Culture and help-seeking behaviour in the rural communities of Limpopo, South Africa: unearthing beliefs of mental health care users and caregivers

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Abstract

The study employed a qualitative approach to explore the cultural beliefs of mental health care users (MHCUs) and caregivers regarding help-seeking behaviour in the rural communities of the Limpopo Province, South Africa. Forty participants were interviewed, comprising 30 MHCUs and 10 caregivers. Mental illness was ascribed to witchcraft (*uvuloyi*) and help was mostly sought from traditional and religious healers as the first steps on the path of help-seeking, whereas Western forms of care were usually considered as a last resort. The factors found to influence help-seeking behaviour amongst the participants included lack of knowledge regarding mental illness; traditional beliefs; stigma and discrimination; and the side effects of the antipsychotic medication. The study suggests the importance of psychoeducation for caregivers and the community regarding mental illness and cultural competence in serving communities with cultural beliefs about mental illness. Media platforms should be utilised to raise public awareness. The study also suggests collaboration between different stakeholders working with MHCUs.

Keywords: Cultural beliefs; mental health; help-seeking behaviour; caregivers; mental health care users; traditional healing; spiritual healing; witchcraft

Introduction

South Africa is a country of diverse cultures. These cultures may influence the causative beliefs, and consequently, the help-seeking behaviour of mental health care users (MHCUs) and their caregivers. Vergunst (2018, p. 2) asserts that "the health status of rural people in SA is similar to that of people in many developing nations around the world" and access to mental health services in rural communities is problematic, due to a lack of resources, the high cost of transport, and massive distances that contribute to late presentation to mental health facilities. This is further exacerbated by traditional beliefs regarding illness; unregulated traditional healers of various levels of experience and skill make their services available to somewhat fearful and tradition-bound members of the public in rural areas (Vergunst, 2018). This is confirmed by Gaede and Versteeg (2011, p. 99), who assert that rural communities in SA experience "significant barriers to accessing healthcare", including financial barriers, inadequate transport, and distance to the nearest facility, as well as limited resource availability.

In the mental health context, help-seeking “is an adaptive coping process that is the attempt to obtain external assistance to obtain external assistance to deal with a mental health concern” (Rickwood et al., 2012, p. 180). Help can be pursued from a variety of outside sources, including people who play various roles and have varying relationships. Formal and informal help-seeking have been delineated, with formal help-seeking referring to assistance from professionals who have a legitimate and recognised professional role in providing relevant advice, support, and or treatment, and informal help-seeking referring to assistance from informal social networks such as friends and family (Rickwood et al., 2005). The availability of established and trusted help-seeking paths is one of the most important variables in the help-seeking process. Besides, previous African studies have identified reasons why people do not seek health care when they suffer from a mental disorder, such as a lack of ability to recognise that the illness is a treatable disorder and beliefs that they will recover without treatment, a lack of knowledge or embarrassment, and beliefs that the mental disorder is a somatic illness (Okello & Neema, 2007; Trump, 2006; Seedat et al., 2002). According to Labys et al. (2016), the issue of help-seeking behaviour is inextricably linked to the issue of causal beliefs and insight of illness. Any efforts to untangle the complexity of help-seeking behaviours should include an examination of the beliefs that underpin and guide behavioural choices.

Help-seeking is a predictor of the first event of mental disorder, and caregivers play an important role in deciding who to ask for help (Marchira et al., 2016). Family caregivers are often the first to know that a person is beginning to show symptoms of psychosis (Marchira et al., 2016). Moreover. the family caregivers interpret the illness, they are usually the first to seek help and constitute the “therapy management group”. How family caregivers choose the first visit to a care provider during the first episode of psychosis, may be important in determining the course of treatment a patient receives and thus the duration of untreated psychosis (DUP) (Marchira et al., 2016).

Various studies have discovered that negative attitudes towards mental illness affect forms of help-seeking behaviour. A study conducted in Nigeria by Chikomo (2011) showed that negative attitude was intensified by lack of knowledge on mental illness. Likewise, the study revealed that some people believe that mental illness occurred as a result of possession by an evil spirit, curse or witchcraft. In Malaysia, a study conducted by Khan et al. (2011) exposed that people equated mental illness to evil possession. Moreover, their study discovered that other beliefs that facilitate treatment outcomes include the perception that persons with mental illness are unpredictable, abnormal, violent, and dangerous and unable to benefit from psychiatric treatment. These attitudes are known to affect the help-seeking behaviour of persons associated with mentally ill patients (Khan et al., 2011).

Traditional beliefs and practices regarding illness and health are still extensively followed in rural communities of South Africa (Moletsane, 2004). These beliefs and practices form a coherent system that has maintained individual and social equilibrium for generations (Louw & Edward, 1993). Amidst the differences across cultures and ethnicity in Africa, there remains a general belief that diseases are sourced from external causes such as: “a breach of a taboo or custom, disturbances in social relations, hostile ancestral spirits, spirit possession, demonic possession, evil eye, sorcery, natural causes, and affliction by God or gods” (Nwokocha, 2010, p. 4). Crawford and Lipsedge (2004) highlighted that Zulu people in

