetse ba bo loketse.”*

[“My child’s mental illness started when they bewitched him because they thought the dog that killed a man’s two sheep belonged to him since it was named after him. A person with a mental illness is one born with it. The onset of my child’s mental illness was because he was bewitched.”].

The term *lefofonyane* is described by Pretorius (2010:535) as a sort of “spirit possession which is principally ascribed to sorcery and is brought about by harmful medicines which are controlled by the spirits of the deceased. Such a person sees people or animals that are not visible to others, talks to him – or herself and falls as if suffering from a fit.”

- *“Ka se gaabo rena, ge a checherekane, e be entse ele gore ba modirile, especially ge a sa tswalwa le bona bolwetsi boo.”*

[“In our area, when a person develops a mental illness, it is because they have been bewitched, especially if they were not born with the mental illness.”]

- *“Ankere ba bang ba dira ke batho and then ba bang ba belegwa ka bolwetsi kaona mokgwa oo”*

[“Other people become mentally ill because someone has bewitched them but then others are born with the mental illness just like that.”]

- *“Akere bakgona go go hlakanya hlogo oseke wa tseye gapila e le ka le baka lagore bagoloya. Gapila pila akere ba bang ba belegwa bale so and then ba bang ba go dira, o lwala ontse ole omogolo.”*

[“They are able to mess with the normal functioning of your mind through witchcraft and you become mentally ill. In actual fact, others are just born like that but then the rest are bewitched and mental illness onset starts when they are older.”]

- *“Nkare ga keitse because ga atswala le bona, nkare maybe ke maloyo. Ba mo loyile goya le kamokgo ke believang.”*

[“I would say I do not really know because she was not born with a mental illness, so I would say maybe it is witchcraft. She has been bewitched according to what I believe.”]

- *“Ganchi mo gae motho, go tshwana le ngwana waka kamokgo aleng, motho ga ke amogele gore ngwana o otlile ale so. Ke no nagana gore aowa gora gore batho bantirile so. And then otshwanetse gore ge ole motho o amogele se oleng sona akere. Ba banchi ga ba amogele. Motho onore aowa ngwana o waka o goragore ke semanyamanyane omodirele so and then ebe ele gore vhele ke thlago kganeng otlile ale so ele ka le baka la bontwane bo.”*

[“Most of the time in our village, like the way my child is, we do not accept that the child was born like that. We start thinking that someone has bewitched the child. Whereas as a person it is important to come to terms with whom you are. Most people do not accept and then they would say my child is like this because so and so has bewitched him, only to discover that he is naturally like that.”]

- *“Ke bona mo Ntwane go bakwa ke go seleka ga batho (boloi) le go tseya motho setlotlwane”.*

[“In Ntwane mental illness is caused by witchcraft as well as turning others into zombies too.”]

- *“Ngwanageshu gase abelegwa ka bolwetsi ba hlaologanyo kagobane ile abana le ngwana wa moshimanyana, ngwana yela rare re dutse so, esale vroegonyana so ka bo to nine goanatla selo, otsere ke dilo tsa batho. Kore ne ele mokopa, ntho e ne ele mokopa kagore emoteile mo (points to forehead) gabedi ahlokofala same time. Mokopa obolaileng ngwanela wa ngwanageshu be o rometse ke mo kgekolo wa ka next door wa go loya. Kegore nkare ngwana wa moratho waka ba mo tsere setlotlwane. Aowa go na tshela selo sela, goa tseya matsatsi a sa reng selo, aowa napile a hlakahlakana gotloga gona moo.”*

[“My sister was not born with a mental illness because she even had a baby boy. The child was then attacked by a cobra snake which bit him twice on the head. The cobra that killed my sister’s child was sent by an old woman who was our next door neighbour and was known to be a witch. So what I can say is that they turned my sister’s child into a zombie. After having jumped over the cobra snake that had just killed her baby, a few days went by and my sister became mentally ill.”]

- *“Hai...wa tseba ga senke ke tseba ka gore ena gore atle abe kamokgo; ne bare o itsi thata ko sekolong, atimmela ke puku, ba mo loya. Wa tseba gore batho ba bjang mos.”*

[“Hai.... You know I do not really know because he became like this because they said he was too clever at school and someone stole his book and bewitched him. You know how people talk mos.”]

When coming to bewitchment as a contributory factor to mental illness, many of the participants did not believe that their culture had any influence on their belief.

- *“Aaa...ekare mohlomong...like ge re gola netse re utlwa babolela bare gonale batho ba baloyang. Like bakgona go loya motho gore ahlakane hlogo askehle abeya kamokgo le ale ka teng. So re godile re utlwa gore gonale boloi. That’s why le nna ke kgona go bona gore ekabe e le boloi.”*

[“When we were growing up we used to hear people talk that there are people who practise bewitchment. They could bewitch a person to make them lose their mind and never be normal like they used to be. So we grew up hearing that there is witchcraft which is why I can also see that it could be witchcraft.”]

This statement is supported by the ecological system framework as explained by Gardiner and Kosmitzki (2011:27) in that it proves the impact of the exosystem on the belief system embedded in some of the inhabitants of this community. Although the exosystem is a social setting beyond the focal individual’s immediate environment, through the interaction with other structures in the microsystem, it can have a significant influence in his/her development. Growing up in a community with a common belief in bewitchment being responsible for mental illness somehow influenced this participant through her interaction with microsystems. Subudhi ([sa]:132) believes that every culture has its own set of beliefs and practices which initially guide their explanations of what mental illness entails. In a study by Viljoen (2006:69) most of the participants suggested mental illness to be synonymous with bewitchment where the mental illness is described as intentional punishment for wronging someone who then bewitches a person in revenge. This is evident in the study where one participant mentions that her son was bewitched by someone who believed the dog that killed his sheep belonged to him.

- *“Ga se ka baka la sentwane nne, Kore nkane kare yona ekamokgo, ngwana wa gage ba mo tsere setlotlwane, go etsa kamokgo ne a bereka ka mo motseng oo ka gae a sa bereke selo.ne a re ge a tsoga atsogela moo.”*

[“The way I see mental illness is not influenced by my Ntwane culture. I believe that it is witchcraft because I know it is like that seeing as we saw the witchcraft happen ourselves. My sister’s child was turned into a zombie. My sister used to go to that old lady’s house early in the morning and would clean and do everything there but she would not do any chores at home. We could see that she had bewitched my sister to do things for her and also killed her child by sending the cobra snake to kill the baby by biting the baby on the head.”]

3.8.3.2 Subtheme 3.2: Punishment from ancestors

Some of the participants believed that punishment from the ancestors was the cause of mental illness in their loved ones. Below are the verbatim transcripts on what some of the participants had to say with regards to ancestors being seen as the cause of mental illness as a form of punishment.

- *“Nako engwe ohumana maybe e le dilo tsa badimo so, kagore badimo ge ba sa thaba ba dira dilo tse shoro gore ba go bontshe gore ga o ba thabise because ga o ba direle mmereko, go ba ge e sale a hlokofala gashi o hlabele pudi ya mogoga”.*

[“Sometimes you find that maybe it is ancestors causing the mental illness, because when the ancestors are not happy they do hectic things to show you that you have not been appeasing them by doing ancestral ceremonies for them. Sometimes it is like, since their death you have not slaughtered a goat for them in an ancestral ceremony called ‘mogoga’.”]

- *“Le badimo ge ba kwatile. Ge e le badimo, motho wa teng othoma ka bolwetsi ba gowa and then bo fetoga bolwetsi ba hlaologanyo. Akere gowa mo go mo checherekanya monagano.”*

[“The causes could be when the ancestors are angry. When it is the ancestors, the person starts off falling from epileptic fits. The falling because of epilepsy affects normal functioning of the brain resulting in mental illness.”]