South Africa found Western Medicine useful for treating physical illness since many mental health problems were considered to be understood only by traditional healers from their own culture. Sandlana and Mtetwa (2008) assert that traditional medicine is the oldest form of indigenous African medicine and other methods based on the belief, attitudes, knowledge of culture, and religion prevalent in the community regarding physical, mental, social wellbeing, and causation of the disease and disability. More so, traditional medicine is the form of structured healing that focuses on both the physical and mental parts of illness (Motau, 2015). Traditional healers also use their knowledge to diagnose, prevent, and treat mental, physical, and social imbalances. The knowledge is based on previous experiences and observations that have been passed down verbally or in writing from generation to generation. As a result, the traditional treatment emphasises the balance of the body and mind, making it an integrated and comprehensive approach to healing. Traditional healing is widely criticised for its lack of scientific proof and standardised prescriptions, even though it is the oldest type of systematic healing. This practice has been labelled as evil and un-Christian, and it should be prohibited (Phatlane, 2006). This may have influenced a big number of people to have mixed feelings about traditional healing. People oppose it in public, yet some of them visit traditional healers behind closed doors (Sandlana & Mtetwa, 2008).

Many African communities continue to practice traditional healing despite criticism and injustice. In South Africa, there are over 200,000 traditional healers compared to 25,000 Western medicine doctors, and traditional healers are used by 80% of black people (Motau, 2015). Traditional healers are fuelled by a deep belief in their community's mission to help others (Sandlana & Mtetwa, 2008). Some Africans believe that certain diseases are caused by sorcery, black magic, or witchcraft rather than by normal causes. It is widely believed that persons who have been charmed will die if they do not seek help from traditional healers. As a result, Motau (2015) explains three principles that traditional healers follow. To begin with, the symptoms of the patients are taken seriously rather than being criticised. The patient is allowed to communicate his or her anxieties. Secondly, the healer examines the sufferer, both physically and mentally. Finally, the patient is seen as an important member of the family. Traditional healers are vital members of their community and their cultural milieu, and they are familiar with the ways of the people. Consequently, this understanding helps to create a therapeutic environment for the patient, allowing the individual to be better understood and heal.

The present study focuses on schizophrenia, as this mental disorder is prevalent in the Limpopo Province of South Africa, especially in the Mopani and Vhembe districts, and is one of the most stigmatised mental disorders, creating a vicious cycle of social discrimination and a breakdown in the social network of sufferers (Rössler et al., 2005). The authors of the present study have noted that diverse studies have been conducted regarding mental illness and help-seeking behaviour within the global context. However, no studies have been conducted in Limpopo Province about the cultural beliefs of MHCUs and caregivers regarding help-seeking behaviour. Hence, the authors were inspired to conduct the present study, based on mixed methods, with a qualitative and quantitative phase for a doctoral study (Bila, 2017). The first author is the principal investigator, and the second author is the co-investigator. The qualitative phase will be reported here.

Methods

Research approach and design

This study was located within a qualitative phase and research paradigm, as it reflected the thoughts, feelings, and experiences of the participants as closely as possible, sharing issues and concerns characteristic of cultural beliefs regarding mental health help-seeking behaviour (Bila, 2017). The research purpose was exploratory–descriptive (Rubin & Babbie, 2017), as the purpose was to understand and provide richer details of how MHCUs and caregivers perceive the cultural influence on help-seeking behaviour in the rural communities of Limpopo Province, South Africa. A collective case study design was implemented to involve multiple cases over some time.

Population and sample

The study utilised non-probability purposive and snowball sampling (De Vos et al., 2011) to select 30 MHCUs and 10 caregivers of MHCUs, respectively. The reason for selecting two groups of participants was to establish the possible differences and similarities in their cultural beliefs and whether they identified the same barriers to accessing mental health care services, as well as to understand the decisions caregivers made on the help-seeking path of the MHCUs.

The 30 MHCU participants were all Africans of Tsonga ethnicity living with schizophrenia and were inpatients in three mental health facilities providing Life Care specialised mental health services in the Mopani and Vhembe districts, Limpopo Province, South Africa. Ten participants were selected from each of the three hospitals where they were admitted, namely, Hayani Psychiatric Hospital, Evuxakeni Psychiatric Hospital, and Shiluvana Psychiatric Care Centre (i.e., 3 × 10 = 30) to enhance triangulation. The inclusion criteria of the purposive sampling for MHCUs were: a confirmed schizophrenia diagnosis; aged 20 years or older; and capable of participating in an interview, which was determined by the social workers who assisted in recruiting potential participants. Sadly, during the time of the interviews, most of the participants' families were not involved in their lives and had abandoned them in the hospitals.

The 10 caregiver participants sampled were all Africans of Tsonga ethnicity from a rural village in Malamulele, Vhembe District, LP. The initial plan to recruit caregivers of MHCUs at the same three hospitals failed, as the caregivers were either not visiting or had abandoned the MHCUs in the hospitals. A nurse from a nearby Mobile Primary Health Care Clinic at a rural village in Malamulele provided contact details of caregivers caring for an MHCU with schizophrenia, who came to the clinic every month to collect medication for the MHCU. Snowball sampling was utilised to recruit potential caregiver participants thereafter, with each participant identifying another potential participant. Appointments were made with the potential participants, but only 10 were willing to participate. These participants were not related in any way to the MHCU participants.

Methods of data collection

Data were collected via face-to-face semi-structured interviews and an interview schedule, as Nieuwenhuis (2020) recommends. The interview schedule was pre-tested in a pilot study, as encouraged by De Vos et al. (2011), with four participants who were Tsonga speaking from the Waterberg District, LP. Informed consent to participate voluntarily in the study was obtained from each participant in Xitsonga and the interviews were also conducted in Xitsonga, since it is the predominant African language spoken in the Vhembe and Mopani districts, however, some interviews were conducted in English to those who were conversant with the language. Interviews took 30–40 minutes and were digitally recorded with the permission of the participants. Interviews were conducted in the hospital with the MHCUs and in the caregivers' homes.

The biographical details of the caregiver participants are shown in Table 1, while those of the MHCUs are shown in Table 2.

Table 1. Biographical details of caregivers.

	Demographic factors	Sub-category	No.
Caregivers ($n = 10$)	Gender	Female	10
	Language	Xitsonga	10
	Age range	39–64 years	10
	Level of qualification	Illiterate	6
		Sub B	2
		Std 1	1
		Grade 10	1

Table 2. Biographical details of MHCUs.

	Demographic factors	Sub-category	No.
Patients living with schizophrenia ($n = 30$)	Gender	Male	29
		Female	1
	Language	Xitsonga	30
	Age range	24–81 years	30
	Level of qualification	Illiterate	18
		Form 2	1
		Form 3	1
		Grade 9	3
		Grade 10	1
		Grade 12	4
		Diploma in teaching	2

Data analysis

Data were analysed using Creswell's (2013) seven-step guidelines to thematic analysis: The field notes were compiled by the principal investigator and the research assistant. The co-investigator was not present during the data collection. The principal investigator organised data employing verbatim transcriptions of the recorded interviews in Xitsonga, translated into English. Moreover, the principal investigator listened to the digital recordings several times to gain a better understanding and to determine the quality of the gathered data. The coding process commenced and the principal investigator identified themes, codes were allocated, and annotations were made in the margins of the transcripts and field notes. The conceptual framework showed the core themes, their related primary categories, and their

sub-themes. Coding was done manually by looking at the patterns and their meaning. Similar phenomena were compared and assigned the same name and a list of similar themes was compiled. They were divided into columns: main themes, sub-themes, and categories. The importance of the emerged data was evaluated using the research question to assess the relevancy. The data were interpreted by determining how the individuals under study defined their situation, based on insights and personal views gathered from participants. The themes, sub-themes, and categories were used to catalogue the findings and the collected and analysed data were presented in the form of a written report.

Thematic analysis of the data was conducted using a framework analysis approach (Braun & Clarke, 2006; Nowell et al., 2017), where certain themes and sub-themes were collectively agreed upon by the investigators, based on the objectives of the study. A single framework for analysis was thus developed and the transcriptions were coded based on this predetermined coding framework. The digital files of the recorded Xitsonga interviews were translated into English and transcribed verbatim by the principal investigator. The transcriptions did not include any personal information, to protect the identities of the participants. An independent coder was involved to verify the accuracy of the translations and transcriptions. The information was accordingly analysed and sorted into the following categories: demographics, mental illness, cultural beliefs regarding mental illness, the influence of culture on help-seeking behaviour, the role of traditional and spiritual healing in help-seeking behaviour, and barriers to help-seeking.

An inductive approach to the analysis of qualitative data was employed (Thomas, 2006), the purpose of which was to condense raw textual data into a summary format; establish clear links between the evaluation or research objectives and the summary of findings derived from the raw data, and develop a framework of the underlying structure of experiences or processes that are evident in the raw data. The general inductive approach provided an easily used and systematic set of procedures for analysing qualitative data that can produce reliable and valid findings.

To ensure the trustworthiness of the study, the researchers used Lincoln and Guba’s (1985) constructs, namely credibility, dependability, confirmability, and transferability. Credibility was ensured through reporting the findings accurately, extensive engagement and observation in the field, peer debriefing and member checks. Bracketing was used to remain objective, to eliminate biases, as well as self-awareness to stay engaged throughout the research process (Probst, 2015, p. 38). Self-knowledge assisted to inform and enhance the research endeavour and as the first author is an African South African, she knows how mental health is perceived in the African rural communities. Self-reflection and feedback from the supervisor offered new layers of meaning. A social worker working in the field of mental health was used as a peer debriefer to bounce ideas off (Probst, 2015, p. 43). Member checks were done during debriefing, where the participants were asked to comment on anything that they felt was omitted or unclear. Transferability was ensured by an audit trail and that the study could be replicated in other rural provinces in South Africa. Dependability was ensured through compiling an informed consent form, briefly describing the research process which participants signed before commencing with the interview. Data were analysed by the researchers as well as an independent coder to facilitate sound analysis and interpretation of the data. Creswell (2013, p. 203) emphasises crosschecking of

coding determines the level of consistency in the coding process. Confirmability was ensured by digitally recording the interviews with the participants' permission, transcribing the data verbatim to avoid possible bias and thereafter translating it into English. The quotes were substantiated with literature and the theoretical framework underpinning the study, the strengths-based perspective. An audit trail was established by documenting the process and saving all the data.

Results

The study findings are divided into two categories: sociodemographic results and thematic analysis.