Pretorius (2010:532) states that in some cases ancestors are held responsible for sending misfortune as punishment for breaking some taboo or for the fact that certain customs have not been adhered to. When looking at the ecological system’s theory, the macrosystem, which comprises customs, values and laws considered important in the focal individual’s life, usually has an effect on all other systems, hence the emphasis on the interconnectedness of systems in the ecological systems theory (Gardiner & Kosmitzki, 2011:27). In this instance, the cultural background of the participant, which includes the common beliefs and values held in the community, is perceived as a reality which has the potential to cause mental illness. Failing to appease angry ancestors is presented as contributory factor to the onset of mental illness.

Pretorius (2010:530) suggests that in African communities, fundamental values and norms in society are strengthened and made permanent by a power which is greater than humans and conceptualized as residing in a supernatural realm. These beliefs for Africans are the existence of ancestors (Hammond-Tooke, 1974 in Pretorius, 2010: 530-1). “After physical death, the individual resides in a temporal dimension in which the living are still aware of their existence. It is also believed that the deceased sporadically ‘appear’ to the elder of the surviving family relatives. These appearances are particularly significant in the explanation of crises and the causes of disease and death in the family” (Pretorius, 2010:531). The belief in ancestors has remained to play a part in the lives of many South Africans as it can sometimes be seen as the attribute to certain illnesses in the lives of family members as cited in the verbatim transcripts above.

3.8.3.3 *Subtheme 3.3: Supernatural forces: lightning*

One of the twelve participants believed that if a person walks in a place where lightning had struck that person would acquire a mental illness. This is what was said in this regard:

- *“Aai, nna ena aowa, Ke tse nchi dibakwa kagore nako engwe ge motho ase right kamo (pointing to the head) ohumana bare maybe ofitile mo go fitileng legadima, or maybe ba mo loile, ke dilonyana tse dinchi bjanong o ka se itsi gore gapila etlabe edirile ke eng.”*

[“Aai, the causes are a lot because sometimes when a person is not right in here (pointing to the head), you find people saying the person passed in a place where lightning had struck, or maybe the person has been bewitched. It’s a lot of things so you cannot pinpoint exactly what the cause would be in all instances.”]

The findings indicate a belief in supernatural forces as a cause of mental illness. This is proven in the verbatim statement above which states that walking in a place where lightning has struck makes a person mentally ill. The belief can be said to stem from beliefs embedded in the participant from their community where it might be a widespread belief that walking where lightning had struck would cause mental illness. This statement made clear to the researcher, the kind of impact that a belief held by a community has on the lives of individuals simply through their interaction with different systems, as described in the ecological systems theory. The environment is seen as having an impact of the development and perceptions of individuals. The cultural influence of the systems falls under the macro system guided by cultural values, laws and customs (Algood. et al., 2013:130). James and Peltzer (2012:94) indicate that in Jamaica, it is common for mental illness and other psychiatric diagnoses to be seen as being attributed to supernatural causes resulting in greater use and reliance on traditional healers for treatment.

3.8.4 Theme 4: Treatment sought regarding mental illness

One participant in the study, however, only managed to get assistance for their loved one coincidentally when he was involved in a car accident and admitted to hospital. This is where doctors were able to identify his mental illness and start him on treatment which, according to the participant, made such a difference that it helped him to recover. This is an interesting revelation as it means that some people living with a family member with a mental illness do not even attempt to seek assistance

with regards to their loved one's mental well-being. This is what the participant had to say in this regard:

- *“Rena rethushitše kege achaishitše ke koloï rathusha ke sepetlela sa Middleburg. Ke sona sa go mofokoletša. O ile aya ga malome wagage Middleburg, ge afihla gona achaisha ke koloï. Kganeng koloï ena yamo chaisha o ilo thushega ka ko sepetlela ”*

[“We got helped when he was knocked down by a car and was admitted to Middleburg Hospital. That is where he was able to become better. He was visiting his uncle in Middleburg, upon arrival he was knocked down by a car, only to find that being knocked down by a car meant that he would be assisted with his mental illness too by the hospital.”]

“Kamokgo ne go le thata mokgwateng le bona ne bare kegore ga ateng kagore ile ba be bamo kitimishetša Witbank pele. Aphaphama ko teng ba mmoshu atla kamo Middleburg. Ke ge a tla thoma go tšiya treatment yagage.”

[“Things were so bad after that accident that doctors thought he would not survive since he was even rushed to Witbank Hospital. He regained consciousness there and was returned to Middleburg Hospital. That is when he was then started on treatment for mental illness.”]

Four sub-themes have been identified by the researcher under treatment sought regarding mental illness. The findings demonstrate that most participants consulted both traditional healers and sought medical interventions in the hope that their loved one would be assisted. Pretorius (2010:533) explains that in African culture, with its belief in ancestors and supernatural forces, treatment for any illness comprises not only restoring harmony within the body, but also restoring harmony between the body and the environment. This resonates with the ecological systems theory, which views the individual as being part of many systems that are interconnected and continually impact on him/her. Hence, to heal the individual, his/her surrounding environment needs to be considered (Mutumba & Harper, 2015:56).

3.8.4.1 Subtheme 4.1: Consulting traditional healers

Most participants in the study had decided to seek assistance from traditional healers for their loved one's condition. They sought treatment first from traditional healers because they believed that the mental illness of their loved ones was related to witchcraft. The following statements attest to this approach:

- *“Thuso engwe kei tše kare, nna ne ke dula bobedi. Keile ka leka ka mo tšia a dula le nna plekeng e bareng ke Morareng bopedi, ge a fihla kuwa, ka mo tšia ka mo isha mothong wa se Sesotho gore ba mo thushe. Aowa yena ne se tše a thushega ge nkebe ele gore ena seke anjaga a re nkishe gae...Aowa motho o ne a se tše a mo fodisha. Eng, ne ke moisitse mothong kuwa go nna.”*

[“I tried to assist my sister by taking her to live with me in a place called Morareng in Bopedi where I took her to a traditional healer for help. It was helping until she requested to be taken back to Ntwane.”]

- *“Ile raya dingakeng tse mmalwa nyanatsa sesotho mara ga ra humana thuso.”*

[“We have been to several traditional healers but could not be assisted as she is still the same.”]

- *“Ka bo lwetsi ba go wa ile ra mo isa mo mothong a re irela di phekonyana gomme ntho ela ya emisa. Ena ne asawe mara bjanong oile goya kwa ba mo neya di pilisi mola pilisi tseladi mo dira ka mokgwana o mong a nape a checherekana thata. Re na bone gore aowa ampe re moise mo mothong re bone gore a ka seke a re thusha nna.”*

[“For the epilepsy, we took her to a traditional healer who performed some traditional rituals for us and the epilepsy stopped. She never used to be epileptic until she went to the clinic for assistance and was given medication which brought on the epileptic fits and made her condition worse. Hence we decided to take her to a traditional healer to see if we could get assistance for her.”]

- *“Ke ile ko sesothong kagore akere batho batla go botse bare nke oye sesothong mohlomong ba tla go thusha. Ge o lwalwa akere mang le mang o re man nke o dire sekete mohlomong go tla ba kaone.”*

[“I went to a traditional healer because people would advise me and say just go to a traditional healer, maybe you will get assistance for your child. When you are ill, people will always advise you to try this and that in the hope that you will get better.”]

The findings indicate that most of the participants preferred to seek assistance for their loved one’s mental illness from traditional healers. Gregory (2001 in Ross and Deverell, 2010:37) points out that a traditional healer is highly esteemed in many South African cultures being consulted for a wide range of problems. Until recently, a traditional healer was referred to as “a witchdoctor meaning a doctor who must heal witchcraft” (Pretorius, 2010:536). This fact is supported by another researcher: “In some African cultures, the traditional healer is seen as the counsellor and the process of counselling is regarded as a ritual that mobilises natural or supernatural healing forces on the client’s behalf” (Uys, 1992 in Ross & Deverell, 2010:36).

The participants in the study have been conditioned through their upbringing to seek treatment from traditional healers. This preference for traditional healers is best described through the use of the theoretical framework of the ecological systems theory. This framework believes that a child’s development is moulded by systems that interact with him/her directly as well as indirectly (Gardiner & Kosmitzki, 2011:24). Hence, growing up in a community where treatment for mental illness has always been sought from traditional healers is a belief that has also been embedded in the participants.

3.8.4.2 *Subtheme 4.2: Consulting medical practitioners*

Some of the participants stated that the first place they selected for treatment was a medical institution in the hope that their loved one would be assisted there. The following statements were made in this regard:

- *“Treatment ne ke mo tsamaisa ko sepetlela, mo Philadelphia and then mo sepetlela yabane ke iteya ke eng, dilo tsa gage tse nchi ne ke sa kgone go di*

afforda kagobane ga agole le nou. Chelete ya gage gore ke humane mogole ile ya ntshokotsa moebane gore ilabe ka sekehle ke esala morago ka no nna.”

[“For treatment I took her to the hospital in Philadelphia but my problem with going to the hospital was that I could not afford her things and medication because she is not getting her disability grant. My efforts to get her a grant were futile and I ended up giving up trying.”]

➤ *“For treatment re fele re moisa mo klinikeng mo ge re bona okare ga a right.”*

[“When we see that she is not doing well, we take her to the local clinic for treatment.”]

➤ *“Mme sale a motsamaisa ko psychologisteng. After moo bare botsa gore psychologist ya gae ile leave or bjang, mara ra sehlole re bowella ge re utlwa bare gonale skolo se teng mo kgauswi. So ra se kehle re tswela pele ko teng ra no moisa mo sekolong. Ga sena le ina sekolo sa teng. Ke gona sethomang this year and then ba fele ntse ba ba checke. Di social worker sale diatla gona mola.”*

[“My mother took her to a psychologist. We were then told that her psychologist had taken leave and then we never went back as we had heard that there is a school in the area for mentally ill children so we took her there. The school does not have a name yet as it’s newly established this year and their conditions get monitored at the school. Even social workers have been to the school.”]

➤ *“Re mo sepeditse mo di ngakeng tsa sekgowa re bona gore akere bjanong bo mme ne ba lebeletse gore mogong akabe a tsetse mmage. Kagore le mmage ne ale ka mokgo go tloga go goleng ga gage.”*

[“We took her to medical doctors because our mother thought that her condition was genetic as her mother also had a mental illness from birth.”]

The findings indicate that four of the twelve participants consult medical practitioners for the mental illness of their loved one. Viljoen (2006:71) highlights Western doctors as being viewed as a homogenous group capable of treating mental illness effectively. This indicates that more people do believe in the ability of Western treatment for the mental well-being of their loved ones. James and Peltzer (2012:95)

suggest that it is crucial for medical practitioners to be trained to take into account the traditional beliefs of patients and be aware of the significance of such beliefs for patients when assisting them.

3.8.4.3 *Subtheme 4.3: Consulting both traditional healers and medical practitioners*

Some participants consulted both medical practitioners and traditional healers for assistance. Help was either sought first from a medical practitioner, following which a traditional healer was consulted as another option if change was not visible, or the other way around. Some participants stated that consulting both a medical practitioner and a traditional healer was motivated by the fact that they felt that if there was no noticeable change after consulting either one, then possibly the other would be able to expedite their loved one's recovery. The following views were expressed in this regard:

- *“Mo gae bathomile ka go moisha sepetlela gomme kare aowa a ke mo tsiye ke leke sesothong mohlomong ke tla bona ale kaone. Ke bone afole.”*

[“My family started by taking her to the hospital and then I decided to take her and try my luck with a traditional healer in the hope that I would maybe see change and she becomes better.”]

- *“Re ile ko sekgoweng le ko sesothong. Re ile ko go tsona gobedi. ko se sothong ne ke hlohloetsa ke taba ya boloi. ke itha kere batla thusha. So ge re sa kereye thusho ko teng ke ge re tla leka kamo sekgoweng.”*

[“We consulted both traditional healers and a medical doctor. I decided to go to traditional healers because I thought it was because of witchcraft that my child is like this. When I did not get assistance from traditional healers I then decided to try medical doctors in the hope that we would get help.”]

- *“Hai nna ke shiyanne le batho, ga gona le ko ile ka kereya thusho. Le ko sekgoweng g a ka kereya thusho. Akere ka go botsa gore ke ka nako ela ya strike sela sa mathomo, Ne re moisa ga Ndlovu.”*

[“Hai’, I have been to many traditional healers but that did not help. I even went to medical doctors and that did not help either because it was during that time when there was the first strike at the hospitals. We even took him to Ndlovhu’s medical practitioner.”]

- *“Ne keya mogohle, waitse ke tsamaile shem. Ebile ke utlwa bohloko the way ke tsamaileng ka teng. Kegore nna ne ke noya kagore ne kere maybe ke tlo thushega kamo sekgoweng le kamo sesothong o tlo ba right, bjanong ka humana ebane gore ahh vhele olebegwe ale so, akasebe right.”*

[“For treatment I used to go everywhere (both medical doctors and traditional healers). I have been all over, it even hurts when I think about all the efforts I made in the hope that my daughter would get better. I thought maybe she would get better if I try both traditional healers and medical doctors for assistance. However, I got to the realization that she was born like this and would never be okay mentally.”]

- *“Ne ke tsamaya mo go tsa sekgowa and then le tsa Sesotho. Ile wa bona ge otshwere ngwana ba fele ba fele ba go rare hai otlo ba right. Go nale motho kae kae kae, keya koo, wabona. Ke moisa, moabane gore la ma felelo ile g eke fihla koo ntate omong (ngaka ya sesotho) anthare waitse ke eng ngwanake, otlo senyegelwa ke chelete because ngwana o obelege. Otlo kena mo ba go botsa so o kena mo ba go bea so. A re ngwana o obelegwe, ke thlago ya gage kamokgo, wabona.ke ge vhele ke no itsamaela ko sepetlela until le gona bjanong.”*

[“I sought treatment from both medical and traditional doctors. People would always refer me and say ‘gonale motho ko kae kae kae’ who can assist you and I would go there, until one man, a traditional healer advised me and said to me, ‘You know what my child, your child was born like this and you are wasting your money going from person to person because your child was born like this. One person will tell you this and the next person will tell you that.’ He told me that my child was born like that and the best thing was for me to seek medical assistance.”]

The findings indicate consultations with both medical practitioners and traditional healers for assistance. These findings further indicate the measures that people are willing to go to in order to get assistance for their loved one. When they felt they

were being failed as their loved one's condition remained the same, they moved to the next person for assistance. The participants also noted that other people encouraged them to try different options. This corresponds with the view of the ecological system's perspective that systems somehow impact on the development of individuals even though this does not happen directly but rather through the interactions of the different systems (Neal & Neal, 2013:722). Other researchers support this finding: "Traditional healers play a particularly important role in South Africa where one Western-trained doctor may be responsible for nearly 7000 people. It is estimated that there are between 250 000 and 400 000 traditional healers in South Africa compared to 23 000 medical doctors, and eight out of every ten black South Africans rely on traditional medicine alone, or in combination with Western medicine" (Couper, 1997; Keeton, 2004 in Ross & Deverell, 2010:36-7).