Sociodemographic results

The 10 caregivers and 30 MHCUs in the study samples were not related to each other. The majority of the caregivers and MHCUs indicated an absence of formal western education, which could be an important contributing factor to low help-seeking behaviour and lack of knowledge of the mental illness. This sociodemographic factor affected the help-seeking behaviour of participants, where participants with formal western education had more knowledge about mental illness; however, they shared the sentiments of the participants with the absence of western education regarding the cultural beliefs on the causes of mental illness. Most of the caregivers and MHCUs sought assistance from traditional or spiritual healers despite their age and gender. The reasons were that traditional healers are easily accessible, and their practices are aligned to the cultural practices and religious beliefs, and the traditional healing is perceived to be holistic. Notably, during the time of the interviews, most of MHCUs' families were not involved in their lives and had abandoned them in the biomedical centres.

Thematic analysis

The findings unearthed a deeper understanding of how cultural beliefs influence the help-seeking behaviour of MHCUs and caregivers. Four themes emanated from the present study and the findings from each theme are provided below.

Participants' knowledge of their diagnostic labels

The findings of the study revealed that there was a difference in the knowledge of diagnostic labels between the MHCUs and caregivers. Moreover, amongst the MHCUs, those with a high level of formal western education and those with a low level of western education varied in the knowledge of their diagnostic labels. The participants with high levels of western education exhibited a degree of insight into their diagnosis, they were able to give the DSM labels for their conditions, whilst those with low levels of western education did not have an understanding of their conditions. More so, some participants ascribed their illness to substance abuse. The participants who had a high level of western education realised that they were living with a mental illness, and some were even aware that they had been diagnosed with schizophrenia. The responses of the MHCU participants are captured as follows:

Veri ndzahlanya / I was told that I have a mental illness. I was diagnosed by the doctor here at Hayani and he told me that I have mental illness and I accepted what he was telling me. (MHCU1)

Ndzapenga / I have a mental illness. The hospital staff members told me that I have schizophrenia, even the students who came here have been given our files, so they tell us that you have schizophrenia. (MHCU 12)

I was diagnosed with a mental illness, and they said I have schizophrenia. The doctor explained to me that I have a mental illness named schizophrenia and I have accepted my condition. (MHCU2)

One participant indicated that he burnt down a house. After he was taken to court, he was taken to the hospital. He had this to say:

I was not taken to the hospital straight; my mother was no longer trust me, as I have burnt down the house. I was taken to the court and the magistrate said I should be taken to the hospital. It was then that I went to the hospital. I was diagnosed with a mental illness called schizophrenia. I have accepted that I have a mental illness. (MHCU11)

Another participant denied that he had a mental illness:

Andzibengi mina. Ndzovabiseka ntloko, ka Ngozi yamovo / I do not have any mental illness. I know that I was involved in a motor vehicle accident, and I had a head injury. (MCHU29)

One participant ascribed his mental health condition to substance abuse:

“Mina ndatwisisa swibangelo swabubvazwi swamina, andzitirisa swindzidzidzirisi / Myself, I understand that because I was abusing drugs”. My brain has been damaged with drugs even the nerves have been burnt, my concentration is not quick—. I went to the sangoma seeking help, but I realised now it was a waste of money. (MCHU27)

To differentiate between the MCHUs and caregivers, the code CAGVR is going to be assigned for caregivers. The Caregiver participants predominantly did not have an insight into mental illness. Some of their responses were as follows:

Andziswitivi, kambe nwanaga wafamba kwala switandini, uvabya switsetsele / I am not sure, but my child is roaming around, and he also has epilepsy. (CAGVR1)

Akunamunu andzi tivisile kuri nwananga ubabzwa yini, vamunyika muri / No one has told me what is wrong with my child; they just give us treatment. (CAGVR2)

One participant alluded to the fact that her mother-in-law was suffering from a mental illness:

> My mother-in-law is suffering from mental illness; she was diagnosed at the hospital. (CAGVR5)

Cultural perceptions about mental illness

Most of the MHCU participants' views were based on their cultural beliefs, with the following assertions captured:

> (Va ehleketaku ikhale ni vabya va ehleketa Ku ndzi tswarisiwe swona, mina na ehleketa Ku ndzi loyiwini Marna kuna mulungu un'wani angaze ani nyika mali yo tala khale, ni Yi teke Niya Yi nyika un'wani ari na taxi ayiteka a tshama na Yona malembe yo tala, loko ni hlamusela vale kaya papa vaku ndzi Yi landza) / My family said that I have been born like this, they do not believe in witchcraft, but I think I am bewitched. I was given money by a white person, and these were dollars and then I gave the money to somebody else who had taxis, I told my family and my father said I should go and get the money from the person. (MHCU1)

> I believe that my sickness has been caused by witchcraft; I became sick in my first year of teaching. I only work for one year and after that, I was boarded, I got a job last in North West I was sick, and I was admitted to the hospital. This year again I got a job, but I was admitted to the hospital. All these make me think that this might be witchcraft. (MHCU 6)

> I believe that my sickness has been caused by witchcraft, I do not believe in the traditional medicine but for the issue that there are people who are behind my sickness. (MHCU10)

Three participants did not believe that mental illness has a cultural connotation, and they never consulted a traditional healer, as illustrated by the following participant's response:

> "For me, I do not believe that mental illness is ascribed to cultural beliefs". I had a problem with my mother I was not taken to the hospital straight, my mother was no longer trusting me as I have burnt down the house, I was taken to the court and the magistrate said I should be taken to the hospital. It was then that I went to the hospital. (MHCU25)

However, one participant indicated that his family believed that he was bewitched:

> Hayi mina sweswo ani swi pfumeli marha ekaya avaswi ehleketile. Mukhengulu loko vahari Kona kuze Vani fambise tin'anga avaku nzi lowiyi / "I do not believe that, but my family believes that I am bewitched". When my mother was still alive, she went with me to the traditional healers she believed that I was bewitched. (MHCU23)

Most of the caregiver participants ascribed the mental illnesses of their loved ones to witchcraft. One participant indicated that she was informed at her church that the sickness

was caused by witchcraft. Another participant indicated that she consulted a traditional healer, who confirmed that her son was bewitched.