3.8.4.4 Subtheme 4.4: Religious perspectives

A number of participants mentioned that apart from other assistance sought, they also sought assistance from churches which are known to specialise in healing. The churches consulted differ in their methods of healing as they make use of religious injunctions specific to their beliefs for healing purposes. In a study conducted by Subudhi ([sa]:137) it was noted that up to 70% to 80% of inhabitants seek help for mental illness from religious organizations. Thara et al. (1998 in Subudhi, [sa]:137) also report that 80% of patients with mental illness are taken to religious healing centres for assistance and healing. The views of the participants in this regard have been captured as follows:

- *"Gore etle e be o mo bjane ore ge obolela le ena le utlwane, ne a re ge abona kgogo mola tse kanyana tse (indicating size of a baby chick), ne ke nna gona moo ke saye felo kemo disa, wa etja o e hloba makola a wa etja entse ele e tala. Ke reya ke makuwa wa di shopo a re nke le tseyeng motho o le mo iseng Stompo kwa, go nale moruti wa ma sione. Moruti o ka mahlatsi a ka le thusha. Ankehle ke rera, ga ke go itsi Stompo, ka topa kubjana ya ka raya stompo ra humana ele kereke baruti ba tletse. Ba mo tshwara ba mo arametsa. Ne a sa ralwadieta a sepela ka maoto lenga la gage ele le le kana, ke ge re tla bona a tseye dieta a di rwala le makouso."*

[“For my child to become better and be able to understand and comprehend when spoken to, I used to stand guard and watch over him. When he would see a chicken this size (indicating size of a baby chick), he used to grab the little chick, pluck out the feathers and eat it while it’s alive and raw. I was advised by a man called Makuwa to take my child to a ZCC priest in a place called Stomp. I did not waste time and took my things and off we went to Stomp even though I did not know the place. When we got to the church, we found a church full of priests who performed religious injunctions on him for healing purposes. He never used to like wearing shoes but after the treatment he grabbed his shoes, put them on and showed immense improvement since then until this day.”]

- *“Bjalo ile ra re re mo isha di thapelong goa se loke.”*

[“We tried to take him for prayer meetings but that did not help as there was no difference.”]

- *“For thusho, ke mo isitse ko go mapostolo, ka moisa masioneng, kena fele ke isa mo ke isang, mara ga go be kaone.”*

[“For assistance I have tried the apostolic church, and then I took him to ZCC church. I keep trying different options but it does not get better.”]

- *“Thusho engwekantle le sepetlela kegore enaba rena akere bjanong re masione, rephetha di taelo, ke tse le tsona ke bonang gore dia mo fokoletsa gona moo. Kagore gona bjanong ga a sa wa nne. Net fela ono bona gore ntho ekeneng mo hlaologanyong yagage kegore tshwanetse gore ge le bolela okereye le boledisana gapila, oseke wa tseya tseyega.”*

[“For other treatment options, apart from medical assistance is that, because we are affiliated to the ZCC church, we use the religious injunctions from church as treatment and that is what is helping to make her better because she is no longer suffering from epileptic fits now. It is just that we always need to be aware of her mental situation and not get ahead of ourselves and let emotions rise when talking to her.”]

- *“Nna ke kgethile gore ke ye le ko kerekeng ela ya ba berekang ka metsi bare ke ko St John ga mme omong ko Lesehleng. Ka gore bolwetsi bo boile ge bo*

mo tswara apharama. Ke fele ke moisa moo, aowa ka bona a emella asepela le kamo (pointing to her mouth to represent speech) go ba teng. Ke kereile thuso mo st John.”

[“I chose to go to that church that uses holy water for healing purposes. It is called St John’s church at some woman’s place in an area called Lesehleng. When the mental illness began, she stopped walking, so I kept taking her to that woman’s church and eventually she was able to get up and walk and her speech began to develop. I got helped by the St John’s church.”]

The findings indicate that some of the participants prefer to seek assistance from religious institutions. There they are given religious injunctions for healing purposes. The religious injunctions mentioned by the participants include holy water, smoke inhalations and special teas and coffees. Some participants believe in the healing ability of injunctions as they noted evidence of change after consulting with religious institutions. Pretorius (2010:543) states that the use of smoke inhalation as a treatment is motivated by the belief that the medicine in the smoke will have a quick entry into the bloodstream and brain as well as also chase away evil spirits. Treatment and interventions for mental illness are said to differ from culture to culture due to differences in beliefs, thus mental illness and culture cannot be isolated from each other (Jimenez et al. 2012 in Subudhi [sa]:135; Scott & Marshall, 2004). The ecological framework, which believes in the interconnectedness of systems, has four main systems. The Church is one of many systems which play a role in the life of individuals. Individuals who are raised to believe in the healing powers of church are conditioned to seek help for ailments from these religious institutions. Some of the participants in the study grew up in families that strongly relied on religious institutions for their well-being. This belief has now been embedded in them and gives them hope for healing for their loved ones. The religious injunctions referred to by some participants are also believed to be effective in healing their loved ones. Social networks such as churches are seen as shaping the development of individuals in the ecological framework (Neal & Neal, 2013:723).

3.8.5 Theme 5: Strategies to support families affected by mental illness

One participant in particular felt challenged by the fact that every time her loved one has an epileptic attack, which she attributes to the mental illness, getting assistance for her is difficult. What follows is a verbatim quotation of her challenges in this regard:

- *“Bokete bo ke banang le bona e beya gore, ge atswere ke bolwetsi bo, ga kena transport yagore ke mo kuke kapela ke moise klinikeng.”*

[“The difficulty which I am faced with is that when the epileptic fits of my granddaughter begin, I struggle with taking her to the clinic as we do not have transport and I am too old to carry her myself.”]

The challenges experienced by families affected by mental illness in the community of Ntwane include financial strain; lack of education for their loved one with a mental illness and the lack of specialised care services from specialists in the field of mental illness. These families are faced with many challenges and in some instances are not aware of the services available to them which could ease the burden of caring for a loved one with mental illness.

The three themes which fall under support strategies for families as identified by the researcher through the transcribing and coding of data collected are discussed below with verbatim statements and support from literature.

3.8.5.1 Subtheme 5.1: Need for a social support system

Several participants in the study stated that they need financial assistance as they are doing their utmost and live in extreme poverty. Some of the participants’ financial problems begin with the difficulties they face in obtaining a disability grant for their loved ones. The views of those participants were captured as follows:

- *“Re ka rata ge re ka thushega ka mogolo wa gage.”*

[“We would appreciate it if we could be assisted with his social grant.”]

- *“Nka thushega ka gore le chelete ya gage ya motente sekehle kegore ntho engwe le engwe ke sokola for yena. Wabona. Kagobane le gona bjanong ena okeno sekolo, chelete ya gage ya grant (child support grant) ga emo afforde for skolo fees sa gage. Ke tseya le ya ba bang ke tlatsa mo skolo feeing.”*

[“I would like to be assisted with getting her grant money so that getting things for her will no longer be a struggle for me because even now, she is in school and her child support grant is not enough to cover the costs of her school fees. I end up having to take the other children’s grant money to help her.”]

- *“Kegore gonabjale ka mo gae re kane rare ga rena bophelo kagore gonabjale mokgalabjwe wa kamo orobetse, re setse re na tshephile mma le ena o ngwana wa geshu. Nna ka golanyana ya ban aba bedi. Mokgekolo o ge asotse agola, ke reka sela le sela le sela diafela and then tlabe re emele ge ba gola gape. Le nna tlabe ka emela di 1 ge di fihla ke ya mallong, wabona. Gonabjale le ngwako ashu, go no setse mo le mo kamoreng, ga ra rulela.tshwanetse re rulele, go felle, re reke di samente, re reke di kota.”*

[“We do not have a good life. Our father died and our mother is alive but is not working. Therefore we basically depend on grants for survival. Poverty is at the forefront of our lives. We live in a half-built house because we cannot afford to finish the house.”]