Their responses are as follows:

> I went to a Zion Christian church [Moria]. They prophesied indicating that the condition of my son has been caused by a person [bewitched]. (CAGVR3)
>
> I went to Venda, and they said that there is something inside him that drinks all the medication and that is why he is not getting well and that is witchcraft. (CAGVR10)

Two participants indicated that their families believe their loved ones are bewitched. Their assertions are as follows:

> The family believes that this condition has been caused by witchcraft. On my side I do not have that belief. (CAGVR5)
>
> As my husband is not a Christian, he believes that the child might be bewitched. What worries me is that I have never been told what was wrong with my son. Hence, my husband believes that the witches are behind his sickness. (CAGVR7)

Description of how culture influences the perception of mental health help-seeking behaviour

Many of the MHCU participants thought that mental illness was due to supernatural factors, believing that the illness would be cured by indigenous practices instead of biomedical services. Biomedical facilities were only sourced when the indigenous practices failed.

MHCU participant indicated that his family believed that his sicknesses were caused by other people, and they believed that the cure is found in the indigenous system:

> I consulted a traditional healer. My father took me there; we went to Venda. My father believed much in traditional healing. (MHCU3)

Culture influenced the way caregiver participants perceived the illness, as well as the way they sought help.

The caregiver participants asserted the following:

> I have a thought that this might be caused by people, and I decided to go to church. Because I believed that this condition needs prayers, not a hospital. (CAGVR2)
>
> In my tradition, mental illness is cured only by a sangoma [witch doctor]; a medical doctor is unable to cure it. Therefore, I had to use herbal medication for my son. (CAGVR6)

Consultation of traditional and spiritual healers

Some MHCU participants discussed their first step in seeking mental health services, namely, going to a traditional leader and had a conviction that mental illness exuded from witchcraft. They only went to a biomedical facility when they perceived that they were not recuperating. Some participants had consulted faith/spiritual healers. The responses from some MHCU participants were as follows:

> I have consulted a traditional healer, first and this was because we thought that the illness was caused by black magic. So, for me to get the help we believed that the sangoma was going to help me. After months in the sangoma's place, I was not getting better then, my parents decided to take me to the hospital. (MHCU6)

> I first went to the hospital, but after that, I consulted the traditional healers after I was discharged. I went to the sangoma as I wanted to know who is behind my illness. (MHCU12)

> I have consulted the traditional healers, as well as the spiritual healers. I went to both the sangoma and the pastor as I wanted to get well soon as well as I wanted to know who is bewitching me. I knew that the sangoma was going to tell me about the person behind my sickness. The pastor was going to give me water to protect myself against the witches. (MHCU8)

> Yes, I consulted a spiritual healer, my parents believed in prayer, and we were convinced that if the pastor prayed for me, I was going to be healed and well as protected from the evil spirits. (MHCU9)

Five MHCU participants stated that they did not believe in traditional medicine, with the following responses captured below:

> "No, I never went to the traditional healers". I do not believe in traditional medicine. I know that my illness needs hospital treatment and if I take my medication I will not relapse. (MHCU1)

> I have never consulted the traditional healer. When I was sick my family rushed me to the hospital. I do not believe that traditional medicine will heal my sickness. (MHCU5, MHCU2, MHCU3)

> "I do not believe in traditional medicine". When I showed signs of mental illness, I was taken straight to the hospital. My other brother had the very same condition as me. So, when my parents noted that I was behaving like my brother. They took me to the hospital. Traditional medicine sometimes is poisonous, and it is not done at the hospital. (MHCU10)

One participant added that his friend died from drinking the herbal medication provided by the traditional healer: "My friend died from drink traditional medicine, and it is not safe at all" (MCHU5).

Three MHCU participants indicated that their families or parents consulted traditional healers:

> My mother consulted the traditional healers. As a person, I do not believe in traditional medicine. I feel is the waste of money as you will not get better if you go to the sangoma. (MHCU2)
>
> My parents have taken me to the traditional healers. I was very sick, and I could not deny them when they consulted the sangoma. I am not in favour of traditional medicine. I prefer the hospital treatment as it makes me feel better. (MHCU4)
>
> My family consulted the traditional healers when they saw that I was sick. I was sick and I was very aggressive. I did not know what was going on. I will take off my clothes and I will run around naked. My mother told me that was the reason they went to consult a sangoma. (MHCU7)

Additionally, some caregiver participants had also indicated that their first point of contact was to consult traditional and spiritual healers. Some indicated that they went to the hospital when they saw their loved ones were not getting better, with the following responses:

> I decided to consult spiritual healers and traditional healers before taking him to the hospital. I took him to the hospital, as he was not getting better. (CAGVR3)
>
> I decided to consult a traditional healer before taking him to the hospital, the hospital was my last hope as my child was not getting better at all. (CAGVR4)

One caregiver participant indicated that she was taking her son to a traditional healer and the biomedical facility simultaneously:

> I have a thought that this might be caused by people [witchcraft]. Even now I am thinking like that because my child is not getting well. I am still consulting the traditional healers, as well as taking him to the hospital. (CAGVR9)

Two other caregiver participants indicated that their family members consulted traditional healers:

> I have never consulted a traditional healer, but my husband is the one consulting them. I do know what is wrong with my son. In the hospital, they are not telling me what is wrong, and they just give him medication. My husband believed that his condition is the result of people casting a spell on him. (CAGVR1)
>
> The family has consulted traditional healer. My mother-in-law has gone all over the place looking for help, but she did not get it. I am a daughter in law, and I rely on the family to make decisions. As a person, I do not believe in traditional medicine. (CAGVR5)

Perceived barriers to seeking biomedical services

Most MHCU participants perceived fear and stigma as hurdles to seeking mental health services.

Most MHCU participants alluded to the stigmatisation attached to people living with a mental illness. Their responses were as follows:

> Some people called me names. I did not want to go to the hospital, as this will confirm what people are saying that I am crazy. (MHCU1)

> Some people will call me names saying that I am crazy, so I did not want to go to the hospital due to the fear of being judged. (MHCU2)

Caregiver participants voiced their frustrations concerning the ill-treatment they experience in the community:

> I am blamed by the community that I am neglecting my child. He is roaming around and then people will make him work and give him food. So, they think that I am not taking good care of him. He is now an adult child; I cannot control him. (MHCU5)

> I am blamed by the community they say I am the one who caused my child's mental illness. I am frustrated about this accusation. (MHCU2)

Most caregivers alluded to a lack of knowledge about mental illness, and as a result, they did not know what is wrong with their loved ones. Some participants explained how people seeking mental health services would be mocked and labelled in the community, as it was considered "taboo", and someone would be described as "crazy".

One participant indicated that she stopped going to the hospital, as the treatment given to her son had side effects. Their responses were as follows:

> When my son was sick, I did not know that he was suffering from a mental illness. I was wondering why he is always taking it alone. I did not seek help as I was afraid that people are going to judge me and my son. (CAGVR1)

> I did not know the condition of my child and that was my problem. When he was sick, I did not know what to do or where to go. (CAGVR4)

> No one told me what was wrong with my child at the hospital. They just gave us treatment and I stop going with him to the hospital, as the treatment had a side effect and I stopped it as well. (CAGVR2)

Discussion

Sociodemographic results

The present study was undertaken to unearth the cultural beliefs of MHCUs and caregivers regarding help-seeking behaviour. A total of 40 participants, both males and females, between 20 and 81 years of age were selected. The MHCUs were inpatients in three hospitals in Mopani and Vhembe Districts in Limpopo Province, whilst the caregivers were residents of a rural village in Malamulele, Limpopo Province, and they were not related to the MHCUs. Most participants in the study had low levels of western education and this might have contributed to their lack of knowledge about mental illness, resulting in low mental health help-seeking behaviour. Moreover, most of the caregivers were not informed of the diagnosis of their loved ones. This might be a contributory factor for the caregivers not seeing the value of biomedical services. This is confirmed by the study conducted in India by Srinivasan and Thara (2000), which found that patient gender and education, duration of illness, the key relative's education, and the nature of supportive relationships were associated with family beliefs about the cause of mental illness. A study conducted in Nigeria also found the educational level to be one of the sociodemographic characteristics that significantly affect the perception of mental illness (Adewuya & Makanjuola, 2008). However, there was no difference between educated and uneducated participants in the current study when it came to cultural beliefs about the causes of mental illness. Both MHCUs and caregivers ascribed mental illness to witchcraft, hence they first consulted a traditional or spiritual healer before they solicited biomedical services. This finding is consistent with a study conducted by Adewuya and Makanjuola (2008) revealing that educational status did not affect the belief in supernatural causation. The biomedical services were used as a last resort when they could not get help from traditional or spiritual healing. The participants had different views regarding the causes of mental illness. Some caregivers were not informed of the diagnostic labels of their loved ones. Hence, this might have played a significant role in the help-seeking behaviour of the caregivers. This further justified the pathway of help-seeking behaviour of the caregivers, they first consulted the traditional healers before they go to the biomedical facility. Moreover, they went to the facilities as the last resort when their loved ones were not getting better. The findings are in line with the results from a study by Basic Needs Uganda (2005, in Nsereko et al., 2011), which found that the majority of patients with mental illness first visit traditional healers. As alluded before, the participants did not share the same views on traditional healing. Some participants did not consult the traditional healers as they felt that the biomedical services will provide healing to their loved ones or the MHCUs. There is a concern that traditional medicine might be toxic, diagnostic tools are limited, ingredients of the medicines are unknown and antidotes are unavailable (Stewart et al., 2002). A study conducted by Meel (2007) in Mthatha showed an upsurge in the cases of poisoning from 2.5% in 1993 to 13.7% in 2005 (Meel, 2007) as the result of traditional medicine, suggesting that the use of traditional medicine may be on the rise in rural South Africa, and calls for enhanced methods of dealing with herbal intoxication (Meel, 2007).

Thematic analysis

The present study unearths how culture influences the help-seeking behaviour of MHCUs and caregivers. It was evident that traditional healing and religion were the first steps on the path of help-seeking for the participants of the current study. The study's qualitative approach contextualised the participants' cultural beliefs about help-seeking behaviour. Findings are discussed below, focussing on each theme.

Participants' knowledge of their diagnostic labels

The findings of the present study revealed that the participants had diverse knowledge and perceptions about mental illness. It should be noted that the MHCUs showed much more insight into mental illness as compared to the caregivers, who revealed that they did not have much knowledge about the conditions of their loved ones. The finding is similar to a study conducted by Lehman et al. (2004) in Western Maharashtra, India, reporting that most of the participants had no prior knowledge about the disorders of their relatives. Additionally, the findings of the present study lend from the results of a study conducted in South Africa by Mavundla et al. (2009), who state that the majority of the participants in their study communicated their dissatisfaction with the lack of information relating to their relative's illness and medication.

Another interesting finding from the conducted study was the knowledge shown by the MHCUs about their mental health conditions (DSM diagnostic label), with some attributing their illness to substance abuse. Similar results were observed in a study conducted in Karfi village in Northern Nigeria, where alcohol and drug misuse (including cannabis and other street drugs), were identified in 34.3% of the responses as a major cause of mental illness (Kabir et al., 2004). All the MHCUs who participated in the present study were admitted as inpatients to the biomedical centres, hence their knowledge might be attributed to psychoeducation provided in their respective centres. The other finding was that the families of the MHCUs' were not involved in their lives and had abandoned them in the biomedical facilities or had not visited at all. The finding is consistent with the results from a study conducted in Limpopo Province, South Africa, by Mabunda (2018), stating that the family affiliate of the MHCUs did not visit their loved ones in biomedical centres.

Cultural perception about mental illness

The participants of the current study strongly linked mental illness to the presence of witchcraft (*uvuloyi*) and this played a clear role in how mental illness was perceived and treated. Therefore, most participants had a cultural belief that the sickness can be detected and healed by consulting either a traditional or spiritual healer. This finding is not unusual, as it supports the research of other authors who have shown that caregivers and MHCUs associated mental illness with supernatural factors. For instance, a Nigerian study of caregivers of patients with schizophrenia and major affective disorders also revealed a high proportion of caregivers believing that supernatural elements play a role in psychiatric illness (Ohaeri & Fido, 2001). This finding is further substantiated in a study conducted in South Africa by Phakathi (2005), where it was found that when families are confronted with an issue, they seek social reasons in an attempt to comprehend and resolve the issue,

unearthing that both MHCUs and caregivers have a similar understanding of how mental illness is perceived in their culture.

Description of how culture influences the perception of mental health help-seeking behaviour

The results revealed that a multitude of cultural and social factors shape the widespread use of traditional and faith healers. One factor that was emphasised by the participants was the belief that mental illness cannot be treated in a biomedical system, as it is caused by witchcraft (*uvuloyi*) or an evil spell. Their conceptualisation and understanding of mental illness are based on their cultural connotations. This corroborates findings from other studies which revealed that cultural perceptions of mental disorders as "spiritual" illnesses may be a significant influencing factor in the popularity of traditional and faith healers (Hewson, 1998; Tanner, 1999). In a study conducted in Uganda by Nsereko et al. (2011), it was established that the traditional belief system and cultural explanatory models of mental illness were noted to be very influential in the choice of where to seek help. It is evident from the findings of the current study that cultural beliefs influenced how MHCUs and caregivers sought help.

Consultation with traditional and spiritual healers

Because mental illness is believed to be due to supernatural causes, a significant number of people with mental health problems, tend to initially seek and continue seeking traditional healers' services after receiving help from Western medicine (Abbo, 2011). This was the case in the current study, where the participants had consulted either a traditional healer or a religious healer rather than seek biomedical services. Keeping with this finding, in a study conducted in Nigeria, Adeosun et al. (2013) found that traditional and religious healers were the primary point of help-seeking by most of the patients. Supporting the findings of the current study, Brooke-Sumner et al.'s (2014) study, also conducted in South Africa, revealed that the majority of their participants (clients and caregivers) had consulted a traditional healer both voluntarily, and at the behest of their families. Similarly, the majority of the participants in the current study had consulted traditional healers; they were convinced that mental illness is caused by witchcraft. However, they went to a biomedical facility when they realised that they were not recovering.

Perceived barriers to seeking biomedical services

The participants of the present study unearthed the factors that lead them to not seeking help, including lack of knowledge regarding mental illness and stigma and discrimination from the community members. The sociocultural belief that some mental illnesses cannot be treated by the biomedical system also hampers access to treatment, as such a belief influences where treatment is sought from. Some participants highlighted that they stopped going to the biomedical facilities due to the side effects of the medication experienced by their loved ones. It is evident from the present study that all 30 MHCUs interviewed were using the biomedical system but had first used the traditional and religious systems before they were admitted to the biomedical facility because they did not recover from their illnesses. The current study's finding that participants lack knowledge about mental illnesses

is confirmed by a South Africa study conducted by Seedat et al. (2002), which revealed that most participants waited 3–5 years before seeking help, stating reasons such as not knowing where to go, wanting to handle the problem on their own, being afraid of embarrassment, and being fearful of medication as being contributory.

Our study highlighted that both the MHCU and caregiver participants experienced high levels of stigma, with universal comments such as "highly stigmatised", "viewed in negative ways", and "given derogatory labels". This is consistent with the findings of several studies showing that people's belief regarding mental illness is also the main factor that leads to stigmatisation and labelling. Studies continue to indicate that the stigma attached to people with mental illness remains a significant barrier to positive outcomes across cultures and nations and is related to the threat of mental symptoms, intolerance for diversity, and inaccurate conceptions of mental disorders (Gureje et al., 2005; Stier & Hinshaw, 2007).

Conclusions and recommendations

The present study concurs with the extant literature on the cultural beliefs and help-seeking behaviour of MHCUs and caregivers. The study unearths that the rural areas of South Africa are still deeply entrenched in the cultural beliefs regarding seeking help for mental illnesses. The study provides a unique understanding of the perception of mental illness. It was evident that most caregiver participants lacked knowledge about the illness of their loved ones and had a low level of western education that might have contributed to their lack of understanding regarding the diagnosis. Both MHCUs and caregivers shared the same sentiments regarding the cultural connotations of mental illness, whether they were educated or not. They all ascribed mental illness to witchcraft (*uvuloyi*). It was evident that cultural beliefs influenced how they sought assistance for their illness, as well as the illness of their loved ones. Furthermore, it was evident that there was a heavy reliance on the traditional system as compared to the biomedical system, and biomedical services were only sought as a last option. Stigma and discrimination were recognised as the main barriers that deter both MHCUs and caregivers from seeking help from the biomedical facility. Moreover, some caregivers were not informed of the diagnostic labels of their loved ones and that might have resulted in the devaluing of the importance of biomedical services. It should be noted a few participants did not consult traditional healers, as they valued the biomedical services, and they were concerned about the toxicity of traditional medicine. MHCUs were concerned by the derogatory names they were being called by community members, such as "ihlanya" and "Xipengo" (all these names refer to a person who is living with a mental illness). The caregivers were insulted, as well as isolated from community activities.

The results demonstrate a need for education and awareness programmes about the conceptualisation of mental illnesses (mental disorders). Programmes should address the different treatment options and people should be encouraged to seek help in the early stages of an illness. In developing such programmes, culture-specific notions of mental illness should be taken into account. The importance of the family should be acknowledged, and efforts should be made to understand the needs of families, to provide them with support and skills training and to help them organise family groups and associations. The findings further showed that the caregivers lack information about mental illness. This is an

opportunity that can be explored further by establishing psychoeducation programmes involving the family and also establishing user groups among the family members as a platform where the family and the service providers from the different systems of care can meet and exchange ideas. During the time that the study was conducted, most of the MHCUs had been abandoned at the biomedical centres by their families. The study suggests family involvement policies should be developed. More importantly, the study further suggests psychoeducation and psychosocial rehabilitation programmes for MHCUs.

Concerning possible interventions to address stigma and discrimination amongst family and community members, the present study suggests the need for the psychoeducation of family and community members on the causes and symptoms of mental disorders, as well as how to care for MHCUs. Moreover, the study suggests media campaigns and interventions create awareness about the causes of mental illness and effective treatments and emphasises the need for supportive community environments to reduce stigma and discrimination in communities regarding mental health. The study further suggests a system of collaboration between mental health professionals and traditional/spiritual healers, to improve referral and the early diagnosis of mental illness. This can be accomplished through organised dialogue between the different players in the provision of mental health services, as they are all dealing with “one patient”. Lastly, the study suggests a sociocultural spiritual paradigm that can help to guide policymakers, practitioners, and researchers in developing initiatives and effective approaches to guide mental health care providers in the rural areas of South Africa. Further research is still required to fill the gap related to the cultural beliefs of MHCUs and caregivers from other ethnicities in South Africa, as well as within the urban areas of South Africa.

Limitations of the study

The original plan was to conduct the study between related participants, but in the end, the sampled caregivers were not related to the MHCUs. The caregivers of the MHCUs who participated in this study, disassociated themselves when the MHCUs were admitted to the medical facilities. All caregiver participants were Africans of Tsonga ethnicity, female, and predominantly elderly. MHCU participants were Africans of Tsonga ethnicity and predominantly male, with only one female participating. Moreover, the MHCUs were all inpatients in biomedical facilities in Limpopo Province. Thus, the findings cannot be generalised to the total population of South Africa, but only to this specific ethnic group or a similar group in South Africa.

Contribution of the study

In the authors’ understanding, the present study was the first to tackle and unearth cultural beliefs and help-seeking behaviour within the rural communities of Limpopo Province, South Africa. The study has succeeded in unearthing the beliefs of MHCUs and caregivers, resonating with other studies conducted in Africa and globally. Therefore, the study has managed to join in the global debate by highlighting the cultural beliefs of people residing in the rural areas of Limpopo Province, South Africa.

Compliance with ethical standards

Ethics approval was granted by the Faculty of Humanities, University of Pretoria (23189259), the Department of Health (LP) (H4/2/2), and the Department of Social Development (LP) (S5/3/1/2), SA. There was no funding for the present study. The authors declare that they have no conflict of interest.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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