- *“Akere okereye chelate ge re gotse so oreka tsa gotja and then okereye mola o shota mola, plus re patella le di society akere. Ge setse mmusho a ka re thusha mogong ka tsa gotja mohlomong re ka thushega.”*

[“Money is never enough to cover our basic needs. After getting the grant, buying food and paying societies you find that you have run out of money. If we could be assisted with food it would help us.”]

The findings indicate that some of the participants are burdened financially due to the demands of taking care of their loved one with mental illness. The needs of the individual with mental illness are an added strain for families as they are already living in poverty. Even though most of the families do get the disability grant for their loved ones, the money is seen as not being enough to cover all their needs. A few of the participants are even challenged to get a disability grant for their loved one and

feel that if the application process was simpler it would favour all of them. The financial strain of taking care of a mentally-ill family member is also noted by Quinn (2007:183) where he mentions that 68 out of 80 families in his study indicated that they were financially burdened due to the mental illness of their family member. Caregivers in the study were often in the position of being unable to earn due to having to take care of a family member with mental illness on a full-time basis. The expenses that came with taking care of a family member with mental illness also added to this burden.

3.8.5.2 *Subtheme 5.2: Education for patients with mental illness at government expense*

Most participants indicated the need for the provision of education for their loved ones with mental illness by government. This is viewed as a need because the loved ones with mental illness are seen as having the potential to grow through education in order to make something of their lives and future.

- *“Oho, nna waitse ntho e ke e naganneng gonabjanong, ke naganne gore ngwanaka akene sekolo, a bane le bokamoso ba gage, wabona.”*

[“What I am thinking is that my child goes to school, so that she can have a bright future.”]

- *“Nna ena be ke duma gankebe, goetša le ge ke mo lebelela, ge a ka dira dilo tša dithuto, or adira tšona di computer tše ka gore ga gona selo sa sekolo se semolahlegetšeng. Wa bala sekgowa, wabala ke tsephile ena ge di pampiri di etla ke ena ampalla tšona”.*

[“My wish for him is that he can be educated or maybe even do computer lessons because he is still very much capable of learning and gaining knowledge. He understands English and even reads the newspaper for me”.]

- *“Goya ka rena nkebe ba sa patele ko se kolong kabile ka ge bale baleng gapila basa patele. Ene nna ga ke bereke ka mo lapeng. Re tja yona chelate ya ngwana o. Ena ka bo yena ohloka di aparo le ena ebe opila atshwane le ba bang.”*

[“According to us, these children should not be paying school fees just like children without any disabilities are not paying school fees at government schools because I am unemployed. We survive on his disability grant here at home meanwhile he also has needs which need to be met such as buying clothes so that he can look presentable like other children.”]

- *“Hmmm...because of gona bjanong ba kena sekolong se seng ko dimo kwa...sa tura, so mohlomong ge government baka re tlisetsa sekolo like mohlomong ba rutwa mahala because mo bakenang teng goa tura ene ga rena chelete tseo tsa go ka ba patella koo. Bakereye educationyana ebeterenyana, ba bane le lesedinyana.”*

[The school they go to is very expensive so maybe if the government could bring us a school where they would get taught for free since we do not have money and cannot afford expensive school fees. This would also give them a chance of a brighter future.”]

- *“Sa mathomo thusho yona re lebeletse sona sekolo. Kagore sela re ka sere ke sekolo kagore gashinke se be busy bjago. Ba sa no ba kopantse mo plekeng e one. So ke yona ya mathomo e leng gore ya nyakega. And then legore sekolo sa teng ya se be chelete e ba e patelang enchi eo kagore dilo tse adinyakang le mo gae akere ke tse nchi. Kagore ka kgwedi tshwanetse re ntshe R500 ge ehlakana le ya transport.”*

[“Firstly, we are hoping we can be assisted with a school for children with special needs because the one in this area is not really functioning well. Children with different special needs have all been put together in one class. Secondly, we would appreciate if the school is not as expensive as the one we are paying now because her needs here at home are also a lot. We have to pay R500 school fees every month at that school with transport included.”]

The findings indicate that education for individuals with mental illness is needed in the community. Most participants noted the need for an education for their loved one. The cost of special schools is an obstacle to education for their loved ones which should be explored. The participants relayed their wish that government provide a school for mentally-ill individuals and people with other special needs. The

participants emphasised that the costs to parents should also be affordable or free as the participants noted unfairness in the fact that ‘normal’ children are afforded opportunities for free education, hence the same should be done for learners with special needs such as the mentally ill. People with mental illness are said to often be denied opportunities in obtaining education because of the misconceptions that people have regarding their ability or inability to learn and be educated (Bellomy & Mowbray, 1998:402). This is evident in the study population where people with mental illness are kept at home and there is no local school which focuses on the education of people with special needs such as the mentally ill. It appears that communities have been conditioned to believe that people with mental illness are incapable of being educated due to their mental state of being. This could be explained by the ecological systems theory because this is a common belief which could be motivated by the culture of the individuals.

3.8.5.3 *Subtheme 5.3: Need for specialised mental health services*

A few of the participants identified the need for specialised mental health services with specialists in the field to assist their family members and hopefully give them treatment that would enhance their well-being and their ability to function better in everyday conditions. The following statements were noted in this regard:

- *“Hai man, nna ne ke nagana gore a nang ge nka humana di doctor tse kgolo tse di tsebang ka malwetsinyana agore motho ge a sa itekanela ba ka thusha.”*

[“Hai man’ I think that maybe if we could find a specialist that specialises in illness where a person is mentally ill they could be able to help us.”]

- *“Nna se seka gobateng mo go ena ke go ragore ba mofe dihlare tsa gore aphele gapila and then se seng gape abane le ngwana kagore bjanong akere bao bona ga ba ba lese. Mothwana ena onale ena, net ga ana bana. Akere ge afodile otle bana le bana.”*

[“For me what would help is if she could be assisted with medication that helps balance her mental state of being so that she can lead a productive life and have children of her own because she does have a boyfriend; it is just that she does not

have children. Isn't it that if she is healed by the treatment, then she can have children."]

The findings indicate that a few of the participants recognize that with access to specialised services in the field of mental illness, the mental well-being of their loved one could be enhanced. In a study conducted by Viljoen (2006:71) psychiatrists and medical doctors were noted as possessing the capability to treat mental illness effectively and thereby enhance mental wellness. When looking at this belief from an ecological system's perspective, it indicates the faith that people still have in medical practitioners as they grow up going to them for treatment. Hence consulting traditional healers is not the only treatment option people have faith in due to their culture and upbringing.

3.9 SUMMARY

In this chapter, the empirical findings of the study were presented and discussed. The ethical considerations were also discussed as well as the trustworthiness of the study. Data gathered through semi-structured interviews was transcribed, read thoroughly and coded in order to identify themes. Five main themes were identified and a total of 15 sub-themes emerged from the main themes. The five main themes which emerged are: general understanding of mental illness; perceived causes of mental illness; cultural beliefs about mental illness; treatment sought regarding mental illness; as well as, strategies to support families affected by mental illness. The themes and sub-themes that emerged were based on the verbatim statements of participants from the transcripts of the interviews. These statements were substantiated through direct quotations with the integration of literature where appropriate.

Conclusions and recommendations of the study will be presented in the following chapter.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The following chapter seeks to discuss the findings of the study. It aims to explain the extent as well as how the goal and objectives of the study were achieved by the researcher. The key findings of the study will also be highlighted and presented followed by conclusions drawn from the study. Finally, recommendations are made based on the key findings and conclusions of the study.

4.2 GOAL AND OBJECTIVES OF THE STUDY

The goal of the study was to explore and describe the cultural beliefs of families affected by mental illness from the perspectives of caregivers. The research question and research sub-questions on which the study is based are as follows:

- What are the perspectives of caregiver regarding the cultural beliefs of families affected by mental illness?

The following sub-research questions informed the main research question:

- How do these cultural beliefs influence the manner in which mental illness is viewed?
- How will these cultural beliefs influence the choice regarding treatment options?

The goal of the study was reached through the achievement of the following four objectives.

4.2.1 Objective 1

Objective 1 was to describe culture and mental illness from an ecological system's perspective. It was achieved in an in-depth discussion in chapter two (section 2.2). In chapter one (section 1.2), the theoretical framework was briefly discussed as an

introduction to the topic. In addition, it was addressed in section 2 of the empirical findings of the study in chapter three (section 3.7) where it was incorporated into the findings from the discussion of the key themes. The main focus of the ecological systems theory is on the systems involved in the development of individuals. Although there are five systems, focus was placed on four of them, namely the microsystem, mesosystem, exosystem and macrosystem. These systems are said to be interconnected in the way in which they impact on the development of an individual, whether directly or indirectly.

The ecological systems theory is central to culture and mental illness as it considers the influence of systems on perceptions regarding issues such as mental illness. People are born into families; those families are part of a community which has its own set of values and beliefs. These norms, values and beliefs guide the development of individuals in the community both directly and indirectly through interactions with other systems in the community. In the study, most of the participants viewed mental illness from a cultural viewpoint. Medical as well as religious viewpoints are present but not as significantly as the cultural perspective. Participants are, however, not aware of the influence their culture might have in the way they perceive mental illness. To them their perceived reality is experienced as being real.

4.2.2 Objective 2

Objective 2 was to explore the cultural beliefs regarding mental illness in the affected families. The objective was addressed in the empirical study in chapter 3, section 3.9.3, sub-sections 3.9.3.1; 3.9.3.2; and 3.9.3.3 under the heading cultural beliefs regarding causes of mental illness. The participant's cultural beliefs differ in that some believe the causes are related to witchcraft, others as punishment from the ancestors for failing to appease them, as well as the use, or failure to use the herb called 'stuij' for young children. Most participants believe that if a person is not born with a mental illness, then it is caused by witchcraft; it does not make sense to them that a mental illness could simply develop in an individual who is in perfect mental health. There were also claims of people being used as zombies after having been bewitched. Some participants believe that the bewitchment of their loved one, which

resulted in the mental illness, was due to punishment meted out by the person controlling the bewitchment, for perceived wrongdoing. Epilepsy, which the participants referred to as '*bolwetsi ba gowa*' was seen as the most likely cause of mental illness after witchcraft. Supernatural forces such as walking over an area where lightning had previously struck was also seen as the cause of mental illness

4.2.3 Objective 3

Objective 3 was to explore how the choice of treatment of mental illness is affected by these cultural beliefs. The above objective was addressed under theme 4 of chapter 3, section 3.9.4, more especially in sub-theme 1 (sub-section 3.9.4.1); sub-theme 2 (sub-section 3.9.4.2); sub-theme 3 (sub-section 3.9.4.3); and in sub-theme 4 (sub-section 3.9.4.4). The findings indicate that the participants in the study seek treatment from either medical practitioners, traditional healers or from medical practitioners as well as traditional healers. Some of the participants followed the religious perspective and sought treatment from different churches.

The participants stated that seeking help from both disciplines (medical and traditional perspectives) was motivated by their need to try anything in the hope that their loved one could be healed of the mental illness. The other participants saw no link between their culture and them choosing to seek assistance from traditional healers first and then going to medical practitioners as a second option in the hope that because traditional remedies and religious injunctions had not worked, then possibly medical treatment might help their loved ones.

4.2.4 Objective 4

Objective 4 was to find out how services that are provided to families affected by mental illness can be improved. This objective is addressed in chapter 3 of the study, where participants' verbatim suggestions to improve service are noted. These recommendations are discussed in section 3.9.5 of section 2 of the empirical findings of the study in sub-sections 3.9.5.1, 3.9.5.2 and 3.9.5.3. The main strategies for improvements should be implemented in the following areas:

- Provision of social support systems for families affected by mental illness;

- Education of mentally-ill individuals at the government's expense or at the very least at a more affordable price; and
- Specialised mental health services to mentally-ill individuals in order to enhance their mental state.

4.3 KEY FINDINGS OF THE STUDY

The key findings of the study and conclusions will be presented by the researcher in sequence.

4.3.1 Perceptions of mental illness

The findings of the study indicate that mental illness is mostly perceived through cultural and medical perspectives. Although medical factors, such as stress, illness and epilepsy were noted as causes of mental illness, the researcher detected the fact that culture has an influence on attitudes to it from other reasons given for its causes. For example, most participants noted bewitchment as a cause since this is a phenomenon common to them from childhood. This supports the perspective of the ecological systems framework which emphasises the impact of systems on the development of individuals, whether or not they are directly or indirectly linked to the individual.

4.3.2 Causes of mental illness

The findings indicate diverse views by the participants on the causes of mental illness. Epilepsy, stress, medical negligence, genetics, witchcraft, ancestors as well as supernatural forces were noted as causes of mental illness.

4.3.3 Cultural beliefs regarding mental illness

The findings revealed that there are cultural beliefs regarding mental illness within the community of Ntwane. These beliefs stem from the view and beliefs that mental illnesses are caused by witchcraft; interacting with a child wearing a 'stuij'; supernatural forces, such as walking in an area where lightning had struck and jumping over a snake sent by a 'witch' as well as punishment from ancestors for failing to appease them.

4.3.4 Financial challenges

Findings from the study have revealed that families with a loved one with mental illness face great financial challenges due to the needs of this individual, as well as being poverty-stricken. This indicates that the families are challenged and disadvantaged economically.

4.3.5 Family functioning

The findings reveal that families with mentally-ill loved ones have a lifelong responsibility of taking care of that loved one as in most cases it appears that they are unable to take full care of themselves or think for themselves. The functioning of the family mostly revolves around the needs of the mentally-ill individual.

4.3.6 Causes other than cultural beliefs

The findings of the study indicate that some of the participants believe that the mental illness of their loved one was caused by medical negligence during birth; illness and disease; stress and abuse; genetic inheritance from a mentally-ill mother; as well as simply being ‘born like that’ as opposed to causes attributed to their cultural beliefs.

4.3.7 Type of assistance sought

The findings have revealed that after realising that a family member is suffering from a mental illness, the family seeks assistance from a traditional healer, a medical institution and/or a religious institution. Some participants seek help from both traditional and medical institutions. The study indicates that most participants hold strong cultural beliefs because they first approach a traditional healer for assistance, after which medical practitioners and religious institutions are consulted.

4.3.8 Treatment at a state institution

The findings indicate that challenges are experienced with regards to obtaining treatment for loved ones from state medical institutions in their area. Their

impoverished financial status also increases the challenge encountered in receiving regular treatment as the local hospital is some distance away from their homes.

4.3.9 Support from state institutions

The findings indicate that families of people with mental illnesses feel that they do not receive enough support from government with regards to the well-being of their loved ones. There is no form of community education with regards to mental illness. Cultural beliefs held about the onset of mental illness inform the community's negative reactions to individuals with mental illness and are accompanied by an attitude of fear towards them.

4.3.10 Role of community

The findings also indicate that despite the negative reactions to individuals with mental illness, community members do play a supportive role by giving advice to families with individuals with mental illness and suggesting alternative ways of obtaining help.

4.3.11 Role of education

The findings also reveal the need for the provision of education for the individuals with mental illness, based on their needs. This was emphasised by most of the participants as they felt that their loved ones had the potential to learn and make something of their lives. The high fees charged at the only available school are a concern and the need for a free or affordable school provided by the state was noted.

4.3.12 Range of support required

The findings include strategies to support families of individuals with mental illness as follows: implementation of an education system in the area which accommodates the needs of individuals with mental illness at an affordable price or at state expense; need for social support as they are struggling financially and are poverty-stricken; and provision of specialised mental health services for the improvement of their loved ones' well-being.

4.4 SUMMARY OF FINDINGS

In summary, the overall findings of the study indicate that the cultural beliefs of families in the community regarding mental illness are based on the perception that witchcraft, punishment from the ancestors and supernatural forces, such as walking in an area where lightning has struck, have led to the mental illness of their loved ones. The study's findings confirm the suspicions of the researcher that a relationship exists between the participants' view of mental illness and their culture. The findings of this study also confirm those of studies conducted by Viljoen (2006) and Subudhi [sa] and Quinn (2007), who find that the influence of culture on attitudes to mental illness is pre-eminent with witchcraft being viewed as its cause. In addition, poverty also seems to be at the forefront for these families. The participants indicated the need for greater financial assistance or even to simply be given a disability grant for their loved one, something it has proved well-nigh impossible to obtain.

The findings propose strategies to support families with a member with mental illness, for example, the provision of a free or more affordable education system for the mentally-ill person, the provision of specialised mental health services to enhance the well-being of this family member, as well as economic support to the specific family to alleviate the financial burden of meeting the demands of having a family member with special needs.

4.5 CONCLUSIONS

The conclusions to the study are derived from literature consulted during the literature review as well as from the empirical research findings of the study. They are discussed in the following sections.

4.5.1 Cultural and medical perspectives

It can be concluded that mental illness is mostly understood and perceived through cultural and medical perspectives. The cultural perspective is supported by the ecological systems' perspective which views individuals as part of the environment in which they grew up. That environment has its own set of norms, values and belief

systems, which guide the development of individuals and hence their beliefs and perceptions of the world.

4.5.2 Causes of mental illness

The researcher concludes that there is no common understanding of the causes of mental illness because of the diversity of views expressed by the participants on this aspect. It is therefore important that the knowledge gap be bridged by educating the community on mental illness, its causes and mental health as a whole, in order to promote mental awareness and wellness within the community.

4.5.3 Cultural beliefs regarding mental illness

The researcher concludes that cultural beliefs play a role in defining mental illness within the community of Ntwane even though the participants believe that their views are not influenced by culture but are rather based on their experiences of growing up in the community.

4.5.4 Choice of treatment

The researcher concludes that the cultural beliefs of families regarding mental illness affect the choice of treatment sought for their loved ones, as well as the lack thereof.

4.5.6 Community education

The researcher concludes that with the advancement in knowledge on mental illness through community education, more people in the community should be aware of the most appropriate place to seek help. As a result, they would be encouraged to seek medical assistance for their loved one's mental state. Social workers have a vital role to play in community education regarding mental illness. An educated community will make wiser and more informed decisions regarding the mental wellness of their loved ones.

4.5.7 Education

The research concludes that there is a need for a school that caters for the needs of the individual with mental illness but is also affordable or free as most schools for the mentally well are. Individuals with mental illness should be provided with the same fair opportunity to develop themselves through education and in the expectation of developing their talents and improving their future. The view that the individuals with mental illness do not need an education should be addressed as some of those individuals have been described by their families as being intelligent and capable of learning.

4.5.8 Social assistance

The researcher concludes that if social assistance were provided to families, the financial strain of taking care of an individual with mental illness would be lessened. Because the responsibility of taking care of a loved one is often on a full-time basis, strategies of financial relief should be implemented focussing on the empowerment of caregivers by enabling them to generate an income without neglecting their loved one with mental illness. Dependency, through the provision of grants as the only solution, should be discouraged.

4.5.9 Life-long responsibility

It can be concluded that families with loved ones with mental illness have a life-long responsibility of taking care of the individual. This limits life opportunities for them as they always have to consider the needs of their loved ones before they can consider their own needs, which is a strain for them.

4.5.10 Medical facilities

It can be concluded that the availability of specialised mental health medical facilities that are within the reach of community members are needed.

4.5.11 Community support

Despite a lack of knowledge and negative reactions to mental illness, community support does exist to a certain extent. Individuals provide each other with support by offering advice on alternatives when families require assistance with a loved one with mental illness. Support programmes are limited in scope and should be further developed. Social workers can then be responsible for providing these programmes.

4.6 SUMMARY OF CONCLUSIONS

It can be concluded that each culture has its own values and beliefs which guide the development of individuals. This is explained by looking at the ecological systems' perspective, which views the individual as being part of many different systems. Although these systems may not interact directly with each other, they do affect the focal individual in some way or other through his/her interaction with all other systems. The influence of culture on views regarding mental illness is seen in the descriptions of mental illness and its causes as being related to bewitchment, ancestors and supernatural forces. This view is a reality to the participants in the study. Programmes which aim at removing existing negative views and misconceptions about mental illness should be implemented. There is an urgent need for community education provided by social workers as well as the educating of families on what mental illness entails, the varieties of mental illness, as well as the treatment options available. The needs of families affected by mental illness should be investigated as they have first-hand experience of the situation.

4.7 RECOMMENDATIONS

The following recommendations have been compiled based on the key findings as well as the conclusions of the study

4.7.1 Educating families and community members on mental illness

The provision of community education is seen as the first and most vital step in the improvement of the lives of individuals with mental illness and of their families. With community education, the negative views held as a result of a lack of knowledge

would be addressed; and the correct and most relevant treatment would then be sought for individuals with a mental illness.

4.7.2 Social support system to enhance economic well-being of families

Most of the participants, when asked about support strategies to improve their lives and the lives of their family members and loved ones with mental illness noted the need for some level of financial assistance. Despite the fact that most families receive a child support grant (CSG) and disability grant (DG) for their loved ones, they remain poverty-stricken and lack sufficient money to meet all their needs. The researcher does not believe in creating dependency but rather on empowering individuals to use what they have in order to find a way to enhance and maintain an adequate lifestyle. Having a vegetable garden could, for example, decrease expenses as less food would be bought. The development of social support systems, therefore, needs to be investigated in order to enhance the well-being of families by means of their own involvement. Social workers have also a big role to play in this regard. It falls under community development and can assist the study community.

4.7.3 Development of affordable or free education system

Most participants felt strongly that their loved ones should be provided with some sort of education. The participants mentioned the difficulties they experience with regards to the education of their loved ones with mental illness. Special schools for individuals with mental illness are expensive and distant from their homes. There is only one new school in their area, which awaits development and is too expensive for the participants. The participants consider that the government could do its part by assisting them with a special school for their relatives with mental illness. Moreover, they noted a lack of fairness by the government in failing to provide free education for their children with mental illness as is the case for mentally-well children at local schools.

4.7.4 Specialised mental health services

Specialised mental health services from specialists in the field accompanied by the right treatment are seen as a need by a few of the participants in order to enhance the mental well-being of their loved ones. An institution, akin to what most cities in Gauteng have (Weskoppies being one perfect example), is needed in the area

where individuals with mental illness can receive care from specialists in the field in order to have the best treatment that could improve the well-being of people with mental illness in the area. Social workers form part of the multidisciplinary team assisting individuals with mental illnesses at such institutions.

4.7.5 Further research

There is a need for further research to be conducted in this small, unknown village of Ntwane. People should be made aware of the existence of this cultural group and learn about their culture and beliefs in order to encourage change and growth in its inhabitants. Further research is needed in order to enable the development of programmes that directly address the needs of these community members, needs that they themselves have identified.

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APPENDIX 1

SEMI-STRUCTURED INTERVIEW SCHEDULE FOR CAREGIVERS

Goal of this study

To explore and describe cultural beliefs of families affected by mental illness, the perspective of the caregivers.

BIOGRAPHICAL DETAILS OF THE PARTICIPANTS

1. Age

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2. Gender

Female		Male	
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3. Marital status

Single		Married		Divorced		Widowed		Living with partner	
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4. Language

Sepedi	Setswana	SeSotho	Ndebele	Northern Sotho (Sentwane)	English	Afrikaans	Other, specify
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5. Education level

No education		Primary education		Secondary education		Tertiary education		Other, specify	
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6. Number of dependants

1-2		3-4		5-6		7-8		9+	
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7. In which hospital does your loved one get treatment?

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8. How many years are you caring for your loved one?

< 1 yr.		1 yr - 5yrs		6 – 10yrs		11 -15yrs		16 -20yrs	
21 - 25 yrs.		26 – 30yrs		31– 35yrs		36– 40yrs		40 yrs.+	

MENTAL ILLNESS

1. What is your understanding of mental illness?
2. What do you think are the causes of mental illness?

CULTURE AND MENTAL ILLNESS

1. What are your cultural beliefs with regards to the causes of mental illness?
2. How do your cultural beliefs influence the way you view mental illness?

TREATMENT

1. Explain the treatment you sought for your loved one?
2. Have you consulted the traditional healer or a medical doctor regarding the condition of your loved one?
3. Explain how your cultural beliefs influenced the treatment option you chose for your loved one.


RECOMMENDATIONS

What are your recommendations regarding services provided to families affected by mental illness?



APPENDIX 2:

BANTWANE TRADITIONAL COUNCIL



25 MOSHATE SECTION NTWANE VILLAGE DENNILTON 1030	KGOŠI M.P. MATHEBE 02-12-2014 BANTWANE TRADITIONAL COUNCIL PO BOX 401 DENNILTON 1030	P.O. BOX 401 DENNILTON 1030 072 837 0794 072 129 7263
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TO WHOM IT MAY CONCERN,

Sir,

RE: PERMISSION TO CONDUCT RESEARCH IN THE COMMUNITY OF NTWANE
FOR MRS. LEBOGANG M. MATLALA: 26217482.

This serves as a confirmation that the above mentioned Mrs. L.M. Matlala with student number: 26217482 has been given permission by the Bantwane Traditional Leaders to conduct a research study in the Ntwane community. The title of her study is as follows; the cultural beliefs of families affected by mental illness. The perspectives of caregivers.

The goals and objectives of the study have been clearly clarified by the researcher.

Kind regards,

Yours,



KGOŠI
M.P. Mathebe



APPENDIX 3



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

31 August 2015

Dear Prof Lombard

Project: The cultural beliefs of families affected by mental illness: the perspective of caregivers
Researcher: L Matlala
Supervisor: Ms N Bila
Department: Social Work and Criminology
Reference number: 26217482 (GW20150816HS)

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** on 27 August 2015. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Karen Harris
Acting Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: Karen.harris@up.ac.za

Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

Research Ethics Committee Members: Prof KL Harris (Acting Chair); Dr L Blokland; Dr JEH Grobler; Prof B Hogmeyer; Ms H Klopper; Dr C Panebianco-Warrens; Dr C Puttergill; Prof GM Spies; Dr Y Spies; Prof E Taljard;



APPENDIX 4

Date: _____

INFORMED CONSENT FORM FOR CAREGIVERS

Title of the study/ Hlogo mabapi le nyakišišo:

The cultural beliefs of families affected by mental illness; the perspectives of caregivers

Researcher / Monyakišiši: Lebogang Millicent Matlala

Contact details / Di nomoro tša mogala: 083 667 3031/ 013-932 9952

Purpose of the study / Maikemišetšo a di nyakišišo:

Is to explore and describe caregivers' perspectives on the cultural beliefs regarding mental illness of families affected by mental illness. / Go nyakišiša le go hlaološa ka ga karolo ya setšo go bolwetše ba monagano gotšwa go ba hlokamedi ba motho wa go lwala ka monagano.

Procedures / Lenaneo:

I will be asked to partake in an interview which will be conducted at **my home in Ntwane village** and the duration will be sixty (60) minutes. The interview will be tape recorded with my permission. / Ke tlo kgopelwa go tšia karolo go di nyakišišo tše di tlo go swarelago ko motseng waka mo Ntwane. Di potšišo di tla tšia metsotso ekabago masome a tshelago (60). Di nyakišišo di tla gatišwa goya ka tumello ya ka.

Risks and Discomfort / Di tsietsi le go kokonelwa:

The interviews will be conducted in a safe secure environment. Any information provided during the interviews will be treated confidentially. I will not be required to furnish my personal details or particulars. I am aware that if I need counselling as the result of this interview I will be referred to a social worker. As a caregiver, I will be eligible to give consent on behalf of the patient if he or she is unable to consent for the interview. / Dinyakišišo di tla swarelwa lifelong le le bolokegilego. Seo setla bolelwago ka dinyakišišo se tla bolokwa ele siphiri. Ga ke tlo gapeletswa go hlagisa di taba tša ka tše di bohlokwa. Kea lemoga gore ge go nale bohlokwa ba go thobiwa maikutlo ka le baka la nyakišišo tše, ke tla romelwa go ba direla leago. Bjalo ka motšea karolo, ke neelana ka tumello yaka gore ke tšee karalo dinyakišišong.

Benefits / Dipolelo:

I will benefit from the research in the long term if the mental health services are improved as a result of this study. / Ke tla boelwa go tšwa go di nyakišišo nako eteletšana ye e tlogo ge di tirelo tša maphelo a tša monagano le tša thuto yagona di ka kaonafatšwa ka lebaka la dinyakišišo.

Department of Social Work & Criminology
University of Pretoria
PRETORIA 0002
Republic of South Africa

Tel: Number 00 27 12 420 2325/2030
Fax: Number 00 27 12 420 2093

www.up.ac.za

Participant's Rights / Ditokelo tša motšia karolo:

My participation in the research is on a voluntary basis. I may, if I wish to withdraw at any time that I want to or prefer. Upon my withdrawal, the information I provided for the research will be destroyed. /

Go tšia karolo g aka dinyakišišong ga go gapeletšege. Nka ikogela morago nako engwe le engwe ge ke rata. Ka go ikogela morago ga ka, ditaba tšeo ke ba filego tša dinyakišišo ditla lahlwa.

Confidentiality / Sephiri:

All information gathered for this research will be treated confidentially. The researcher and her supervisor will have access to the information. The thesis will be compiled reflecting the research results and my name will not be mentioned. I am aware that the researcher will use numbers or a letter of the alphabet in the report and this will enhance the confidentiality. / Se setla bolelwago dinyakišišong se tla bolokwa ele sephiri. Monyakišiši le mookamedi wa gage batla kgona gofihlella dinyakišišo. Monyakišiši a ka se hlagiši leina la ka dinyakišišong. Kea tseba gore monyakišiši otlaberekiša di nomoro goba di tlhaka go netefatša sephiri.

Data storage / Go boloka ga dinyakišišo:

I am aware that the collected data will be stored for 15 years at the Department of Social work and Criminology according to the policy of the University of Pretoria and when necessary may be used for future research. / ke ya tseba gore ditaba tše di tšerego mo dinyakišišong di tlo bolokwa mengwaga e lesome hlano ko Lefapheng La Tša Leago Le Tša Dikgolego go ya ka lenaneo (policy) la Yunibesithi ya Pretoria. Ge go hlokega, dinyakišišo di tla berekišwa go dinyakišišo tše di tlogo kapetšiana.

I understand my rights as a research participant, and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being conducted. /

Nna, ke kwišiša ditokelo tša ka tša gotšia karolo, gomme ke neela ka tumello ya ka kante le kgapeletšo gore ke tšie karolo dinyakišišong. Kea kwišiša gore dinyakišišo di mabapi le eng le mohola wa tšona.

Participant/ Motšia karolo:

Date/ Letšatši:

Signature:

Researcher/ Monyakišiši:

Date/ Letšatši:

Signature: