

**Title: Knowledge and perceptions of University of Limpopo (Turfloop Campus)  
undergraduate students towards mental illness**

**B L Smit**

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## **Declaration**

With the submission of this mini-dissertation, I declare that the entirety of this work is my original work. I am the sole author thereof, unless otherwise stated. I have referenced all sources, and to my knowledge, have not plagiarised.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**In loving memory of Viriato Lima**

## **Abstract**

Current understandings of mental illness are deeply rooted in a predominantly westernised paradigms of mental health. Constructs such as mental illness have been found to be socially constructed and rooted in historical contexts and informed by cultural and societal influences. Most of the existing research conducted on the knowledge and perceptions of tertiary-educated individuals towards mental illness have been quantitative in nature. The aim of this study was to qualitatively explore the knowledge and perceptions of undergraduates using Social Representation Theory as a theoretical framework. Purposive sampling was utilised to draw a sample of 16 undergraduate students between the ages of 18-25 years, at the University of Limpopo (Turffloop Campus). Thematic Content Analysis (TCA) was used to analyse the semi-structured interviews which were used to collect data. The results of this study found that negative views and perceptions existed amongst the sample pertaining to mental illness and the mentally ill. It was also found that participants conceptualisations of mental illness were not wholly western or traditionally African. Participants perceptions were informed through their cultural and social experiences with the mentally ill. Generally, the study pointed towards a greater need for psycho-education on mental illness.

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## CHAPTER 1: INTRODUCTION

### 1.1 Introduction to the study

Current understandings of mental illness are deeply rooted in a predominantly westernised paradigm of mental health. This paradigm has historically neglected to address non-western pools of knowledge and perceptions in the conceptualisation of mental illness. Westernised understandings of mental illness are problematic when directly applied in non-western countries, where mental illness is not viewed from the same perspective (Watters, 2010).

Recently, a global movement towards a more culturally inclusive conceptualisation of mental illness has been underway (Seligman & Csikszentmihalyi, 2014). As a result, it may be argued that the foundations of a more culturally and socially informed understanding of mental health have been laid. Considering South Africa's rich socio-political history and diverse cultural groups, the influence of both westernised and indigenous notions of mental health hold the potential to play an intricate part in the discourse on mental illness.

The westernised approach to illness in the 19th Century was the biomedical model of medicine (Wade & Halligan, 2017). The biomedical model posits that mental disorders or illnesses are largely neurophysiological (Deacon, 2013). Emphasis is placed on pharmacological intervention in treating the presumed biological abnormalities of the brain. The biomedical model underpins 19<sup>th</sup> and early 20<sup>th</sup> Century conceptualisations of mental illness which has dominated policy and practice in the global healthcare system for decades (Schomerus et al., 2012).

A contemporary movement has been made towards a more inclusive model of understanding mental illness, namely the biopsychosocial model, which considers biological, psychological and social aspects. The biopsychosocial model is currently the primary model of contemporary mainstream western psychiatric and psychological practice (Schomerus et al., 2012). Currently, the common understanding within the mental healthcare system is that mental disorders occur as a result of genetic predispositions and/or environmental stressors, which together cause patterns of distress or dysfunction that manifest in different types of mental illness (Álvarez, Pagani, & Meucci, 2012).

Conversely, African perspectives in conceptualisations of health and illness tend to be socially constructed (Leavey, Loewenthal, & King, 2016). The social construction of mental illness that is prevalent amongst most of sub-Saharan Africa reveals some common themes. African understandings of mental illness centre on beliefs underpinned by the existence of ancestral spirits which are understood to impact on an individual's health and wellbeing (Semrau et al., 2015).

In many traditional societies it has been understood that the major cause of adversities and ill health is attributed to the activity of supernatural agents (Akomolafe, 2012). Additionally, mental illness from an African perspective has commonly been treated as a taboo subject. The taboo nature with which mental illness is viewed is largely due to social stigma attached to mental-health illnesses which have resulted in what Amuyunzu-Nyamongo (2013) refers to as a silent epidemic.

It is evident from the aforementioned literature; mental illness is conceptualised in fundamentally different ways by culturally diverse groups. These perspectives are informed by the prevailing models, paradigms and cosmologies of the social paradigm prevalent at that period. It has been argued that epistemological imbalances have meant that western conceptions of mental health are favoured over non-western or indigenous perspectives (Akomolafe, 2012; Burns, 2011). In South Africa both westernised and indigenous conceptualisations of illness play an important role in the healthcare system.

Contextualising the concept of mental illness as relating to mainstream conceptualisations of health may allow for a broader understanding of the notion within the South African context. The World Health Organisation (World Health Organisation [WHO], 2008) has defined health as a state of well-being in several domains, including the physical, mental and social spheres. Health is not solely conceptualised as a purely biological concept, nor as the strict absence of disease. Rather, health and subsequently mental health, is defined as an overall (or global) state of well-being. Within this state of well-being, an individual has the capacity to realise his or her own potential, can effectively cope with life stressors and is able to work productively and make meaningful contributions to the community (WHO, 2014). Mental illness may have the capacity to severely alter an individual's state of overall well-being.

The Diagnostic and Statistical Manual of Mental Disorders – 5 (DSM-5, 2013) offers arguably the most commonly used and standardised criteria for the classification of mental illnesses. The manual is used and relied upon by clinicians, researchers, pharmaceutical companies and policy makers (APA, 2013). Mental illness refers to a recognised disorder which is characterised by a clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour. Such a disturbance reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Accompanying this definition there are a myriad of requirements that must be met to make a diagnosis and subsequent recommendations for treatment (Pescosolido & Martin, 2015). The cultural and social environment of an individual is also considered when diagnosing and assessing for mental illness as conceptualisations of mental illness are constructed differently depending on cultural, social, religious and context-specific variants (APA, 2013).

Literature covering various aspects of mental illness and mental health exists, spanning both European, American and African countries. Within this area of research, studies about different conceptualisations and understandings of mental illness and disorder exist (Burns, 2011; Engelbrecht & Kasiram, 2012; Furnham & Hamid, 2014). Different conceptualisations of mental illness are impacted on by the knowledge, perceptions and thoughts held towards those individuals identified as mentally ill (Lasalvia, 2015). Stigmatisation, prejudice and alienation form part of the most pressing socially and culturally informed challenges that mentally ill individuals are confronted with (Ukpong & Abasiubong, 2010).

Perceptions held towards the mentally ill often represent such individuals as foreign, or as deviating from the prevailing societal norm (Barke, Nyarjo, & Klecha, 2011; Lauritzen, Reedtz, Van Doesum, & Martinussen, 2015). Global trends reveal that a lack of knowledge, poor insight and misperceptions relating to mental illness and the mentally ill have been identified as contributing to the further estrangement of such individuals (Barke et al., 2011; Bener & Ghuloum, 2011; Chikaodiri, 2009; Ukpong & Abasiubong, 2010).

Studies pertaining to knowledge and perceptions of mental illness have also been conducted in South Africa before. Most of these studies have focussed on the perceptions and attitudes of specific professional populations, such as medical doctors, psychologists or psychiatric nurses (Egbe et al., 2014; Ljungberg, Denhov, & Tapoor, 2015; Sehoana & Laher, 2015; Ukpong & Abasiubong, 2010). Some studies have been conducted involving laypersons and members of the public to ascertain their knowledge, understandings and perceptions towards aspects of

mental health and mental illness (Angermeyer & Dietrich, 2006; Evans-Lacko, Henderson, & Thornicroft, 2013). These studies reported similar results, echoing the notion that a lack of knowledge about mental illness and concepts thereof may lead to negative perceptions of the mentally ill.

Auxiliary studies have indicated that individuals with higher education levels tend to hold more positive attitudes towards the mentally ill, and are more knowledgeable about aspects of mental illness (Hatzenbuehler, 2017; Mutiso et al., 2014; Jorm, 2012). It has also been stated that with higher education levels, mental health literacy is improved (Blee, Reavley, Jorm, & Mcann, 2015; Jorm, 2012).

University students at a peri-rural university such as the University of Limpopo (Turffloop Campus) may offer a unique perspective on the prevailing knowledge pool and perceptions held towards the mentally ill. Generally, tertiary education institutions place importance on knowledge production, freedom and expression where the free-flowing of ideas are encouraged. A study on the knowledge and perceptions of the mentally ill within the aforementioned context may produce valuable data. Most of the existing research conducted on the knowledge and perceptions of tertiary-educated individuals towards mental illness have been quantitative in nature (Ali et al., 2017; Hyde, 2011; Furnham & Hamid, 2014). Qualitative methods of inquiry have largely been neglected.

## **1.2 Research problem**

The interplay of western and African perspectives of mental illness is of particular interest to the researcher. Interest on the topic has been fuelled by the movement to decolonise the field of psychology in order to include indigenous knowledge systems in the conceptualisation and understanding of mental illness (Cruz & Sonn, 2015).

It has been argued that by adopting western perspectives, aetiologies and diagnostic systems as standard practice, the reinforcement of a western hierarchical system is propagated (Akomolafe, 2012; Aphane, 2015; Burns, 2011). Current conceptualisations of mental illness have been shaped by western hegemonic perspectives that are at odds with the prevailing socially constructed beliefs and practices of the culturally diverse groups that characterise South Africa's population (Akomolafe, 2012). The conceptualisation of mental illness in African countries may possess contrasting viewpoints when compared to their western counterparts. The contrast has been found to be most prominent when considering issues of

mental illness, which in a country such as South Africa has been shown to be purposively informed by cultural and societal norms (Burns, 2011; Engelbrecht & Kasiram, 2012).

Considering the above, conceptualisation of mental illness within the South African context are of particular significance, especially with regards to the youth and their understanding thereof. This is an important group as many mental disorders worldwide only appear during adolescence and early adulthood (McGorry, Purcell, Goldstone & Amminger, 2011).

The premise exists that perceptions and existing knowledge pools in terms of mental illness are culturally or socially constructed which is supported by literature within the African context (Aphane, 2015; Burns, 2011; Engelbrecht & Kasiram, 2012). However, perceptions and knowledge pools are not understood as static constructions (Engelbrecht & Kasiram, 2012). Rather, these malleable, dynamic constructions hold historical reference points and may be informed by either traditionally western or African notions of mental illness, or both.

This study was proposed in order to explore the existing knowledge and perceptions of undergraduate students registered at the University of Limpopo (Turfloop Campus) towards mental illness.

### **1.3 Study aim**

- To investigate the knowledge and perceptions of University of Limpopo (Turfloop Campus) undergraduate students with regards to mental illness.

### **1.4 Study objectives**

- To explore the knowledge and understandings of mental illness by undergraduates at the University of Limpopo (Turfloop Campus).
- To investigate how undergraduates at the University of Limpopo (Turfloop Campus) perceive individuals identified as mentally ill.

### **1.5 Operational definitions**

In this study, various operational definitions imperative to the study are employed. These include:

- Undergraduates: are defined as students who are within the age range from 18 – 25 years and who have not gained a degree.

- Perceptions: are defined as the way in which something is regarded, understood, or interpreted and may extend in to the common ways of conceiving, thinking about and evaluating a social phenomenon (Höijer, 2011).
- Mental illness: all diagnosable mental disorders which causes changes in one's emotion, thinking and behaviour and significant distress in a variety of spheres (APA, 2013).

### **1.6 Purpose of the study**

The purpose of this study is to ascertain the existing knowledge base of undergraduate students at the University of Limpopo (Turffloop Campus), aged between 18 years and 25 years of age, with regards to their understanding of mental illness. Furthermore, the study purposes to explore their perceptions towards individuals identified as mentally ill within the aforementioned framework.

### **1.7 Significance of the study**

The proposed study may have future implications for understanding conceptualisations of mental illness amongst an undergraduate student population. Furthermore, the proposed study may shed light on the broader social and culturally constructed context of knowledge systems at a peri-rural tertiary education institution with regards to mental illness. Data obtained may also serve to inform on help-seeking behaviours and potentially address future interventions with regards to mental illness.

### **1.8 Overview of chapters**

Chapter 1 introduces the study and notes its significance.

Chapter 2 gives an overview of literature on the topic.

Chapter 3 provides the theoretical framework for the study.

Chapter 4 gives a comprehensive overview of the research methodology for the study.

Chapter 5 presents the results and gives a discussion related to those results.

Chapter 6 gives the study limitations, strengths and recommendations as well as a final conclusion.

### **1.9 Chapter summary**

The researcher found that current understandings of health, mental health and mental illness are deeply entrenched in a westernised modality, historically based upon the biomedical model of illness. Conversely, traditionally African conceptualisations of mental illness which incorporate indigenous knowledge systems, informed by socially constructed and culturally relevant notions have been largely neglected. This chapter introduced the topic giving an introduction, background and significance of the study. Chapter 2 provides an overview of literature related to the topic.

## **CHAPTER 2: LITERATURE REVIEW**

### **2.1 Introduction**

An overview of literature relevant to the study is presented in the following chapter. Although many of the studies included are over five years old they have been included based on their relevance to the topic under review. The chapter begins with a general overview of the available literature regarding the knowledge and perceptions of mental illness in public as well as professional populations.

Included within this chapter is a discussion of mental health literacy and its components, in both developed and developing countries. The most important components of mental health literacy are outlined and discussed in detail (with regard knowledge and beliefs pertaining to mental illness). Thereafter, issues relating to the stigmatisation of mental illness are addressed as well as aspects relevant to culture and understanding of mental illness. South African studies most relevant to the knowledge and perceptions of mental illness are also included. Lastly, literature on the topic relevant to student populations is presented.

### **2.2 General overview of the literature**

The existing body of knowledge relating to the views and perceptions held towards mental illness and those individuals identified as mentally ill is extensive. Internationally there is much literature on the stigmatisation and generally negative views held towards mental illness and the mentally ill (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012; Pescosolido, Medina, Martin, & Long, 2013; Schomerus et al., 2012). Generally, the literature reviewed indicates a lack of knowledge in terms of the understanding of mental illness (Corrigan et al., 2012; Mirnezami, Jacobsson, & Edin-Liljergren, 2016; Schomerus et al., 2012).

International research indicates that most of the public are unable to identify, recognise or understand concepts relating to mental illness (Sheals, Tombor, McNeill, & Shahab, 2016). The public have been found to misunderstand both psychological and psychiatric terms related to mental illness (Corrigan, 2014; Schomerus et al., 2012). Poor recognition and knowledge of mental illnesses are also found to hinder appropriate help-seeking behaviours in the individuals who experience symptomology for illness such as depression (Jorm, 2012).

The lack of knowledge about mental illness has been found to contribute significantly towards the stigmatisation of the mentally ill (Corrigan et al., 2012). Numerous studies have been conducted pertaining to perceptions of mental illness in members of the public within the international community (Angermeyer, Matschinger, & Corrigan, 2004; Buckley et al., 2007; Corrigan et al., 2000; Gonzalez, Alegria, & Prihoda, 2005; Jacob, 2001). Negative views held towards the mentally ill are found to be intertwined with perceptions of the mentally ill being violent and untrustworthy (Mirnezami et al., 2016).

Research further exposes an inherent connection between a lack of knowledge about mental illness and fear of the mentally ill. This is associated with discrimination and stigmatisation of the mentally ill. This lack of knowledge contributes towards how members of the public perceive and behave towards the mentally ill (Choudhry, Mani, Ming, & Khan, 2016; Pescosolido et al., 2013; Sheals et al., 2016).

A longitudinal Swedish study (1976 - 2014) examined perceptions, views and attitudes held towards the mentally ill within a community context. The investigation concluded that perceptions held towards individuals with mental illness did not become more positive over succeeding decades but remained overwhelmingly negative (Mirnezami et al., 2016). The study further revealed that individuals with lower education levels held more negative views than individuals with higher education levels. Another revelation indicated that respondents younger than 20 years of age held more positive views about mental illness than older age groups. In another study it was found that greater familiarity with mental illness and contact with the mentally ill was associated with more positive attitudes and perceptions towards them (Corrigan et al., 2000).

Some studies have found that negative perceptions, stigmatisation and discrimination towards the mentally ill are widespread, even in health professionals who are considered more knowledgeable and informed on the topic (Struber, Rocha-Christian, & Link, 2014; Yeo et al., 2001). In the United States of America (USA) it was found that as compared to the general public mental health professionals held significantly more positive perceptions and attitudes towards individuals with mental illness (Struber et al., 2014). Conversely, a study by Struber et al. (2014), revealed that some mental health professionals' conceptions about the dangerousness of individuals diagnosed with Schizophrenia were similar to laypersons who thought they were more prone to violence. Furthermore, the study found that some of the mental health professionals that took part in the investigation exhibited a desire for social distance

from individuals if they had a psychiatric diagnosis. Generally, younger females with a tertiary qualification in a health profession were found to have more positive attitudes towards the mentally ill (Struber et al., 2014).

Studies from the African continent suggest a high level of stigma and discrimination amongst those who provide services for the mentally ill (Egbe et al., 2014; Mirnezami et al., 2016). One such study found that many health professionals held negative perceptions towards the mentally ill and that this could prevent suitable treatment and interventions (Sheals et al., 2016). General trends revealed from this type of study within the global community suggest negative perceptions towards the mentally ill amongst both the general public and healthcare providers.

Recently however, some studies have indicated that there is a lessening of negative perceptions and attitudes towards mental illness and those identified as mentally ill (Bonabi et al., 2016; Mirnezami et al., 2016; Van Boekel, Brouwers, Van Weeghel, & Garretsen, 2013). However, as Saxena (2016) reports there are still many strongly held negative beliefs. These are based on misinformation and poor knowledge about mental illness amongst health professionals and the general public.

This review indicates that there are there are contradictory findings in terms of mental illness and mental health amongst health professionals and the general public.

### **2.3 Mental health literacy (or knowledge)**

The term ‘mental health literacy’ was first defined by Jorm et al. (1997), as the knowledge and beliefs about mental illnesses which aids in their recognition, management and/or prevention. This includes the ability to recognise specific disorders and knowing how to seek mental health information and data about mental health risk factors and causes. The knowledge of self-treatments as well as perceptions that promote appropriate help-seeking behaviours in the mentally ill are also included in the term mental health literacy (Jorm et al., 1997).

The most relevant concepts relating to mental health literacy with regards to the current study include: (i) the ability to recognise mental illnesses or different types of psychological distress; (ii) knowledge and beliefs about risk factors and causes of mental illness and; (iii) knowledge and beliefs about interventions and/or treatment of mental illness (Jorm et al., 1997). The components of mental health literacy in developed countries will be briefly outlined whilst mental health literacy in developing countries such as in much of Africa, will be discussed in greater detail.

### **2.3.1 Knowledge and beliefs about mental illness in developed countries**

Studies relevant to the knowledge and beliefs of the general public on mental illness in developed countries have been conducted by Jorm, spanning the years 1997 – 2005. These studies revealed that most of the samples he used did not understand the meaning of various terms related to mental health and illness (Jorm, 2000; Jorm et al., 1997). Developed countries and more westernised populations have however, been found to show a higher degree of recognition in terms of mental illness than participants from developing countries (Ayalon & Arean, 2004; Jenkins, 1988).

An influential study conducted on a representative sample of the Australian public were shown vignettes of individuals suffering from Major Depression and Schizophrenia. Most of the research participants recognised that in the vignette, a mental health problem was involved, but they were unable to recognise what the mental health problem was. The overall results however revealed that Major Depression was correctly used as the label by 39% of the participants and Schizophrenia by 27%. In the Major Depression vignette, 11% thought the person had a physical illness as opposed to a mental illness (Jorm et al, 1997).

European studies using surveys consistently found an apparent lack of understanding of the term Schizophrenia which is a psychiatric diagnosis of a mental illness as well as the term mania which is commonly found in Bipolar disorders (Jorm, 2000; Jorm, 2012). One study revealed that Schizophrenia was often understood as suffering with multiple personalities, instead of a psychiatric disorder where hallucinations and delusions are the prominent symptoms (Angermeyer, Matschinger, & Riedel-Heller, 1999). Such findings reveal the lack of knowledge and ability to differentiate symptoms found within a wide spectrum of mental illnesses.

Failure to appropriately identify the difference between mental and physical illness based on a lack of knowledge may perpetuate misdiagnosis and stigma related to mental illness. It has been postulated that poor mental health literacy may cause problems of communication with health practitioners when a diagnosis is made (Kessler, Lloyd, & Lewis, 1999). Research reveals that the accurate identification of a mental illness is more likely if the patient presents with psychological issues rather than presenting physical problems (Herran, Vázquez-Barquero, & Dunn, 1999; Kessler et al., 1999). However, the endorsing of psychological symptoms as opposed to physical symptoms may be hindered by ignorance as to what constitutes a mental health problem. For instance, some psychological symptoms are somatised

which confuses medical doctors who are not well trained in psychological and/or psychiatric disorders (Herran et al., 1990).

Cross-cultural studies indicate that when compared to non-western populations, western populations show a greater medical knowledge of mental disorders and display lesser levels of stigma towards the mentally ill (Angermeyer & Dietrich, 2006). Such findings may be attributed to the predominantly biopsychosocial approach to mental illness conceptualisations in developed countries. These findings are complimented by an American study conducted in 2012 which revealed the positive evolution of public perceptions towards mental illness (Schomerus et al., 2012). Findings suggest that mental health literacy and perceptions of the treatment of mental illness have improved due to increased mental health literacy movements in western countries (Clement et al., 2015).

### **2.3.2 Knowledge and beliefs about mental illness treatment in developed countries**

Studies during the 1990's indicated that only a minority of individuals who met the diagnostic criteria for a mental disorder sought professional help (Regier, Hirschfeld, & Goodwin, 1998; Regier, Narrow, & Rae, 1993). More recent studies have also found significant barriers in help seeking behaviours for mental illness which may be attributed to negative perceptions and an insufficient understanding of mental illness (Gulliver, Griffiths, & Christensen, 2010; Thornicroft, 2011).

A study that asked members of the public to rate a range of interventions for likely helpfulness revealed self-help interventions to be at the top of the list in both Australia and the United Kingdom (UK), as opposed to seeking professional help (Jorm, 2000; Jorm, 2012). A more recent study conducted in the UK yielded similar results. This study found that hindrances to help-seeking behaviour were informed by poor knowledge regarding the pathogenesis and treatment of mental health problems (Matcham et al., 2014).

In developed countries those seeking professional help for mental illness usually approach a General Practitioner [GP] (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). A more recent study found that GPs were the most usual point of contact in the mental health services spectrum in the UK (Rickwood, Deane, & Wilson, 2007). The need to improve a GPs ability to accurately identify mental health issues has been recognised. General Practitioners (GPs) were more likely to diagnose Major Depression than any other mental illness which, in some instance, was not the most accurate diagnosis. In a study by Gaebel et al. (2015), it was found

that psychologists and psychiatrists were not as highly rated as GPs in treating mental illness. This finding which could point to poor public knowledge pertaining to who should diagnose and treat a mental illness.

Other studies using samples of the general public indicated consistent findings across many developed countries. For instance, negative beliefs about utilising medication in the treatment of mental illnesses (Jorm, 2000; Regier et al., 1998). These findings are in direct contrast to another study conducted on professional healthcare populations which indicated that they viewed psychopharmacological medication as effective in treating mental illnesses (Jorm, 2000).

According to Hillert et al. (1999), the public's negative views about medication were also found to contrast with their own positive views about medication for common physical disorders. In a study conducted in Europe Matcham et al. (2014), found that poor mental health literacy hinders mental healthcare. Another European study found that negative beliefs about medication led to a failure to seek help (Clement et al., 2015).

This section reveals that there are still significant barriers to treatment and help-seeking behaviours in European countries.

#### **2.4 Mental health literacy in developing countries**

The estimated prevalence of mental illnesses in developing countries has been suggested to be as high as that found in developed countries (Jorm, 2012). A review of eleven prevalence studies conducted across five developing countries including: Chile, Brazil, Pakistan, Lesotho and Zimbabwe found the median prevalence rate of common mental illnesses to be in the range of 20% -30% (Acharya, 2001). Despite these figures, literature reveals that studies with regards to mental health literacy in developing countries are sparse and predict poorer outcomes when compared to developed countries (Jorm, 2012). Poor mental health literacy is of especial concern in low and middle-income countries where the availability of, and access to, mental health services is scarce.

A general trend is revealed suggesting that public knowledge about mental illnesses and their treatments in developing countries are generally poor and improperly understood (Ganasen et al., 2008). The combination of such high prevalence rates of mental illness, especially in sub-Saharan Africa, and the scarcity of resources is thought to contribute to the poor mental health literacy outcomes noted in the study (Duthe, Rossier, Bonnet, Soura, & Corker, 2016).

Studies relating to the knowledge and beliefs relating to mental illness and treatment in developing countries is discussed in the next paragraphs in greater detail.

#### **2.4.1 Knowledge and beliefs about mental illness in developing countries**

Research has revealed that in developing countries an understanding of mental illness is neither unitary nor universal but is socially constructed and defined (Rogers & Pilgrim, 2014). Various societies and populations have different ways of conceptualising the nature, causes and determinants of what a mental illness is (Arrendondo & Toporek, 2004). Knowledge and beliefs with regards to mental illness is derived from sources such as existing social conceptions and cultural and personal beliefs (Jorm, 2012).

A 2014 study was conducted within developing countries to ascertain the public's ability to recognise mental illness amongst three different groups. Members of the public, scholars and young adults from non-English-speaking developing countries were included in the study. The findings revealed that mental illnesses such as Major Depression and Schizophrenia were easily recognized, whereas mental illnesses such as Anxiety or Personality Disorders were not and were poorly understood (Furnham & Hamid, 2014). This reflects a trend in similar studies conducted in developed countries, where Major Depression and Schizophrenia are more easily recognised as constituting a mental illness (Jorm et al., 1997). However, Schizophrenia is often confused with other mental illnesses in both developed and developing countries (Jorm, 2012). A paper reviewing several studies conducted in the sub-Saharan region yielded similar results. The paper revealed that research participants were largely unable to identify psychiatric illnesses and, if they did, supernatural causative factors in why the illness occurred prevailed (Atilola, 2014).

In a Nigerian study, clinically stable out-patients with a spectrum of psychotic disorders were surveyed to assess their knowledge and beliefs about the causality of mental illness (Adebowale & Ongulesi, 1999). Beliefs in supernatural causes of illness were widespread amongst patients, caregivers and their relatives. Similar studies undertaken in both Malaysia (Razali, Khan, & Hasanah, 1996) and Ethiopia (Alem, Jacobsson, Araya, Kebede, & Kullgreen, 1999) revealed similar results in that the supernatural was stated as causes of mental illness.

A seminal study conducted in a sub-Saharan Africa village examined the existing knowledge, perceptions and beliefs about the causation, manifestation and treatment of mental illness amongst adults from the community. Findings revealed that more than a third of respondents believed substance use, supernatural components and spiritual possession to be the main

causative factors of mental illness (Kabir, Iliyasu, Abubakar, & Aliyu, 2004). This suggests some level of understanding that biological causes related to substance use can cause mental illness however, supernatural causes and witchcraft were also noted as causative factors.

A Nigerian study on caregivers of patients with psychiatric conditions found that a high proportion of caregivers' beliefs attributed spiritual elements to the advent of mental illness (Ohaeri & Fido, 2001). Another study concluded that beliefs in ancestrally influenced spiritual causes of mental illness are common in many non-western, developing countries (Aphane, 2015; Ganasen et al., 2008).

Limited knowledge about mental illness can be attributed to how it is stigmatised in general populations (Bener & Ghuloum, 2011). Despite efforts to increase acceptance of the mentally ill there is a lack of awareness in developing countries (Lasalvia, 2015). Studies reveal that the mentally ill are still perceived as different to others and are not accepted socially (Olwit, 2015). Furthermore, people who are labelled as mentally ill tend to associate themselves with society's negative perception which increases the incidence of self-stigmatisation (Hanafia & Van Bortel, 2015).

In the aforementioned literature findings that the supernatural is a causative factor in mental illness underpin how this type of illness is socially constructed. Mental illness is also interpreted negatively which leads mentally ill people to self-stigmatise.

#### **2.4.2 Knowledge and beliefs about mental illness treatment in developing countries**

A recently published review of existing literature and studies about knowledge and the treatment of mental illness in most African countries reveals consistent findings (Clement et al., 2015). For example, a study conducted in Ethiopia found that traditional interventions, such as witchcraft, the use of holy water and herbal remedies, were preferred over psychiatric interventions for a range of mental illnesses. By contrast, medical intervention was overwhelmingly preferred for physical health problems (Alem et al., 1999). This is underpinned by studies from Malaysia (Razali et al., 1996) and Ethiopia (Alem et al., 1999). These studies indicated that beliefs in supernatural causes result in traditional help-seeking as opposed to seeking help through the medical establishment. In the Malaysian study, it was found that patients who believed in supernatural causes were more likely to make use of traditional healers and were less willing to comply with medication. Similarly, in the Ethiopian study, the use of witchcraft and traditional herbalists were favoured treatment pathways for mental illness.

It is suggested that culture may be closely linked with causal attributions of mental illness which influences treatment pathways (Alem et al., 1999; Aphane, 2015). Recent studies conducted within Africa have found that traditional healing practices for severe mental illnesses were preferred to psychiatric treatments (Abbo, Ekblad, Waako, Okello, & Musisi, 2009). Individuals are thus motivated to find help for mental illness in terms of their knowledge and belief system and prevailing social paradigm (Alphane, 2015).

Severely constrained resources for mental health services and access to care in sub-Saharan Africa has been underscored by the need for mental health literacy and knowledge with regards to treatment options available (Atilola. 2014). Barriers in access to care and treatment for mental illness in Africa include the negative views and misinformed knowledge base that informs collective (and individual) understandings of mental illness as well as stigma (Adewuya & Makanjuola, 2009; Bruwer et al., 2011).

The complex interplay between cultural beliefs as well as the socially constructed nature of mental illness are particularly relevant in developing countries. The on-going stigmatisation of the mentally ill and mental illness continues to block pathways to care and effective treatment.

## **2.5 Stigma related to mental illness**

Stigma and discrimination associated with mental illnesses are a global public health concern. Stigmatisation is defined in various ways throughout the existing literature (Flanagan, Farina, & Davison, 2016). In psychology, stigmatisation is defined as the process by which an individual's or groups identity is negatively associated with a past, imagined or perceived condition that is different from the norm. Stigmatisation is often accompanied by harmful physical or psychological consequences for an individual or group (Dijker & Koomen, 2007).

Thornicroft (2013) further conceptualised stigma as an amalgamation of knowledge, behaviour and negative perceptions towards something or someone that is different from societal norms. Various types of stigma have been researched extensively, ranging from public and professional stigma to self-stigma, regardless of the type, findings indicate that mental illness stigma exacerbates low self-esteem, marginalisation from society, social isolation and social anxiety (Clement et al., 2015; Flanagan et al., 2016).

Research reveals that physical illness tends to be associated with lesser levels of stigma than mental illness. This may contribute to the high level of somatic complaints in individuals with an underlying mental illness, especially in countries with low mental health literacy

(Ranguram, Raghu, Vounatsou, & Weiss, 2004). The stigmatisation of individuals with mental illness is associated with difficulty in securing employment and housing and poor social support. Furthermore, those diagnosed with a psychiatric condition have difficulty integrating into society (Kapungwe et al., 2010).

The role of poor knowledge about mental illness has been found to perpetuate stigma towards the mentally ill. It is also true that stereotypical views filter through different social and cultural contexts (Sadler, Kaye, & Vaughn, 2015). The interpersonal difficulties derived from the pattern of stigmatisation and discrimination experienced by the mentally ill hamper help-seeking behaviours. Treatment stigma has also led to major barriers in accessing psychiatric health care and illness management (Egbe et al., 2014).

Reducing stigma has been identified as an important factor in improving the lives of the mentally ill (Egbe et al., 2014; Ranguram et al., 2004). Negative stereotypes, in westernised countries, portray the mentally ill as violent and dangerous which also perpetuates negative stereotypes (Kapungwe et al., 2010). Research in disadvantaged countries with collectivist cultures supports this as the mentally ill are portrayed as a danger to themselves and others which perpetuates stigmatisation and discrimination (Chikaodiri, 2009; Ranguram et al., 2004). Individual beliefs, socio-economic contexts and personality characteristics have also been identified as significant determinants of negative public perceptions towards people living with mental illnesses (Kakuma et al., 2010).

Stigma attached to mental illness is high on the African continent according to available literature (Angermeyer et al., 2015; Egbe et al., 2014). Studies have found that individuals diagnosed with mental illness are considered un-intelligent and are often labelled as dirty dangerous and violent (Chikaodiri, 2009; Gureje et al., 2005). Studies conducted in African communities revealed that the origins of mental illness were believed to be as a result of familial problems or evil spirits (Nyati & Sebit, 2002; Richman & Hatzenbuehler, 2014; Ssebunnya, Kigozi, Lund, Kizza, & Okello, 2009). This type of belief adds to the marginalisation of the mentally ill and their families and negatively contributes to their quality of life (Gureje et al., 2005).

Research within sub-Saharan Africa reveals that many communities believe that the mentally ill cause, or contribute to, their illness as a result of religious transgressions, witchcraft or ancestral interference (Aphane, 2015; Chikaodiri, 2009). As a result of this communities

perceive that their negative attitudes towards the mentally ill are justified (Olugbile et al., 2009).

Despite an increase in mental illness and mental healthcare awareness programmes mentally ill individuals are still at an increased risk of being ostracised, negatively labelled, ill-treated and misunderstood by society (Ukpong & Abasiubong, 2010). Additionally, studies indicate that populations within the African continent hold negative attitudes and beliefs towards the, mentally ill as they have a poor knowledge-base about psychiatric illness generally (Barke et al., 2011; Chikaodiri, 2009).

Poor knowledge and specific cultural and social norms are related to individuals with a mental illness being misunderstood and generally experiencing stigmatisation in both westernised and developing countries.

## **2.6 South African studies**

Literature with regard to the views and perceptions of mental illness and the mentally ill within a South African context are presented in this section.

In some traditional populations in South Africa the mentally ill are perceived as being bewitched, this results in becoming outcasts from their communities (Bener & Ghuloum, 2011). A study involving Xhosa families of patients diagnosed with Schizophrenia underpins this sentiment as the research found that most participants believed mental illness was caused by possession, witchcraft or evil spirits (Mbanga et al., 2002). These findings are supported by a more recent quantitative study which found that respondents had poor overall knowledge about psychiatric illness. In the same study the mentally ill were described as spiritually possessed, dangerous and socially isolated (Todor, 2013).

Additionally, a qualitative study incorporating vignettes describing community perceptions towards the mentally ill as negative also found that most participants thought that the aetiology of mental illnesses was stress. As a result, most participants did not think that seeking professional intervention or medication was necessary (Hugo et al., 2003).

In a quantitative study conducted by Sorsdahl and Stein (2010) members of the public had to respond on a 5-point scale to questions about living with mental illness. The questions related to the following mental illnesses: Major Depression, Schizophrenia, Panic Disorder, Post-Traumatic Stress Disorder and Substance Abuse. Only 31% of the respondents correctly identified a mental illness while 29% reported the behaviours as typical of a general medical

condition (GMC). These findings revealed that poor recognition and identification of mental illness has negative implications for mental health treatment and help-seeking behaviours.

Poor mental health literacy levels in South Africa have negative implications for treatment and help-seeking behaviours for mental illness (Jorm, 2012). Ventevogel, Jordaan, Reis and de Jong (2013) state that public opinions and descriptions of mental illness are related to unique socio-political and cultural landscape of the nation. This is especially relevant as traditional treatment is high in South Africa and ultimately led to integrating traditional healers within the healthcare system in the country (Aphane, 2015). In support of this a study by Jack et al. (2013), concluded that treatment interventions that integrated mental health care into existing traditional health systems would be the most efficient approach to increasing access to care. Furthermore, the research found that an accurate and thorough assessment of health care systems was needed, as well as more data pertaining to traditional medicine and practices within the national context (Jack et al., 2013).

A South African study (part of a larger international study) of individuals suffering from Mood and Anxiety Disorders, revealed that most participants waited approximately 3-5 years before seeking help. The reasons attributed to waiting for such extended periods of time included: being uninformed on how to access treatment; attempts to cope without intervention; fear of embarrassment and fear of psychiatric medication (Seedat, Stein, Berk, & Wilson, 2002). The authors concluded that these findings inferred a poor knowledge base about psychiatric illness generally and fear of stigmatisation in seeking mental health care.

Major studies conducted within South Africa within professional populations have found a significant level of negative perceptions and beliefs towards mental illness as a whole (Lethoba, Netwera, & Rankhumise, 2006; Mavundla, 2000). Of particular significance was the finding that mental health nurses practicing within the public sector held a statistically significant level of negativity towards mental healthcare users (Lethoba et al., 2006).

In another study nurses' knowledge of mental illness and their perceptions of the mentally ill in 13 community clinics in the Western Cape was examined. The study found that most of the sample were unable to correctly identify mental illnesses presented in the research. Furthermore, the sample of nurses held negative views towards individuals with mental illness. It was also found that the sample of nurses in the research favoured psychotherapeutic treatments over psychotropic drugs as a mode of intervention (Yeo et al., 2001).

Other studies focussing on mental illness knowledge pools and perceptions in South Africa have addressed aspects of stigmatisation and the marginalisation of mentally ill individuals by specific professional populations for instance, medical doctors and psychiatric nurses (Egbe et al., 2014). Research has also revealed that people who are labelled as mentally ill self-stigmatise in relation to how they are perceived by their communities. In other words, if they are perceived as mad, dirty and dangerous by their communities they self-stigmatise in those terms (Hanafia & Van Bortel, 2015). Additionally, a South African study conducted on young professionals, aged between 23 and 26 years of age with a tertiary education, found that the majority of them actively distanced themselves from involvement with the mentally ill (Morkel, 2008).

In community settings the stigmatisation of mental illness and the mentally ill usually based on misinformation with regards to the origin of the illness for instance, ancestral spirits (Botha, Koem, & Niehaus, 2006; Hugo et al., 2003; Lupuwana & Simbayi, 1999). Communities generally ostracise the mentally ill as they 'fear' the spirits will cause the same type of illness in their families.

Research which aimed to establish the status of mental health knowledge in South Africa and what interventions, if any, were being made to counteract stigma or prejudice revealed several findings. Knowledge was generally poor in the country. It was concluded that anti-stigma campaigns and a better understanding of the knowledge informing stigma must be established through national intervention campaigns (Kakumal et al., 2010). The implementation of any mental health awareness, anti-stigma campaigns or interventions need to be urgently addressed within the country (Clement et al., 2015). This is underpinned by Ganasen et al. (2008) who state that good mental health knowledge is a predictor of better treatment of the mentally ill regardless of ethnicity or socio-economic status.

In South Africa an explanation for poor mental health literacy are the ongoing economic constraints and other societal issues that are viewed as more pressing (Jorm, 2012). Developing countries such as South Africa may attribute more importance to basic human needs such as food and shelter which means that mental health care needs are not prioritised (Sue, Sue, & Sue, 2003).

It is clear that lack of knowledge and incorrect information about psychiatric disorders are high in South Africa and that mental health literacy is not a priority.

## **2.7 Studies on mental health in student populations**

The majority of studies on attitudes and perceptions towards mental illness have been conducted on members of the general population and only a few have focused on student populations (Cuomo & Ronacher, 1998; Dietrich, Heider, Matschinger, & Angermeyer, 2006; Granello & Pauley, 2000; Zolar, Strbad, & Svab, 2007).

Viljoen (2005) conducted a qualitative study on the attitudes or perceptions of students towards suicidal behaviour and depressive symptomatology. The study used a qualitative approach in investigating the attitudes of the students towards aspects of mental illness. The results indicated that students who had previous experience with mental illness were more sympathetic towards those who committed suicide. It was also found that more sympathy was elicited when a co-morbid mental illness such as Major Depression was identified as being present (Viljoen, 2005). The researcher concluded that knowledge of mental illness and pre-existing misrepresentations of mental health are not separate from stigma but are inter-related.

In a study on the use of psychological services amongst a student population at the University of Cape Town (UCT) conducted by Flisher, De Beer and Bokhorst (2002), it was found that females (aged between 20 and 24 years) were more likely than men and other age groups to seek treatment for mental health problems. Moreover, the research indicated that the mental health services at the institution were under-utilised (4% of the entire student population). The researchers concluded that the limited use of mental health services was most likely due to the discrimination and stigmatisation as well as concerns about confidentiality (Flisher, De Beer, & Bokhorst, 2002).

In a 2012 study conducted on a student population at a university in Dublin (Ireland) a quantitative review of the relationship between negative perceptions of mental illness and that of gender, self-compassion and satisfaction with life was undertaken. The study examined the perceptions of psychology students as compared to law students. Results yielded that knowing someone with a mental illness, while studying within an academic field that places importance on mental health, resulted in more positively held perceptions towards the mentally ill (Fleming et al., 2012). It was concluded that the results of the study supported other literature which indicated that higher education levels leads to more positive perceptions about the mentally ill (Jorm, 2012), as well as more accurate knowledge about mental illnesses (Fleming et al., 2012).

A quantitative study investigated the knowledge of causes of mental illness and attitudes towards the mentally ill amongst a Nigerian teaching hospital student population. This cross-sectional descriptive study of a sample of 208 participants from the University of Uyo Teaching Hospital (using the Community Attitudes towards the Mentally Ill (CAMI) scale) indicated that student participants held very negative attitudes towards the mentally ill. Authoritarian and restrictive attitudes and views that supported custodial care were prominent in the findings (Ukpong & Abasiubong, 2010). The widespread belief in the supernatural causation of mental illness was found as well as notions that the mentally ill were a threat to public safety. Interestingly, the study found that 75% of the student respondents believed that there was something about the mentally ill that made them easily identifiable from a person with a physical illness (Ukpong & Abasiubong, 2010).

A cross-sectional descriptive study was adopted to study the attitudes of undergraduate students towards mental illness at a university in India in 2010. A total of 268 undergraduates were selected to complete the Attitude Scale for Mental Illness (ASMI) and the Opinions about Mental Illness in the Community (OMICC) questionnaires. Results generated significant differences between the number of nursing and business management students who agreed with certain statements posed by the survey regarding their attitudes towards mental illness. For example, many respondents indicated that they would move out of their community if a mental health facility was established in the area. They noted that they were not afraid of mentally ill individuals that have received treatment but that untreated individuals are violent (Vijayalakshmi, Reddy, & Thimmaiah, 2013).

Nursing students, in another study, were found to hold more benevolent perceptions as compared to business management students about the mentally ill. The nursing students believed that individuals with mental illness could secure employment and function relatively well in society following treatment. Nursing students were found to hold less pessimistic attitudes towards the mentally ill and believed that the public are generally prejudiced towards individuals with mental illness (Vijayalakshmi et al., 2013). The authors concluded that it was likely that the attitudes of nursing students and other health professionals may be more positive than those of business students and the general public due to the nature of their field of study within a healthcare framework. In a study amongst a student population that surveyed 456 students from various departments it was reported less stigmatising attitudes were found after the sample completed a workshop on mental illness (Gyllensten et al., 2011).

An important study by Zolar, Strbad and Svab (2007) investigated if a background of psychiatric education affected stigma towards the mentally ill amongst a student population. Findings revealed that the students who completed psychiatric studies as part of their coursework, held less negative views towards the mentally ill than students who had not. However, identified themes emerging from the study revealed that fear and alienation directed towards the mentally ill were prominent while mentally ill individuals were viewed as incompetent. This trend is mirrored in both developed and developing countries, and is quite apparent in South African research on the topic (Cuomo & Ronacher, 1998; Dietrich et al., 2006; Zolar et al., 2007).

A qualitative study conducted at the UCT sought to explore the negative perceptions of mental illness in a sample of university students (Hyde, 2011.) Thirteen participants from four respective faculties volunteered to participate. The themes elicited from the study revealed interconnected domains which may contribute to the shaping of negative belief structures. In defining mental illness, participants failed to view mental illness as occurring along a continuum and considered the term mental illness to relate to being 'crazy.' Perceptions of the causes of mental illness such as biological, social and cultural were found. In keeping with other available literature pointing to cultural and socially constructed explanations of mental illness (Aphane, 2015) themes of religion, spiritualism and witchcraft emerged (Hyde, 2011). Furthermore, the author highlighted the scarcity of research on the topic within the South African context and recommended further investigations in the field.

The literature reviewed suggests that negative perceptions of the mentally ill are decreased with higher education and/or exposure to the mentally ill. However, there is still much negativity within student populations towards those with psychiatric illnesses. Moreover, the views towards mental illness and help-seeking behaviours may very well stem from the existing knowledge base of students on aspects of the causation of mental illness as well as their cultural ascriptions.

## **2.8 Chapter summary**

Literature that the researcher reviewed revealed that attitudes and perceptions towards the mentally ill are generally negative and that much stigmatisation and discrimination exists. However, she also found that literature revealed that in student populations (with a high educational level) and some health care professionals are more empathic and understanding. The complex interaction of culture and conceptualisations of mental health were also identified

and found to be socially and culturally informed in developing countries which impacts generally negatively on health-seeking behaviours.

## CHAPTER 3: THEORETICAL FRAMEWORK FOR THE STUDY

### 3.1 Introduction

This chapter presents the theoretical framework which underpins the study. In this research study, it was thought appropriate to use the Theory of Social Representations. The rationale for underpinning the study with Social Representations (SRT) is that it is appropriate in understanding constructions of mental illness.

### 3.2 Social Representations Theory (SRT)

Embedded within a social psychological framework, SRT seeks to study psychosocial phenomena. The concepts and ideas comprising SRT is understood as being entrenched within social, cultural and historical conditions, which are outlined briefly.

The term *social representation* was originally Moscovici (1981) which is essentially understood as a collective elaboration of a social object by individuals for the purpose of behaving and communicating. The elaborated social object becomes a social reality by virtue of the object's representation which the community or society holds. From Moscovici's (1981) formative work, the concept of a social representation has evolved into a theory that refers to a system of knowledge, beliefs, perceptions, ideas and practices amongst groups of individuals comprising a community or society that is socially constructed.

From this perspective, a social representation is a collective phenomenon which is socially co-constructed by individuals within a particular social grouping. In social representations theory, a social group is considered as comprising of four or more individuals. The ensemble of thoughts, feelings, perceptions and knowledge expressed verbally or through action constitutes the social construction of a particular phenomenon, in this case, mental illness (Moscovici, 1981).

### **3.3 Rationale for underpinning the study with Social Representations Theory (SRT)**

From the literature, various findings emphasise the role of socially constructed understandings of mental illness, especially within the African context (Allen, Balfour, Bell, & Marmot, 2014; Jorm, 2012; Rogers & Pilgrim, 2014).

Social representations of mental illness may be thought of as a culmination of beliefs, social practices and shared knowledge that exists within the fabric of a specific population or society. Such a view emphasises the social nature and origins of individual beliefs and behaviours and recognises the cultural and historical grounding of prevailing beliefs and practices. In conceptualising mental illness amongst a student population considering both the agency of individuals and society, this theory is ideally suited to the study (Gilbert et al., 2013).

Social Representation Theory (SRT) maintains that phenomena and processes can only be properly understood if they are seen as being embedded in historical, cultural and macrosocial conditions. Mental illness as a social representation is thereby understood as the collective elaboration of a social object by the community within which it exists, for the purpose of behaving and communicating (Clemence, Doise & Lorenzi-Cioldi, 2014). As such, a social reality exists by virtue of the representation of which the collection of individuals or community holds. Furthermore, a social representation of mental illness is understood as a collective phenomenon pertaining to a community which is co-constructed by individuals (Purkhardt, 2015). These individuals thereby, form representations in their daily activities which may comprise of various activities such as talk and action.

Social Representations Theory (SRT) has been used in qualitative research in order to study various social and psychological phenomena, including the social construction of mental illness. The most prolific use of social representations theory in understanding mental illness is found in a study that found that a group of individuals forming a community had established a socially constructed understanding of mental illness. This informed their manner of engaging, communicating and interacting with the mentally ill. Implicit in the accounts and observations is an overall representation of mental illness as foreign, other and threatening (Batel, Castro, Devine-Wright & Howarth, 2016). In the study, knowledge, perceptions and views were found to be informed by distinct understandings of mental illness within the group of individuals comprising the community. Morant's (2006) exploration of the social representations of mental illness from the perspective of French and British mental health practitioners underpinned these findings.

Understandings of mental illness draw simultaneously on a range of different models and belief systems which are derived from historically rooted cultural belief systems. Due to the multiplicity of understandings of mental illness amongst different cultures and social groups, no one model of mental illness is found to rule. Rather, individuals are found to draw simultaneously on a range of knowledge, perceptions and belief systems serving to inform their understanding of mental illness.

Research into lay representations of mental illness clearly represent mental illness as a phenomenon which is generally viewed negatively, with fear and suspicion. The social representations of mental illness have been associated with abnormality, danger and difference. This representation of a social construct has also been associated with individuals and groups rejecting, excluding and separating themselves from the mentally ill (Purkhardt, 2015).

In this study the overall student population constitutes its own distinct social group with its own socially constructed understanding of mental illness. The SRT enables the examination of the cultural and social dynamics of the student group under review. As such, the theory provides a framework for conceptualising the broader branches of knowledge that circulate in the student population about socially meaningful objects, including the social representation of the mentally ill. Furthermore, SRT also posits that groups have both material and symbolic manners of coping with what they do not fully understand and constructing meaning.

Social Representations Theory (SRT) posits that basic understandings within a group's existing representations come to the fore and are used for the naming and understanding of certain socially constructed phenomena such as mental illness. The theory further asserts that groups, whether culturally or politically defined maintain a particular discourse regarding the socially constructed phenomena that is, mental illness (Purkhardt, 2015). Through the framework of SRT the nuanced meanings, knowledge and perceptions towards mental illness and the mentally ill can be ascertained amongst a purposive sample of students registered at the University of Limpopo (Turfloop Campus).

### **3.4 Chapter summary**

In this chapter the researcher explained why SRT was used and clarified the reason for its use in this research. The following chapter provides the research methodology for the study.

## **CHAPTER 4: RESEARCH METHODOLOGY**

### **4.1 Introduction**

This chapter gives a comprehensive overview of the research processes used in the study and includes the research design, sampling procedure, data analysis and ethical considerations.

### **4.2 Research design**

For the purpose of this study a qualitative approach was utilised using an exploratory research design. This approach allows for the understanding and interpretation of the meanings and the intentions underlined in the specific context (Harper & Thomas, 2011; Ho, 2011).

### **4.3 Population**

The population that was sampled was all undergraduate students at the University of Limpopo (Turfloop Campus).

#### **4.3.1 Area**

The research took place at the University of Limpopo (Turfloop Campus), Sovenga, Polokwane, Limpopo Province.

#### **4.3.2 Sampling**

The sample population includes undergraduate students, currently enrolled in either their 1st, 2nd or 3rd year of study at the University of Limpopo (Turfloop Campus) between the ages of 18 – 25 years old. The University of Limpopo (Turfloop Campus) houses four faculties, namely: The Faculty of Health Science; The Faculty of Humanities; The Faculty of Science and Agriculture as well as the Faculty of Management and Law (at the time of the research the Medical Faculty had not been established). A purposive sample of 16 undergraduate students, four from each faculty at the University of Limpopo (Turfloop Campus) was considered appropriate for this qualitative study.

### **4.4 Data collection and data collection tool**

The questions prepared for the interviews were pre-tested on three non-participating students. The questions were understood by these students and no other problems for instance, in sentence construction and/or bias were found thus the interview protocol was not changed.

Information posters were placed strategically on campus in areas such as the student centre and library detailing the study and in the different Faculties. Students were asked to contact the researcher. The researcher asked the first 2 males and first 2 females from each Faculty to take part in her study (to ensure gender representivity). Names were kept of other students in case any participants' 'dropped out.' This list was destroyed when the data was collected as no participants dropped out.

Semi-structured interviews were used as a data collection technique. The interviews were conducted following a semi-structured interview, included as Appendix A, aimed at eliciting specific data with regards to participant's knowledge and perceptions of mental illness and the mentally ill. Due to the flexible nature of semi-structured interviews it is often referred to as a conversation with a purpose (Guest, MacQueen & Namey, 2011) in this case, the purpose being to illicit the participant's knowledge and perceptions. With a semi-structured interview, the interviewer and the interviewee are equal partners, allowing the interviewee to explore the different paths that may arise during the interview (Lincoln, Lynham & Guba, 2011). Questions in the semi-structured interview format were constructed after a reading of the relevant literature.

During data collection, it was important for the interviewer to maintain the balance between flexibility and control throughout the interview process. The researcher identified herself to the participants and then each participant was given an opportunity to introduce themselves. This facilitated rapport building between the researcher and the participants. The researcher then introduced the topic to the participants and briefly elaborated on the research aims. All interviews were taped and recorded and permission was granted for this (Harper & Thomas, 2011) in order to aid the ease of which the interviews may be transcribed for analysis. As the medium of instruction at the University of Limpopo (Turfloop Campus) is English, the interviews were all conducted in English as well. Debriefing was offered to the participants at the end of the interview, with any questions or concerns raised by the participants addressed. They were also told that counselling was available should they feel they needed it.

#### **4.5 Data analysis**

Thematic Content Analysis (TCA) was utilised as the method for identifying and analysing patterns of meaning in the study's dataset. Thematic Content Analysis (TCA) allowed for the illustration of important themes that emerged in the description and understanding of the

phenomena under review (Harper & Thomas, 2011). Through incorporating the use of TCA, salient groupings of themes present in the data were obtained.

The six phases of TCA as outlined by Braun and Clarke (2014) were utilised in the study and each will be outlined below.

Phase 1 included familiarising oneself with the data through repeated reading and submersion in the raw data obtained. The researcher immersed herself in the data to the extent that she became familiar with the depth and breadth of the content as outlined by Braun and Clarke (2014). This was obtained through repeated reading of the data in an active manner. Transcription of the interviews was conducted during this phase, transcribing participant's interviews verbatim which aided the familiarising process.

Phase 2 included the production of initial codes from the data into meaningful groups of data. After having been familiarised with the data, the generation of an initial list of ideas about the data was produced as initial codes for the dataset. The initial codes were manually coded on hardcopies of the transcribed data and systematically applied to the entire dataset. Additionally, participants were coded according to which faculty they studied under. The coding was included for purely convenience purposes and so as to ensure the participant's confidentiality when quoting their responses in the study and is outlined in Chapter 5.

Phase 3 involved searching for themes from the data coded and collated in Phase 2 of the analysis process. Phase 3 focused on the broader level of themes and collating all the relevant coded data extracts within the identified themes. The different codes were subsequently analysed and sorted into potential overarching themes which emerged from the dataset. The relationship between codes, themes and different levels of themes were manually recorded on the transcripts.

Phase 4 incorporated a process of reviewing the themes identified in Phase 3. Essentially, data within and across the initial themes identified in Phase 3 were analysed. The analysis process addressed whether there were clear manners of cohering together meaningfully amongst initial themes whilst still ensuring that clear and identifiable distinctions between the themes were made. In order to review the initial themes, the collated extracts from each theme were considered with regards to whether or not they formed a coherent pattern. Themes that did not appear to form a coherent pattern were essentially reviewed. Thereafter, the validity of individual themes in relation to the dataset and thematic content was analysed.

Phase 5 involved the naming and defining of the prevailing themes. Identifying the essence of each theme and sub-theme was essential in this phase, so as to effectively define and describe the scope and content of each theme. At this point in the data analysis process, the naming of the various these and sub-themes was conducted.

Lastly, Phase 6 required the production of a comprehensive report of the entire process of Thematic Analysis from the raw data which is included in Chapter 5. Particular examples from the dataset are included, as well as extracts which capture the essence of the theme or sub-themes accordingly. The underpinning of the study with SRT is presented in a narrative format.

#### **4.6 Quality criteria**

Shenton (2004) developed criteria that ensure reliability and validity in qualitative studies which were used in this study and are discussed below.

**4.6.1 Credibility:** The researcher ensured credibility by collecting and analysing data for the study similar to that used in other qualitative studies. Secondly, the sample drawn from undergraduate students at the University of Limpopo (Turfloop Campus) was compatible with site sampling; ensuring the students drawn are from the same context. Thirdly, the participants were informed of the nature and implications of the study and made aware of their rights. Probing was used to acquire clarity from participants where necessary. Lastly, criticism and inputs were given during faculty and school presentations at the University of Limpopo (Turfloop Campus) the proposed study for adjustments on areas overlooked by the researcher, and these inputs had been incorporated into the study accordingly.

**4.6.2 Transferability:** Transferability is attained when the study uses existing literature to ground the research. The researcher used multiple sources and conducted a broad literature review to ensure this. In other words, readers must be able to read this study and look at the findings in comparison to a similar study as this will help them to gain a proper understanding of the investigation.

**4.6.3 Dependability:** The researcher provided a description of the research methods which were used to ensure the research process is dependable. The researcher gave a detailed explanation of how the research was conducted. She also ensured that the participants verified the data transcripts so that meaning was not lost. This ensures that other researchers will be able to reproduce or replicate this study and find some similarities in terms of research results.

**4.6.4 Confirmability:** Confirmability has been attained through the researcher employing every means possible to remain objective and unbiased whilst also conferring with a research supervisor at the University of Limpopo (Turfloop Campus). The researcher was able to maintain this objectivity by using ‘bracketing,’ that is she was able to put her own thoughts and judgments aside. She did this by engaging in reflection and having meetings with her researcher supervisor.

**4.7 Bias:** The researcher remained cognisant of possible bias and as far as possible remained unbiased by consulting with her research supervisor at the University of Limpopo (Turfloop Campus). This was carried out so any possible bias could be determined when discussing the research. All of the participants came to the same place at the same time (though on different days) and the same questions and rapport building were entered into which obviated administrative bias. Continual reflection on her role in the investigation allowed the researcher to recognise any biases she might have had.

## **4.8 Ethical considerations**

### **4.8.1 Confidentiality and anonymity**

All participants were told that information was confidential and that only the researcher and her supervisor would read the transcripts which would be anonymous as participants’ names would not be included. Participants were also told that a mini-dissertation and a journal article were the final outcomes of the research and if they agreed to this. All participants agreed to the research being published in a mini-masters and a journal article as long as their names were not used.

### **4.8.2 Informed consent**

Informed consent was obtained from the participants after being informed in a manner in which is clear and concise, about the study and its requirements (Ritchie, Lewis, Nicholls, & Ormston, 2013). All participants filled in and signed an informed consent release. An explanation of procedures in terms of anonymity and confidentiality was provided to all participants. The ethical clearance certificate obtained from the University of Limpopo (Turfloop Campus) is available for perusal in Appendix C. No data was collected until approval was gained through the University of Limpopo (Turfloop Campus) structures.

### **4.8.3 Voluntary participation and autonomy**

It was made clear to all participants that participation in the study was voluntary and that should the participants decide against participation at any point, no negative consequences would arise. This means that participants must know their rights in terms of the research and that agreement to participate is not binding. They are autonomous and can withdraw at any time.

### **4.8.4 After-care for participants**

Although the risks associated with participation in this study were estimated as minimal, protection from any psychological harm resulting from the participation in the study was upheld. If any psychological risk did arise, which to the best of the researchers' knowledge it did not, counselling and debriefing was made available (Corbin & Strauss, 2014).

Furthermore, safety and security as well as issues of confidentiality with regards to the recordings were discussed with the research participants and all efforts to ensure the safekeeping of the recordings were maintained (Bryman, 2015).

## **4.9 Chapter summary**

The researcher explained the research design and approach in this chapter as well as the sampling, data collection, data tool and data analysis techniques. The researcher also gave a proper explanation for the ethical procedures used in the investigation. In the following chapter (5) results are presented and discussed.

## CHAPTER 5: PRESENTATION AND DISCUSSION OF RESULTS

### 5.1 Introduction

Social representations of mental illness denote that meaning and experience are socially produced and reproduced. Thematic Content Analysis (TCA) was conducted within this ambit to analyse data gleaned from the participants. The framework (SRT) seeks to underpin responses within the socio-cultural context and structural conditions that enables the participants to provide their accounts (Braun & Clarke, 2014). Five dominant themes emerged in the analysis of data, namely: 1) Factors informing the knowledge and perceptions about mental illness and the mentally ill; 2) Definitions and understandings of mental illness; 3) Views of the mentally ill; 4) Causes of mental illness and 5) Treatment of mental illness.

The aforementioned themes are presented in tabular format for ease of reading. A general meaning is given for each theme and sub-theme is provided. Themes are highlighted in their specific colours, while sub-themes have been typed out in their specific colour codes to aid reading in the table.

For ease of reading the table is presented on the next page (so it is not broken up).

**Table 1: General meaning of themes and sub-themes**

<b>Theme</b>	<b>General meaning of the theme</b>
Knowledge and perception informing factors	Factors informing the knowledge and perceptions about mental illness and the mentally ill
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Experiences with the mentally ill	Experiences with the mentally ill manifested either through first person lived contact or through word-of-mouth and observation
<b>Theme</b>	<b>General meaning of the theme</b>
Definitions and understandings of mental illness	Content constituting the definition and understanding of mental illness
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Experience of dysfunction in certain areas of functioning	Mental illness is defined as a dysfunction in various spheres of functioning
Deviation of normality	Mental illness is defined as abnormality
Alteration in mental state	Mental illness is understood as an alteration in a person's mental state
<b>Theme</b>	<b>General meaning of the theme</b>
Views of the mentally ill	How the mentally ill are viewed
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Mentally ill as Other	The Other refers to conceptions as being other than oneself
Mentally ill as dangerous	Mentally ill viewed as being dangerous
Mentally ill as unpredictable	Mentally ill viewed as unpredictable with regards to their thoughts, behavior and emotions
Mentally ill as dysfunctional	Mentally ill viewed as being dysfunctional
Mentally ill as in-need	Mentally ill viewed as being in-need of care
<b>Theme</b>	<b>General meaning of the theme</b>
Causes of mental illness	Ascribed causes of mental illness
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Biological causes	Ascribed biological causes of mental illness
Socio-environmental causes	Ascribed social and environmental causes of mental illness
Cultural causes	Ascribed cultural causes of mental illness
<b>Theme</b>	<b>General meaning of the theme</b>
Treatment of mental illness	Understandings of the treatment of mental illness
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Treatment vs cure of mental illness	Understandings of whether mental illness is treated or cured
Treatment options available	Treatment option available for treating mental illness
Means of accessing treatment	Pathways of accessing care treatment for mental illness
Perceived effectiveness of treatment	Perceptions related to the effectiveness of mental illness treatment

## 5.2 Demographic results

The sample consisted of 16 participants, four from each Faculty at the University of Limpopo (Turffloop Campus) with a total of 6 male and 10 female participants overall as presented in Table 2. Gender representivity is Females (62.5%) and Males (37.5%). More females than males wanted to take part in the study thus full gender representivity could not be achieved.

The following table provides the gender, age and level of study of participating students in a concise format.

**Table 2:** Demographic information of undergraduate students who participated in semi-structured interviews

Gender	Number	Age	Level of study
Male	6	21, 21, 25, 21,19, 21	2 <sup>nd</sup> , 2 <sup>nd</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> , 1 <sup>st</sup> , 3 <sup>rd</sup>
Female	10	19, 18, 20, 20, 19,21, 25, 22, 23, 19	1 <sup>st</sup> , 1 <sup>st</sup> , 2 <sup>nd</sup> , 2 <sup>nd</sup> ,1 <sup>st</sup> , 3 <sup>rd</sup> , 3 <sup>rd</sup> , 3 <sup>rd</sup> , 2 <sup>nd</sup> , 1 <sup>st</sup>

Additionally, during the data analysis process participants were coded according to which Faculty they studied under. The coding was included to ensure the participant's confidentiality when quoting their responses to questions asked. Six males and 10 females took part in the study drawn from 1<sup>st</sup>, 2<sup>nd</sup> and 3<sup>rd</sup> year undergraduate levels.

**Table 3:** Coding of participants' responses according to faculty

Faculty	Participant coding
Humanities	H1, H2, H3, H4
Health Sciences	HS1, HS2, HS3, HS4
Science and Agriculture	SA1, SA2, SA3, SA4
Management and Law	ML1, ML2, ML3, ML4

Four participants were registered in Management and Law, four in Science and Agriculture, four in the Health Sciences and three from the Humanities.

### 5.3 Factors informing knowledge and perceptions

All responses are given verbatim and have not been corrected (neither sentence construction nor grammar) to add accuracy and veracity to the research.

From the dataset, the theme of participant's perceptions and knowledge regarding the mentally ill and mental illness emerged. From this broader theme, a sub-theme pertaining to the participant's experiences with the mentally ill emerged. Such experiences were described by participants as a) either through first person contact or b) through word-of-mouth and c) through observation of those who the participant thought was mentally ill.

Individuals with first person knowledge attributed knowing family members or friends that were diagnosed as mentally ill or suspected of being mentally ill (because of their behaviour). The social representation of mental illness was thus informed by individual participant's interactions with these persons. According to SRT interacting and communicating within a specific socio-economic context enables individuals to conceptualise mental illness socially. The following responses underpin this themes and how concepts of mental illness are formed socially.

*Yes. Like my aunt, I don't know what was wrong with her but I was still young. She just started singing, doing all these crazy things...and also my uncle, affected by the same thing, but I've just seen whereby he is not taking his meds so he just started going crazy, swearing at people, always shouting (Participant HS4).*

*I heard an uncle who was mentally ill, he used to go to like a clinic to get the medication... (Participant ML2).*

*...I've interacted with a lot of mental, a lot of people suffering from mental illness. I also have relatives who are suffering from it, so I understand it a lot more... (Participant ML3).*

Experiences with the mentally ill within a community setting informed some of the participant's perceptions about the mentally ill. Definitive patterns of talking about, hearing about and how this information was constructed and reconstructed led to participants understanding of mental illness. Deviations in behaviour characterised as abnormal in the

communal context was found to be associated with the belief that mental illness was implicated in that individual's behaviour. Social constructions of normality are informed by the behaviour of the many and those who behave 'differently' are thus not 'normal' in the eyes of a community. Mental illness is thus perceived, through means of interacting and communicating in a specific culture with specific social systems in terms of SRT. This is reinforced by the followings statements from participants,

*There is a particular person where I'm staying at the village, he's having a mental illness...in our village they focus too much on the person doing funny things and laughing...we don't treat them the same... (Participant ML4).*

*Yes, I know them [mentally ill] because it is this lady where I come from, I come from Phalaborwa, she used to walk in the street with a whip. Whenever she finds you she would beat you with that whip, but sometimes she is cool, she can even greet you on the way...I'll just say she's mentally disturbed (Participant SA4).*

Communal living which is found within a village or community is established and perpetuated through social interaction and construction. The majority of participants were from small per-urban or rural communities and formed a new community on entering the institution. However, learned behaviours from their up-bringing persist and may even be added to in the new environment (for instance, if peers show discrimination towards students perceived as mentally ill). The behaviour described in the examples above, although giving no clear reference to a mental illness with regards to the diagnostic criteria for diagnosis required (APA, 2013), illustrates a clear deviation from social expectations. This has been formed and reformed through social interactions and informs the participants understanding of mental illness in terms of SRT.

Additionally, the ostracism of individuals who have been conceptualised as mentally ill within the community context was noted by one participant.

*I think what I've observed from my own community...we don't treat them as part of the community...they go through a process of ostracism, whereby they don't form part of the community, we don't see them as people who can contribute towards the issues of*

*the community [even at university], in most cases we even hide them... (Participant SA2).*

The theme of ostracism of the mentally ill was found throughout the sample. One participant stated that many members of the community are taught to relate to mental illness and the mentally ill in a specific manner.

*Given that the people living in a community, with the people affected by mental illness since they are not taught how to treat them and how to react to them since those people will not understand what they will be doing... (Participant H3).*

It is evident from the above examples, friends, family, community members and peers, as well as cultural practices and beliefs inform the social construction of mental illness.

#### **5.4 Definitions and understandings of mental illness**

Definitions of mental illness are important in informing the views and perceptions the participants possess towards the topic. It must be noted that the participants' views of mental illness as an entity (on its own) and the mentally ill as individual's is complex and intricately interwoven.

The manner in which mental illness is defined is understood as informing the level of knowledge that participants possess in terms of psychiatric illness generally. The following themes were elicited in participants understanding of the concept of mental illness in terms of dysfunction in certain areas of functioning, understanding mental illness as a continuum, understanding mental illness as abnormal (in terms of existing norms) as well as changes in mental state as a characteristic of mental illness.

#### 5.4.1 Experience of dysfunction in certain areas of functioning

The participants relied heavily in their definitions of mental illness as dysfunctional in different spheres. This is illustrated by the following responses.

*Okay, to my understanding of mental illness. I think a mental illness is a condition or disorder that affects a person's thinking, mood and behaviour (Participant SA3).*

*According to my own understanding, a mental illness is a state whereby the properties of the mind...are not working together harmoniously to produce balance or an equilibrium...in order for a person to function (Participant SA2).*

Participants understood that dysfunction accompanying mental illness exists within the areas of behaviour, cognition, emotion and some understood it could affect an individual physically (somatic) as well. The emphasis however was on biological factors as well as deviant or bizarre behaviours characterised by acting in an irrational or strange manner (that is, different from the accepted norms in participants' communities). Further dysfunction was defined as manifested by oddities in speech and thinking. This is underpinned by the following responses.

*I think mental illness is... someone is suffering in the brain, it doesn't function well...they are they are sad and the way they are thinking... sometimes they say negative things (Participant HS3);*

*I think mental illness...a person who has a problem with mind or yes, a problem with mind. Mind disturbance, maybe this person, I don't know, I heard people saying that it happened that the person is the blood on the mind...(Participant ML4).*

*The senses aren't functioning well... that person mentally he is... not functioning as a whole (Participant HS1).*

Terms most commonly used to define mental illness included:

- *mind disturbance* (Participant H4, ML4);
- *mentally disturbed* (Participant H2, HS2, SA1, SA4);
- *mentally unstable* (Participant H1, H3).

Overall in defining mental illness participants' described states of mind or cognitions but did not refer to biological or genetic aetiologies for psychiatric illness.

#### **5.4.2 Deviation in normality**

In defining mental illness, the notion of abnormality arose. Concepts of what constitutes normality, although not explicitly stated in the dataset, revealed that conceptualisations of mental illness represented the clear presence of abnormality. This abnormality was represented as a social deviation from the norm in participants' communities.

*...this one man where I used to live was mentally disturbed, but that one, he would become mad and sometimes he would be normal... (Participant SA1).*

*I think whatever they are doing at that particular time, doesn't correspond with the normal way of living (Participant ML1).*

Social representations of abnormal behaviour informed participants' understanding of mental illness. These observations form part of the social representation of the phenomena of mental illness which are inherent to social communication in terms of SRT. Furthermore, the existence of abnormality in defining mental illness filters into the 'othering' of the mentally ill (see 5.5.1).

*I think mental illness is a state of being mentally ill. Because the person is like mentally disordered, it's not like, eish, they are the same as us, but mentally they are not (Participant ML2).*

*I think mental illness of the brain is abnormality in a person that makes him to be sort of ostracized or set apart from the community because of the behaviour that emanates from this state of mental illness (Participant SA2).*

The concept of abnormality inherent in definitions of mental illness is intricately linked with aspects of stigmatisation and discrimination. Previous findings in research using SRT utilising conceptualisations of mental illness amongst participants are linked to notions of abnormality and deviance from the norm (Batel et al., 2016). The social construction of concepts of normality and abnormality and what defines their existence is intricately linked to phenomena such a mental illness (Allen et al., 2014).

Conceptualisation of abnormality contribute to participants' knowledge about mental illness which is socially constructed and societally informed. This is succinctly conveyed by the following responses.

*I think people, when they are behaving unhuman like that's mental illness (Participant ML1).*

*...not acting normally, acting strangely... doing things that are not done by normal people around in the community (Participant H2).*

*...but in our village they focus too much on the person doing funny things and laughing... (Participant ML4).*

Although defining mental illness as behaving 'unhuman' and as acting 'strangely' in the community serve as extreme examples in defining mental illness it is likely these conceptualisations occur commonly.

### **5.4.3 Alteration in mental state**

Inherent in defining mental illness is the concept of a stable state of function (norm) that exists within the socio-economic and cultural norms that participants' have experienced throughout their lives.

*Mental illness I think is the state whereby an individual is unfit mentally. In a certain extent whereby they do things and after some time, they are not even aware of the things they have done... (Participant HS4).*

*Mental illness is a state whereby the brain is not functioning well (Participant H2).*

*I only know this one man where I use to live was mentally disturbed, but that one, he would become mad and sometimes he would be normal. His mental illness was not that bad. You could tell that this person sometimes knows what he's doing but sometimes his mind just gets disturbed (Participant SA1).*

Participant's understanding of mental illness incorporates various changes in an individual's mental state. Participants believed that the majority of the mentally ill suffer from disturbances in reality (they cannot differentiate what is real from what is not). Responses from 2 participants underpin this notion.

*Isn't it mental illness is like when you're not all there together upstairs, in your head. You can just be there one minute knowing what's what and then another time you don't know what you're doing or saying. I've seen them, it's like sometimes they don't even*

*know it is happening. Then when they talk with you it's like they don't know what they did, but we can all remember (Participant HS2).*

*...they [mentally ill] just happen to be functioning at another dimension of mental state... (Participant SA2).*

The above responses convey the message that although the mentally ill may not be aware of their illness or their altered mental state other members of their community or social group are. These memories and observations have lived on in their consciousness and infers that their understanding of mental illness is linked to an individual fluctuating between states of abnormality and reality. A progressive relationship between what participants noted as the expression of symptoms and understanding of when an individual became mentally ill was not clearly established within the emergent themes of the dataset.

Definitions of mental illness amongst the student population were mixed as presented in the aforementioned themes. Nonetheless, it was clear that participants' understandings of mental illness were linked to what was considered dysfunction in the cognitive arena and that those suffering from mental illness were unable to untangle the real from the imaginary (unreal).

## **5.5 Views of the mentally ill**

Various themes emerged as to the views of the participants towards the mentally ill. The dominant themes emerging from the dataset include viewing the mentally ill as other, namely as dangerous, unpredictable, dysfunctional and in need. Each of these will be reported on below in further detail.

### **5.5.1 Mentally ill as the 'other'**

A dominant tendency was the notion around conceptualisations of 'us' and 'them,' with mentally ill individuals as the 'other,' The inference was that the 'other' was not normal but an out-group that was abnormal in some way and was perceived in a negative manner.

*They are different to us; you can see them with mental illness. You will know in the village who is mentally ill and who isn't. Sometimes the other people will tell you that or you will hear from around (Participant HS2).*

The notion of 'othering' arose as a distinction between mentally ill individuals as different from the socially constructed phenomena of the participants' social norms which was articulated by one participant:

*People are not acting normally, they're acting strangely. They are doing things that are not done by normal people (Participant H2).*

A clear violation of societal notions and of what is, and what is not acceptable, was stated. Participants' perceived the mentally ill as violating notions of social normality on multiple levels. The following response echoes this sentiment.

*...they don't think like us, there are a lot of things that are differing from us, the way they talk, they talk some things that doesn't make sense some of the time and then which means the mind is disturbed...we are not the same... (Participant ML4).*

This perceived violation of social norms was consistently found in the data transcripts. This 'othering' suggests the complex interplay between culture and the construction of societal norms. An extreme form of 'othering' is seen in the following statement where a participant perceives mental illness as so foreign that it is conceptualised as unhuman:

*I think people, when they are behaving unhuman like that's mental illness. I think whatever they are doing at that particular time doesn't correspond with the normal way of living (Participant ML1).*

### **5.5.2 Mentally ill as dangerous**

Mentally ill individuals are often described as violent, scary, sick and dangerous in the dataset out of which the theme of the mentally ill as dangerous arose. This conceptualisation of the mentally ill as dangerous was closely linked with elements of fear, as was voiced by one participant in the following comment:

*I think we must be careful around them...they may be dangerous; they may hurt you (Participant H1).*

Associations of dangerousness with mental disorders cause fear and helps maintain the stigmatisation and discrimination of the mentally ill.

*...I'm scared of people who are mentally ill...I know they are violent; I like to play far from people who are mentally ill (Participant ML1).*

*Some of them they are scary, Ya, but some of them you can live with them, Ya it depends on how she acts (Participant SA4).*

The above statement conveys how elements of fear, based on conceptualising the mentally ill as violent serve to help actively distance so-called normality from so-called abnormality. Conceptualisation of the mentally ill as dangerous emerged as participants interpreted their strange or different behaviours as dangerous which were reinforced by the element of unpredictability accompanying such behaviours. These understandings frame social representations of mental illness and the mentally ill.

### **5.5.3 Mentally ill as unpredictable**

Notions of the mentally ill conceptualised as unpredictable are intricately intertwined with perceptions of their dangerousness. Notably, their perceived unpredictability was found to introduce an element of fear based on their perceived lack of control over their behaviour(s). The following responses underpin this theme.

*...if the mind can just change at a time, they may be dangerous...* (Participant H1).

*...we just need to learn how to live with them and how to react with them since they can do improper things, somewhere, somehow* (Participant H3).

Participants' social representations of the mentally ill as dangerous and unpredictable elicit fear and when individuals are afraid they are likely to discriminate against, and stigmatise the group they fear. These notions are underpinned by the social constructionist nature of the understanding of the mentally ill and how they function. Social representations of the mentally ill as unpredictable, impulsive, and unable to control their minds and/or behaviour informed participants responses.

### **5.5.4 Mentally ill as dysfunctional**

The theme of the mentally ill as dysfunctional or defective was perceived by some participants' as a result of a dysfunction in their brain. This dysfunctionality was associated with concepts of being sick, weak, unstable, mentally disturbed and unable to cope effectively. Further dysfunction was perceived as being demonstrated by oddities in speech and thinking. The following responses from participants reinforces this theme.

*... someone is suffering in the brain, doesn't function well...they are they are sad and the way they are thinking... sometimes they say negative things* (Participant HS3).

*The senses aren't functioning well... that person mentally he is not a whole... not functioning as a whole (Participant HS1).*

This perceived dysfunctionality is underpinned by social constructions often related to specific cultural norms as supported by the following participants' responses.

*...you know the way we grew up, we were told that if one does that, that person can result in mental illness, can result in having mental problems and I think actually sickness... (Participant HS1).*

*The stories we were told as youngsters about how these things can be, that you start to act crazy and cannot be functioning normal. You know, within these African cultures that is what you are told and made to believe (Participant HS2).*

### **5.5.5 Mentally ill as in-need**

Despite the largely negatively perceptions towards the mentally ill, participants acknowledged that the mentally ill are at risk and in need of care and psychiatric, social and psychological interventions. The view of the mentally ill as requiring care and interventions were informed by the previous themes which represent them (socially) as dysfunctional, sick and weak suggesting that they must be in need of care.

Various levels of care were noted for instance, community and more specialised interventions as well as more global services.

*...you have to help them...we have to try and take care of those people...they still deserve our care... I think it's better if psychologists and all those that can, are in a position to help mentally ill people can actually do their job to help those people, because it would be for the benefit of everyone around them and the benefit of their families to actually be helped to function well. (Participant HS2).*

Culture was found to play an important role in the conceptualisation of mental illness and the mentally ill. This emerged as an understanding that there was a need for specific rituals and/or traditional practices or prayers (religious) in the healing of mental illness in African communities.

*...prayers, candling someone who believes in the Word of God... (Participant HS1).*

*...special attention, and being welcomed in certain groups so that they cannot feel being rejected (Participant H4).*

*...ritual help (Participant SA1).*

Culture and social representations of mental illness, inherent to the social context of a specific culture have been well established in literature related to the mentally ill and their social environment (Rogers & Pilgrim, 2014). The larger macro system in which cultures exist is also implicated for instance, within the legal system in the national context.

*In South Africa they are now trying to protect these people [the mentally ill] by restricting them from doing certain things. Which means they, in fact let me say their brain is failing to protect their own selves from certain things, so they are using certain law procedures to protect these people. (Participant H3).*

Participants perceived the mentally ill as in need of care and appropriate interventions and treatment. This was captured by one of the participants.

*I'd really like people to educate those who are around people with mental illness on how to treat them and how to socialise with them (Participant HS4).*

## **5.6 Causes of mental illness**

Causes of (or the aetiology) of mental illness were mostly perceived as cultural or traditional. Cultural beliefs emerged as a major feature in participants' understandings of the aetiology of mental illness.

*...but I think we Africans who believe in traditional whatever's [causes] and everything, I think that's what caused his or her mental illness (Participant SA3).*

A broader level of thematic inference in terms of causes of mental illness are presented next although, as noted earlier, the majority of participants perceived that mental illness was caused by ancestral issues or witchcraft.

### 5.6.1 Biological causes of mental illness

Some of the participants reported biological causes of mental illness. Themes that emerged from the data are consistent with themes from the natural sciences and medicine. References were made to:

*Being born with it [mental illness] (Participant ML4).*

*Genetic [mental illness] in terms of origin (Participant SA2).*

Furthermore, one participant attributed mental disorders to the development of the foetus within the mother's womb.

*I think the problem happens during the process of developing inside [the mother's womb]. Ya maybe there were some errors and that leads to mental disorders (Participant SA4).*

Another participant stated that the possibility of a traumatic brain injury (TBI) could lead to a mental illness. This participant had some knowledge that not all mental disorders are genetic and can be acquired for instance, due to an illness or accident. This is illustrated by the following response.

*There are so many things, there are injuries and accident's whereby the brain has been damaged (Participant HS4).*

The use and abuse of substances were also implicated as a cause of mental illness as well as chemical imbalances that occurred as a result of substance abuse. Substances most commonly implicated included alcohol and Nyope, (a South African street drug composed of a mixture of heroine, cannabis and various other agents such as anti-retroviral drugs, rat poison and pool cleaner). A participant made this response underpinning this theme.

*We are getting exposed to more and more things and most people say that our scientists ...are creating more drugs that are having forceful side effects to people's brains for example this Nyope thing is something that was created under laboratory and...is now affecting people's minds (Participant H3).*

### **5.6.2 Socio-environmental causes of mental illness**

Social and environmental factors were also found within the participants' understandings of causes of mental illness. Included within this broader theme of causes of mental illness was the exposure to, and experience of abuse both physical, emotional and psychological by parents, significant others, strangers or peers. It was also suggested that lack of support in familial and relational contexts added to this as children and young adults particularly could not cope with abuse and became mentally ill. In this research environmental and social stressors as well as poor coping mechanisms were seen as influences in the initiation of mental illness.

*... thinking too much to the extent that the brain cannot take it anymore...you might take drugs or alcohol (Participant SA2).*

One participant revealed:

*...when a person is free and you don't think too much, you won't have any problems in your mind, but immediately when you start having those problems [social stressors], you are sick or you are stressed about the environment where you are living and you start to develop [mental illness]. (Participant H4).*

Common stressors included familial stressors such as divorce as well as the distress that arises within relational contexts. Social stressors accompanying ongoing substance abuse and stress related to academic requirements were also attributed to the causes of mental illness.

*...when you grow up, maybe some acquire [mental illness] after studying, long periods...when they get more stressed...' (Participant SA1).*

### **5.6.3 Cultural causes of mental illness**

Culturally informed components which contributed to mental illness emerged from the data set in the form of beliefs in bewitchment, curses and traditions. These cultural factors were intertwined with participants' notions of race and spirituality.

*...as we are African, Black people, we think those people, maybe they've been cursed...' (Participant HS3);*

*So we black people believe that they've been bewitched (Participant SA4);*

*...I think as Africans who believe in traditional [causes] I think that's what caused his or her mental illness (Participant SA3).*

The culturally-informed supernatural was thus identified as a cause for mental illness. Another participant stated the following which suggests that believing in traditions and culture can result in an individual experiencing mental 'problems.'

*... the traditional things we believe in, you know mental illness, can result in having mental problems... (Participant HS1).*

Previous research has emphasised the role of socially constructed understandings of mental illness within the African context (Allen et al., 2014; Jorm, 2012). These findings are echoed in the current research.

## **5.7 Treatment of mental illness.**

The knowledge and beliefs surrounding the broader theme pertaining to treatment for mental illness gleaned various elements in participants' understandings. This included beliefs in regard to whether or not mental illness can be treated, views on access to treatment, treatment options available and perceptions as to the effectiveness of such treatment. These themes are discussed below accompanied by relevant examples from the data set.

### **5.7.1 Treatment versus curing of mental illness**

From the participants existing knowledge base a distinction was made between treating, managing and curing mental illness. It appears that mental illness is understood as incurable however, it is also seen as conditions that can be managed and controlled with the correct treatment. Responses supporting this theme include the following

*I think it can be treated but then it cannot be cured. It can be normalised...yes they can be treated ...and can behave in a way that is acceptable to society and be able to adapt to the norms and values of society (Participant SA2).*

*Yes, it can be treated but I don't think it can be cured because it is very much difficult to cure mental disorder or illness, but it can be treated... (Participant ML3).*

*I know that mental illness cannot be cured but it can be controlled better in a way for a person to behave more normally but then they are never cured of the illness (Participant HS3).*

Another theme emerging out of this one was gleaned through a reading and re-reading of data it discusses the treatment and/or management of mental illness.

### **5.7.2 Treatment options available for mental illness**

The existence of an understanding that various treatment methods are available for mental illness treatment was found amongst responses by participants.’ This also involved the perceived effectiveness of treatments and accessing treatment. Treatment options referred to included psychiatric hospitalisation and rehabilitation centres, pharmacological treatment and the utilisation of psychiatrists, psychologists and medical doctors.

More culturally informed treatment options were also included, such as traditional rituals, spiritual intervention through prayer and visits to Sangoma’s.

### **5.7.3 Means of accessing treatment for mental illness**

Accessing care or treatment for mental illness was understood to occur through different channels, either through self-help methods or through care imposed by another (family member, physician etcetera). This theme was elicited from data which referred to participants’ beliefs in whether those with mental illness required help or not. This theme is supported by the following responses.

*All I know is that if someone is mentally ill you must be taken to a psychiatric hospital where they will be getting all the treatment that they need (Participant SA1).*

*Some, they take them to a particular school [special school] where they train them, train them, tame their minds (Participant ML4).*

Less advocated self-help measures were also acknowledged as methods to access treatment, or as a treatment mode in itself. This included seeking to speak to others about problems, and activities as revealed by the following response.

*Exercising and keeping yourself busy. (Participant H4).*

### **5.7.4 Perceived effectiveness of treatment for mental illness**

Perceptions of the effectiveness of receiving treatment for mental illness was informed by social interactions within the participant’s immediate social circles as well as the broader community. References to hearing of the treatment of family members and members of the community served to inform participants’ perceptions of the effectiveness of treatment.

Interestingly, it emerged that just as causes and understanding of mental illness were diverse so were understandings of treatment for mental illness. Participants listed available options and based their beliefs on the effectiveness based on word-of-mouth. This infers that social representations of the treatment of mental illness are intertwined with social constructions of mental illness.

*I never seen someone being cured from that disorder [mental illness] that's why I don't like to call it a disease (ParticipantSA4).*

*I don't think it could be [treated] no because you cannot change how the other human being thinks...Ya I saw people like, maybe when someone is disturbed in mind, they take him to a psychologist but I don't know Ya.(Participant HS3).*

## **5.8 Discussion of results**

The study findings revealed the role of socially constructed understandings of mental illness in the undergraduate sample at a previously disadvantaged tertiary institution in South Africa. The role of socially constructed understandings of mental illness, especially within the African context has been emphasised in previous studies (Allen et al., 2014; Jorm,2012). In this study social representation of mental illness are reported as a culmination of beliefs, social practices and shared knowledge amongst the sample. This is inferred in the samples understanding and conceptualisation of mental illness and the mentally ill.

Socially informed knowledge pools contribute to understandings of mental illness. These are gained through an individual's upbringing in communities which share common beliefs. These beliefs are communicated through words, actions and behaviours and become social representations which inform an individual's personal beliefs (mind-set). Experiences with the mentally ill within a community setting are relived and reproduced through social interactions such as speaking, listening and observing. (Purkhardt, 2015). This is very important if considered from the perspective of SRT.

The manner in which mental illness is defined and understood by participants in this research does not support some studies which suggests that student populations definitions of mental illness are less socially obstructive than older, less educated persons (Granello & Pauley, 2000). Indeed, in this study participants generally displayed negative attitudes and beliefs towards mental illness and the mentally ill. However, the sample did suggest that those with mental

illness should be helped. However, participants were generally unable to establish clear boundaries of dysfunction in their definitions and understanding of mental illness and the mentally ill. None of the participants suggested that they might benefit from psycho-education or workshops on the topic.

The definitions constructed by participants in the research are critical to an understanding of how they define and understand mental illness and the mentally ill. It was clear from their notions of mental illness that their conceptualisation of the mentally ill was inherently dysfunctional. Participants' understood that dysfunction accompanying mental illness was found in areas related to behaviours, cognitions, emotion and biology. This is in-keeping with most of the previous research on the topic (American Psychiatric Association, 2013).

Deviations in behaviour characterised as abnormal in the communal context, through socially constructed ideas of what constitute normality and abnormality were strongly associated with the belief that mental illness is identifiable by strange behaviour(s) which supports findings in other studies (Mirnezami, Jacobsson, & Edin-Liljergren, 2016).

The belief that lack of reality testing is a part of mental illness was also noted by participants in the study. The participants perceived that most of the mentally ill could not distinguish between what is real and what is not. This is not correct as it is only illnesses in which psychosis occurs that inability to perceive reality takes place. This echoes findings in previous studies which underpins lack of knowledge and understanding about mental disorders generally (Furnham & Hamid, 2014; Jorm et al, 1997; Yeo et al., 2001).

Mental illness was also referred to in terms of extremes, which infers a total breakdown or inability to behave appropriately (conform to social norms) by the mentally ill. In this study the mentally ill were described as 'unhuman,' and 'crazy.' This type of discrimination has been found in research amongst other student populations (Kirsh et al. 2016). Conceptualisation of the mentally ill as dangerous was linked also linked to fear (of the 'other') which serves to perpetuate negative views of mental illness. Similar findings in South African student populations have been found (Hyde, 2011). It is also true that these representations serve to maintain stigma and discrimination towards those identified as mentally ill which is also found in past research (Choudhry, Mani, Ming, & Khan, 2016). Notions of the mentally ill conceptualised as unpredictable is linked to perceptions of their dangerousness which was found in this research. This supports the conceptualisation of the mentally ill as impulsive, unpredictable and irrational by Segal as early as 1978.

In this study biological determinants of mental illness were noted as well as spiritual or ancestral aetiologies of mental illness which were not always found in other research (Aphane, 2015). Social and environmental causes of mental illness such as exposure to and experience of abuse physical, emotional and psychological in nature were also found in this research. This finding is supported by a recent student study conducted at UCT which emphasised social factors such as abuse and stress and their interplay in contributing to the aetiology of mental illness (Hyde, 2011). However, supernatural, spiritual, ancestral and traditionally informed perceptions of the causes of mental illness were also found in the current research which supports research by Rogers and Pilgrim (2014) and Yeo et al. (2001).

The knowledge and perceptions on the treatment for mental illness was gleaned through participants' existing knowledge base where a distinction between treating and curing mental illness was found. In this study mental illness is understood as incurable and viewed as a condition which may be managed through various forms of treatment. These treatments are both traditional (African) and westernised. This finding contradicts older studies which found that the beliefs in supernatural causes led to more traditional pathways of help-seeking as opposed to psychiatric or medical care (Alem, Jacobsson, Araya, Kebede, & Kullgreen, 1999; Razali, Khan & Hasanah, 1996).

Conversely, and much less advocated, self-help measures were also acknowledged as methods to access treatment, or as a treatment mode in itself. Perceptions of the effectiveness of receiving treatment for mental illness was found to be informed by social interactions within the individual's immediate social circles and the larger community. This may further serve to underpin the socially constructed nature of the construct of mental illness and perceived effectiveness of treatment thereof. Reference to hearing of the treatment of family members, members from the community and surrounds informed participants' perceptions of the effectiveness (or not) of receiving treatment for mental illness. Culture was found to be a powerful entity in shaping the conceptualisations of mental illness as participants spoke about or referred to their communal and societal influences which informed their understandings of mental illness (Ukpong & Abasiubong, 2010).

Research has revealed that in developing countries the understanding of mental illness is neither unitary nor universal (Rogers & Pilgrim, 2014) which is supported in the findings of this study. Overall, the findings in this study support those of Viljoen (2005) which suggest that individuals who have first-hand experience with mental illness or the mentally ill are more

likely to perceive them positively than those who have second-hand or word of mouth knowledge about the mentally ill (Granello & Pauley, 2000; Cuomo & Ronacher, 1998).

## **5.9 Overall conclusion**

The researcher found that the present research echoes global, African and South African research which concludes that mental illness is not well understood and often badly misunderstood. She also found that stigmatisation and discrimination of the mentally ill by participants was informed by social representations in their communities. These representations were learned in childhood and adolescence and were perpetuated in their new university community. Social representations during youth are continued if individuals do not learn new modes of doing or are not exposed to new representations of the mental illness and the mentally ill. The researcher recommended that the institution where the research took place introduces concepts of mental illness to students during their first year orientation and through different platforms throughout their studies. This should be extended to include academic and administrative staff so that social representations can be broadened and changed through appropriate workshops and interventions.

## **CHAPTER 6: METHODOLOGICAL LIMITATIONS, STRENGTHS, AND RECOMMENDATIONS OF THE STUDY**

### **6.1 Introduction**

This chapter concludes the present study.

### **6.2 Study strengths**

The major strengths of the study are as follows:

- The study used semi-structured interviews which are appropriated for an exploratory study.
- Participating students were asked directly and respectfully about their knowledge and perceptions with regards to mental illness and the mentally ill.
- The study used an appropriate mode of analysis namely Thematic Content Analysis (TCA) as well as appropriate theoretical framework namely Social Representations Theory (SRT).
- The study was conducted following extensive perusal of the available literature, with interview questions directly aimed at breaching the gaps identified in the literature.

### **6.3 Study limitations**

The major limitations of the study were:

- Limited sample size, as only 16 participants were sampled from the various faculties.
- A larger, quantitative study which would enable generalisations to the entire student population is recommended.
- Gender representivity was not achieved.
- The study was conducted in English. Many conceptions of mental illness, especially within the socially constructed realms may not be encapsulated in the English vocabulary. As such, a study conducted in participant's home language may be better able to capture their lived experiences and provide richer qualitative data.

#### **6.4 Study recommendations**

- A larger study using a representative sample should be conducted at the University of Limpopo (Turffloop campus).
- A study using focus groups should be conducted at the University of Limpopo (Turffloop campus). This would enable the collection of more in-depth information pertaining to the experiences of the undergraduate students with regards to mental illness and the mentally ill.
- At an institutional level, which may be of benefit to the students of University of Limpopo (Turffloop Campus), involves the potential revision or establishment of mental health programmes and services made available on campus. Workshops and psycho-education tools (posters and fliers, for instance) should be made available to staff and students enhancing their mental health literacy.
- Results will be made available to the institution in the form of a journal article.

#### **6.5 Summary of chapter**

This brief chapter concluded the study with recommendations from the researcher for future research as well as documenting the strengths and limitations of the present research.

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## **Appendix A: Semi-structured interview**

The researcher will explain the research to participants. During this part of the research rapport will be built. Demographic questions such as age will be asked first.

1. What do you understand by mental illness?
2. Why do you think of mental illness in this way? Probing may be required here for instance: Have you heard mentally ill people described in a specific way?
3. What do you believe to be the causes of mental illness?
5. Do you think mental illness can be cured?
4. Do you believe that mental illness can be treated?
5. What do you know about the treatment of mental illness?
6. Do you personally know someone who has been affected by mental illness?
7. Have you had any experiences with mental illness that you would like to share?
8. What words would you use to describe someone affected by mental illness?
9. Has anyone got anything else they would like to say?

## Appendix B: Transcript of semi-structured interviews and coding

For each semi-structured interview, participants are coded with numbers and abbreviations from their faculty (refer to 5.2 Demographics results table 3 for a detailed description) to ensure confidentiality when quoting responses verbatim.

Responses from all interviews are included, verbatim with grammatical errors.

Themes are presented in tabular format for ease of reading. A general meaning is given for each theme and sub-theme is provided. Themes are highlighted in their specific colours, while sub-themes have been typed out in their specific colour codes to aid reading in the table.

<b>Theme</b>	<b>General meaning of the theme</b>
Knowledge and perception informing factors	Factors informing the knowledge and perceptions about mental illness and the mentally ill
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Experiences with the mentally ill	Experiences with the mentally ill manifested either through first person lived contact or through word-of-mouth and observation
<b>Theme</b>	<b>General meaning of the theme</b>
Definitions and understandings of mental illness	Content constituting the definition and understanding of mental illness
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Experience of dysfunction in certain areas of functioning	Mental illness is defined as a dysfunction in various spheres of functioning
Deviation of normality	Mental illness is defined as abnormality
Alteration in mental state	Mental illness is understood as an alteration in a person's mental state
<b>Theme</b>	<b>General meaning of the theme</b>
Views of the mentally ill	How the mentally ill are viewed
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Mentally ill as Other	The Other refers to conceptions as being other than oneself
Mentally ill as dangerous	Mentally ill viewed as being dangerous
Mentally ill as unpredictable	Mentally ill viewed as unpredictable with regards to their thoughts, behavior and emotions
Mentally ill as dysfunctional	Mentally ill viewed as being dysfunctional
Mentally ill as in-need	Mentally ill viewed as being in-need of care
<b>Theme</b>	<b>General meaning of the theme</b>
Causes of mental illness	Ascribed causes of mental illness
<b>Sub-theme</b>	<b>General meaning of the sub-theme</b>
Biological causes	Ascribed biological causes of mental illness
Socio-environmental causes	Ascribed social and environmental causes of mental illness
Cultural causes	Ascribed cultural causes of mental illness

Theme	General meaning of the theme
Treatment of mental illness	Understandings of the treatment of mental illness
Sub-theme	General meaning of the sub-theme
Treatment vs cure of mental illness	Understandings of whether mental illness is treated or cured
Treatment options available	Treatment option available for treating mental illness
Means of accessing treatment	Pathways of accessing care treatment for mental illness
Perceived effectiveness of treatment	Perceptions related to the effectiveness of mental illness treatment

## Participant H1

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**Interviewer:** What do you think mental illness is and what is your understanding thereof?

**Interviewee:** Mental illness is whereby the state, whereby a person can't think straight, like the person's mind is unstable.

**Interviewer:** Unstable? OK. What do you think, why do you think of mental illness in this way?

**Interviewee:** Because people who are mentally unstable, they're like, they don't think in such a way that, in the same way was people who are like not mentally ill.

**Interviewer:** OK. What do you believe contributes to the cause of mental illness?

**Interviewee:** It may be the overuse of drugs and alcohol.

**Interviewer:** Anything else?

**Interviewee:** Substance abuse.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** Yes.

**Interviewer:** What do you know about the treatment of mental illness?

**Interviewee:** People who are mentally ill, they can be taken to the Rehabs, they can be taken to the clinics, take medication, for the treatment. Then they're going to be okay.

**Interviewer:** What are your perceptions or views of the mentally ill?

**Interviewee:** I don't understand.

**Interviewer:** What is your attitude then?

**Interviewee:** My attitude?

**Interviewer:** Of the mentally ill people?

**Interviewee:** My attitude towards the mentally ill? People who are mentally ill must be treated like the same as people who are not. We must take care of them because they are sick, just like sick.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** I don't get it?

**Interviewer:** What do you think of individuals with mental illness?

**Interviewee:** What do I think?

**Interviewer:** Yes.

**Interviewee:** You are not being clear.

**Interviewer:** In your mind, what do you think of relating to individuals with mental illness? What do you think about them?

**Interviewee:** Let me think. I think, what do I think? OK, I think we must be careful around them because like, if the mind can just change at a time, they may be dangerous, they may hurt you.

**Interviewer:** OK. Do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes.

**Interviewer:** Have you had any experiences with mental illness that you would like to share?

**Interviewee:** No.

**Interviewer:** What words would you use to describe someone who is mentally ill, or affected by mental illness? What words would you use?

**Interviewee:** Words? You mean like terms? Mentally unstable.

**Interviewer:** Any other word?

**Interviewee:** No.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** No

**Interviewer:** Thank you for your time.

## Participant H2

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**Interviewer:** What do you think mental illness is and what is your understanding thereof?

**Interviewee:** Mental illness is a state whereby the brain is not functioning well.

**Interviewer:** OK next question. Why do you think of mental illness in this way?

**Interviewee:** Because, people are not acting normally, they're acting strangely. They are doing things that are not...they are doing things that are not done by normal people.

**Interviewer:** OK. What do you believe causes mental illness?

**Interviewee:** What?

**Interviewer:** What do you believe causes mental illness?

**Interviewee:** Maybe the brain cells, they are not functioning well, maybe overuse of drugs.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** No, I couldn't try no. Mental illness is not treated, but can be controlled.

**Interviewer:** OK. What do you know about the treatment of mental illness?

**Interviewee:** The treatment?

**Interviewer:** Or as you mentioned, the way it can be controlled?

**Interviewee:** By you taking pills or medication properly, exercising and talking, like talking to people about their feelings.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** What?

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** I don't understand?

**Interviewer:** What are your views of the mentally ill? What are your views? How do you view them?

**Interviewee:** Mental illness?

**Interviewer:** In other words, what is your attitude towards someone who is mentally ill?

**Interviewee:** They are scary sometimes.

**Interviewer:** Do you personally know someone who has been affected by mental illness?

**Interviewee:** Family or?

**Interviewer:** Family or neighbour or someone.

**Interviewee:** Yes.

**Interviewer:** So you do know someone?

**Interviewee:** Yes.

**Interviewer:** Have you had any experiences with mental illness that you would like to share?

**Interviewee:** Yes.

**Interviewer:** Can you tell me about it?

**Interviewee:** Sometimes they just cry, I don't know why but I've seen them. They've been throwing things away, being alone. Or sometimes they so quiet.

**Interviewer:** What words would you use to describe someone who is mentally ill?

**Interviewee:** Mentally disturbed.

**Interviewer:** Any other word?

**Interviewee:** No.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** No.

**Interviewer:** Nothing else? OK Thank you for your time.

### Participant H3

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**Interviewer:** Welcome, I'm going to ask you a series of questions regarding the topic that I have already told you and you're going to furnish me with the answers.

**Interviewer:** So the first question is what do you think mental illness is and what is your understanding thereof?

**Interviewee:** I think mental illness is a state where a person's brain is failing to have to have a correct, let me say when he has poor judgement. Mostly on his actions and or on some of the things that he's doing, he's failing to judge correctly. You might find out that he's doing irrelevant things in public or humiliating things, or things that end up humiliating that person, but he cannot see that it humiliates him.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** I think mental illness is actually becoming more dominant in the world that we are living in due to certain things that people are exposed to. For example, the use of drugs is bringing a lot of effects to people's brains, so that is how I think on that one.

**Interviewer:** OK. What do you believe is contributing to the causes of mental illness?

**Interviewee:** Ok, what I can say is that most of the things is usually happening in a developed world. We are getting exposed to more and more things and most people say that our scientists that are being produced are the ones that are creating more cause of this thing because they are now doing their experiments to create drugs that are having forceful side effects to people's brains for example, the Nyope thing is something that was created under laboratory and as the science is received it is now affecting people's minds.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** It depends on which stage are you, because some of, there are certain points you can understand what you are doing, at that point we can say that you are just fine, at that moment you are normal. But let me say it is not, most of them are not treatable, but at some

point, it can disappear from your mind, so your mind can remain clear so that you understand what you are doing so it's something that we just live with.

**Interviewer:** OK. What do you know about the treatment of mental illness?

**Interviewee:** The treatment of mental illness? What I know for, is the rehabilitation that is happening, and let me say. Given to the people living in a community, with the people affected by mental illness since they are taught how to treat them and how to react to them since those people will not understand what they will be doing, so so far it's just the teachings and the rehabilitation that are there.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** My perception of the mentally ill is that in this world that we are living in since mental illness is increasing and items that are having effect or let me say the contributing items towards this problem of mental illness are more increasingly, we can say that it is more probable that we live in a world of fifty fifty normal people and mentally ill persons.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** My thoughts relating to individuals with mental illness is that we just need to learn how to live with them and how to react with them since they can do improper things, somewhere, somehow. We shouldn't overreact to that issues, we just have to accommodate them in the community the way they are and learn to live with them.

**Interviewer:** OK. Do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes, I personally know some of the people that are affected that mental illness.

**Interviewer:** Have you had any experiences with mental illness that you would like to share?

**Interviewee:** Yes the experience that I have experience from people with mental illness is that they become more abusive at some point and for example when you are talking to them they will take it as if you are arguing with them or harassing them and they also enjoy harassing people but they just take it as a joke to them, but we normal people take it serious.

**Interviewer:** What words would you use to describe someone who is mentally ill?

**Interviewee:** The words I would use to describe a person affected by mental illness is that this person is someone who is failing to judge his actions, for example, In South Africa now they are trying to protect these people by restricting them from doing certain things. Which means they, In fact let me say their brain is failing to protect their own selves from certain things, so they are using certain law procedures to protect these people.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** That's all I can say.

**Interviewer:** OK Thank you for your participation.

## Participant H4

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**Interviewer:** What do you think mental illness is and what is your understanding thereof?

**Interviewee:** According to my understanding, mental illness can be a mind disturbance, mind problem whereby a person does not think and see things according to the way they are in general and also mental illness can be as a result of stress or some family issues whereby you are thinking too much and at the end of the day you get mental illness.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** Because many at times when a person is free, and you do not think too much you'll be, you won't have any problems in your mind, but immediately when you start having those problems, family issues problems, you are sick, or you are stressed about the environment where you are living and you start to develop.

**Interviewer:** Have you ever had mentally ill people described in a specific way?

**Interviewee:** Not yet.

**Interviewer:** OK. What do you believe is contributes to the causes of mental illness?

**Interviewee:** I think, as I said before, family issues, like your parents are divorced, as a result you as a child or anyone who is related to the parents who are divorced, then you start to have those problems or also there's this problem of substance abuse that can also contribute to mental illness, Nyope dagga et cetera.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** Yes.

**Interviewer:** OK. What do you know about the treatment of mental illness?

**Interviewee:** Rehabilitation centres.

**Interviewer:** Anything else?

**Interviewee:** Keep yourself busy, with different sporting activities.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** I think...?

**Interviewer:** In other words, perceptions, what are your views of the mentally ill?

**Interviewee:** Yes, I understand you but I don't know how to say it. But I understand the views.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** My thoughts? I think those people they really need special attention, and being welcomed in certain groups so that they cannot feel being rejected.

**Interviewer:** OK. Do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes.

**Interviewer:** Have you had any experiences with mental illness that you would like to share?

**Interviewee:** At the moment, I haven't.

**Interviewer:** Haven't? Okay.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** That person he will be like living in his own world, because he will be living in the world of his own imagination, because he can't do relativistic thing, he can't think live in reality, he will be like, he will imagine himself being somewhere doing something. Sometimes you might find him or her focused on a certain thing that he or she doesn't know what it is.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** Yes. What I can say is when you come across those people who are mental, who have go problem of mental illness you must report them to the rehabilitation centres so that they can get help fast, or if you know someone who is starting to get into the substance abuse before he gets in trouble of mental illness, he must be reported to the psychologist, or psychiatrist or rehabilitation centre so that he may get help fast.

**Interviewer:** OK Thank you for your participation.

## Participant HS1

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**Interviewer:** So the first question is what is mental illness? What do you think do you think mental illness is and what is your understanding thereof?

**Interviewee:** OK, I think mental illness is whereby ones five senses are not functioning well that is what I think mental illness is.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** Because I think for one person to be defined as someone who is normal, that person's five senses are functioning well, like all the senses. So like a situation whereby one of the senses isn't really functioning well, it actually means that person mentally he is not in a whole, he shouldn't...

**Interviewer:** OK. What do you believe to contribute to the causes of mental illness?

**Interviewee:** Umm I believe so many things can cause mental illness. Well some of the things, the first one might be someone might be having stress. If someone is having too much stress it might lead to situation whereby that person thinks a lot and you know all that it can cause one

of your senses to not function well. I also think mental illness can be caused you know the traditional things we believe in, you know the way we grew up , we were told that if one does that, that person can result in mental illness, can result in having mental problems and also I think actually sickness I think there are actually those kind of sickness that can actually cause one to have mental problems.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** Umm, personally I think that somehow it can, because if one gets therapy I think that person can be treated and also given the physiological perspective I think if one can also do psychological or therapy or whatever you might call it and also the biblical aspect, prayers, candling someone who believes in the word of God and all that, I think that mental illness can reach a point whereby it can be treated.

**Interviewer:** OK. What do you know about the treatment of mental illness?

**Interviewee:** Umm, actually I know nothing because I haven't really witnessed someone close to me or around my circle who has suffered from mental illness. So actually I don't know about the illness unless it's whereby, it's those situations whereby we just see people, this person was once had mental problems but now that person is recovering, I've once witnessed those situations, but not in my close circle.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** OK, my perceptions of the mentally ill peoples is actually based on two aspects. At first I would pity them, if I see someone who is mentally disturbed but then at some point I reach to a point whereby I wasn't feeling pity, why, because some people you don't know what caused them to be mentally ill sometimes it's actually because of what they did or their own problems that caused them to be mentally ill, but some on the other hand it's not their problem, they were born like that , some just got it like just started being mentally disturbed and let it stay. I can't really give my one point perspective I think life is just like that, you meet some who are born like that and some who can yes.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** OK. My thoughts, people who are mentally ill, sometimes you have to help them, because as I said before it might not be their problem, or it might not be one of their causes that made them be mentally ill, but nevertheless if it's their problem, we have to try and take care of those people, because I believe one or two of those people who are mentally ill, they are someone's brother's , they are someone's mothers, fathers, sisters or siblings to those people I think they still deserve our care.

**Interviewer:** OK. Do you personally know someone who has been affected by mental illness?

**Interviewee:** Umm, No I don't know anyone.

**Interviewer:** Have you had any experiences with mental illness that you would like to share?

**Interviewee:** Umm I haven't had any, any that I have to share, but you know those things that happen in the society, whereby you just hear that some next door kids they did tramp mental illness you and all that so but I haven't really experienced like to the extent that I can share about someone who is mentally ill.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** What words? I can just say that someone that is mentally, he is actually mentally disturbed, they need all the help that we can give them, if all their senses is not functioning well. For us we have got all the senses that are functioning well, we should help those who lack that.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** Anything that I can add? Is that I think it's better if psychologists and all those that can, are in a position to help mentally ill people can actually do their job to help those people, because it would be for the benefit of everyone around them and the benefit of their families to actually be helped to function well.

**Interviewer:** OK Thank you very much mam, thank you very much.

**Interviewee:** You're welcome.

## Participant HS2

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**Interviewer:** What do you think do you think mental illness is and what is your understanding thereof?

**Interviewee:** Isn't it mental illness is like when you're not all there together upstairs, in your head. You can just be there one minute knowing what's what and then another time you don't know what you're doing or saying. I've seen them, its like sometimes they don't even know it is happening. Then when they talk with you it's like they don't know what they did, but we can all remember

**Interviewer:** Why do you think of mental illness in this particular way?

**Interviewee:** I can say I view them as they are different to us, you can see them with mental illness. You will know in the village who is mentally ill and who isn't. Sometimes the other people will tell you that or you will hear from around.

**Interviewer:** What do you believe to contribute to the causes of mental illness?

**Interviewee:** The stories we were told as youngsters about how these things can be, that you start to act crazy and cannot be functioning normal. You know, within these African cultures that is what you are told and made to believe.

**Interviewer:** Do you think mental illness can be treated?

**Interviewee:** Ya maybe it can be treated, actually it could be treated ya but maybe not cured.

**Interviewer:** Alright. What do you know about the treatment of mental illness?

**Interviewee:** I know that you have to help them, we have to try and take care of those people, they still deserve our care. I think it's better if psychologists and all those that can, are in a position to help mentally ill people can actually do their job to help those people, because it would be for the benefit of everyone around them and the benefit of their families to actually be helped to function well. That is what I know.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** OK, my perceptions of the mentally ill is that they maybe can be dangerous you never know what will happen, but they just need care from us, in the community, we don't care for them but even can laugh at them.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** I don't think of them so much, maybe just if I hear or see someone in the village or around that is acting crazy then I think maybe they have mental illness.

**Interviewer:** Okay I see. Do you personally know someone who has been affected by mental illness?

**Interviewee:** No not personally I don't know anyone but from around the community I know of them.

**Interviewer:** Have you had any experiences with mental illness that you would like to share?

**Interviewee:** No nothing lately, no.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** I can say that someone that the person is crazy or mental.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** Just that we must care for them, stop discriminating and thinking these funny things towards them. We must help them.

**Interviewer:** Thank you very much.

**Participant HS3**

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**Interviewer:** What do you think mental illness is and what is your understanding thereof?

**Interviewee:** I think mental illness is when someone is suffering from a stress like as we are African, black people, we think those people, maybe they've been cursed or something. Yes although someone is suffering in the brain, doesn't function well.

**Interviewer:** OK. Why do you think of mental illness in this way?

**Interviewee:** Huh?

**Interviewer:** Why do you think of mental illness in this way? That something will be wrong in the brain?

**Interviewee:** Because those people they are sad and the way they are thinking, they don't think positively, like ordinary people, they just say, sometimes they usually say negative things. Yes they're not positive.

**Interviewer:** OK.

**Interviewee:** Ya, they won't see, the way they see life, their opinions and our viewpoints, we differ and you can see that this person not the same.

**Interviewer:** Ok so the next question is what do you believe contributes to the causes of mental illness?

**Interviewee:** I think this people as the whole people, they should see them with care. They should counsel them and then, there should be, there should be centres whereby they are comfortable, that people who have...

**Interviewer:** Mental Illness?

**Interviewee:** Ya the people who have mental illness.

**Interviewer:** And what do you think causes mental illness?

**Interviewee:** The causes? I think its stress ya, I think acute stress ya. People get stress and then ya, stress.

**Interviewer:** Ok, do you think mental illness can be treated?

**Interviewee:** No, I don't think it could be no, because cannot change how the other human being thinks, they could be anything that could be, ya I don't think.

**Interviewer:** Ok what do you know about the treatment of mental illness? What have you heard that people use to treat mentally ill people?

**Interviewee:** Ya, I saw people like, maybe when someone is disturbed in mind, they take him to psychologist. I don't know ya.

**Interviewer:** Ok, what are your views? What are your views of the mentally ill? How do you view them?

**Interviewee:** I think those people, they should treat them like, they should treat them with care, we cannot discriminate against a person who is not thinking normal. We should treat them the same.

**Interviewer:** Ok, do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes, I used to see them in my village there are many ya.

**Interviewer:** In your life have you ever had any experience with mental illness that you'd like to share?

**Interviewee:** Yes, I've seen so many people doing crazy, those people do crazy stuff. Ya, you can see that.

**Interviewer:** What kind of crazy stuff?

**Interviewee:** They just say things, a whole things, lots of stories, shocking stories, they just say things without thinking.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** huh?

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** What words?

**Interviewer:** Yes.

**Interviewee:** Like one word?

**Interviewer:** Yes, one word or two words.

**Interviewee:** I think dysfunctional.

**Interviewer:** Okay any other?

**Interviewee:** No, I don't have other words.

**Interviewer:** Is there anything you would like to add regarding the topic under discussion?

**Interviewee:** Is that, these people should be treated equally, like the way we are, we cannot change the way they are if we can change how they are by offering them facilities whereby they would provide them with counselling so that to discuss their problems, like why do they feel that way, because they need someone who can listen to them and advise them.

**Interviewer:** OK Thank you very much for your time.

## Participant SA 1

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**Interviewer:** Welcome, so the first question is what is mental? What is your understanding? What is mental illness and what is your understanding thereof?

**Interviewee:** Mental illness is, Mental disorder whereby anyone, someone has got, has got not the ability to think properly, their mind is kind of disturbed. So Ya.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** Because you can see by the characteristics actually, how a person acts, it is more important potential, to recognise how a person acts. So, then you can, that's how you can discover that a person is mentally disturbed.

**Interviewer:** What do you believe contributes to the causes of mental illness?

**Interviewee:** Depression sometimes also contributes to mental illness and even, uh, maybe some are born with the mental illness already, so there are different types of illnesses, whereby you acquire mental illness, when you grow up, maybe some acquire them after studying, long period, some acquired them right from birth, some acquired them by depression when they get more stress and stuff.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** Yes. Well depending on the situation, it can be treated, some they just have to live with it.

**Interviewer:** What do you know about the treatment of mental illness?

**Interviewee:** Umm, all I know is that if someone is mentally ill you must be taken to a psychiatric hospital, where they will be getting all the treatment that they need.

**Interviewer:** OK. What are your perceptions of the mentally ill?

**Interviewee:** What are my perceptions?

**Interviewer:** what are your views regarding?

**Interviewee:** What are my views? Mental illness is something that you have to adjust and live with. If ever you are mentally disturbed or, but then mental illness too can be cured, if you have a situation that was not that much bad.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** Ok my thoughts are that if ever someone has a mental illness, they must get proper care and proper guidance because you may never know, that person may get well, and maybe find out that you are treating them badly, that will be another issue.

**Interviewer:** Do you personally know someone who has been affected by mental illness?

**Interviewee:** I only know this one man where I used to live, was mentally disturbed, but that one, he would become mad and sometimes he would be normal, his mental illness was not that bad. You could tell that this person sometimes knows what he's doing but sometimes his mind just get disturbed.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** I would describe that person as a sick person who needs help, it can be from a medical practitioner or maybe ritual help yes.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** OK, mental illness is not that serious, but is something that you have to prioritise, if you hear of someone who is mentally ill that you know and assist them, that will be all.

**Interviewer:** OK Thank you for your time.

## Participant SA2

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**Interviewer:** So the first question is what do you think mental illness is and what is your understanding thereof?

**Interviewee:** According to my own understanding, a mental illness is a state whereby the properties of the mind or the structures of the mind are not working together harmoniously to produce a balance or an equilibrium.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** The reason why I think of mental illness in this way, it is as I stated that it has to do with equilibrium, in order for a person to function normally, and relate well to the society, all the properties of the brain they need to work together. So that person should be, to be normal, because I think mental illness of the brain abnormality in a person that makes him to be sort of ostracized or set apart from the community because of the behaviour that emanates from this state of mental illness.

**Interviewer:** What do you believe is contributes to the causes of mental illness?

**Interviewee:** I think there are a number of causes that contribute to mental illness. Some is I can say, is genetic in terms of the origin, like you're Down Syndrome, you're MR, mental retardation and of course some, some people are not born that way but then along the path of life they start to have mental illness, maybe due to stress, thinking too much to an extent that the brain cannot take it anymore and it starts to dysfunction.

**Interviewer:** Do you think mental illness can be treated?

**Interviewee:** I don't think, I think it can be treated but then it cannot be cured. It can be normalised in the form of pills, that's why we have pharmaceutical companies and stuff like that. Yes, they can be treated but a person can, can behave in a way that is acceptable to the society and be able to adapt to the norms and values of society.

**Interviewer:** OK. What do you know about the treatment of mental illness?

**Interviewee:** What I know about treatment of mental illness is that, for example in South Africa we do have centres in our community, even though it is not in every community, but then we have centres, mental health centres in communities that try to stabilise the situation of mental illness amongst some of the inhabitants of the community who are suffering from mental illness.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** My perception about mental illness, is that mental illness is something foreign hey, if you can study the history of mental illness, you'd find that it is as old as human creation, ever since the inception of man, we people have experienced mental illness, and there's been a couple of attempts to try and heal mental illness. Till today, we still, we still have mental illness in our society. So mental illness to me is not something new to us, as we are living in the 21<sup>st</sup> century, that's always been a part of mankind.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** I think from what I've observed, from my own observations from my community, it's like we don't treat them as part of the community, in most cases as like I said before that they go through a process of ostracism, whereby they don't form part of the community, we don't see them as people who can contribute towards the issues in the community, in most cases we even hide them, you know we put them in the background, we don't want them to be seen, as like they are people who must be hidden away from society.

**Interviewer:** Do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes, I do. I know a couple of people from my community who are ostracised from the community.

**Interviewer:** Have you had any experiences with mental illness that you would like to share? Have you had any experiences with mental illness that you would like to share?

**Interviewee:** Mental, you mean experiencing someone with a mental illness that I would like to share? What I've noticed is mental illness, they do differ and the behaviour that emanates from patients with mental illness they do differ, you understand? So it sort of depends on the type of mental illness that a person has. Some of these people they are, sometimes they are able to behave in a way that is acceptable to society, given the fact that they take medication, there's someone who is looking after them and they are being treated normally as citizens of the community, yes, they behave normally so.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** Words that I can use to describe someone with mental illness, I can say from my own point of view, we should see them as normal people, we should not sort of put labels on

them, we should see them as part of the society, so my perspective towards people with mental illness is that they are normal people just like us, they just happen to be functioning at another dimension of mental state, but then they are not that different from us.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** Yes, I will say that as professionals, as normal people, as families with people who have mental illness, let us try to accommodate them in our society. Let us try to treat them as part of us, let us shy away from a fact of labelling them, of ostracising them and sort of mistreating them and let us change our perception towards them, as professionals as parents who have such people, or such children who are suffering from mental illness, let us change our perspectives, let us look positive towards people with mental illness and treat them as our own people and as our own brothers and sisters and respect them regardless of their mental capacity or mental state.

**Interviewer:** Thank you very much for your time.

### Participant SA3

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**Interviewer:** The first question is what is your understanding of mental illness?

**Interviewee:** OK, to my understanding of mental illness, I think a mental illness is a condition or disorder that affects a person's thinking, mood and behaviour.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** Because of most people that suffer from mental illness you find that they are suffering from, from depression and maybe anxiety disorder or stress that leads them to behave in a certain way or they are unable to cope with the real situation of the real world.

**Interviewer:** OK. What do you believe to contribute to the causes of mental illness?

**Interviewee:** I think it's the environment and sometimes some of the mental illnesses are genetical and some are just addictive behaviour. I think it's the things that cause mental illness.

**Interviewer:** Do you think mental illness can be treated?

**Interviewee:** Yes, I think it can be treated by maybe a combination of medication and talking with a therapy, psychologist.

**Interviewer:** OK. What do you know about the treatment of mental illness?

**Interviewee:** I don't know much but, I can't say I know anything about the treatment of mental illness, but I think, is if you are suffering from depression, which I think is one of the mental illnesses, you can treat you easily by giving you some medication that will make you at least

not panic or something, or they can give you sessions with a therapist which it's easy for you to relieve what you feel and talk about your emotions and everything , which will make it better for you.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** My perceptions? Ok I don't know but I think most of the mental illnesses you lead yourself to it, or some of them you lead yourself to it, or some of them is because you are just weak and unable to take heavy things in, I don't know.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** My thoughts? Depending on what kind of mental illness that person is suffering from, but I think I don't know. I think it's the same as my perceptions, more or less the same thing. They're just people, they're unable to cope with real life and they end up behaving or acting in unacceptable or another way.

**Interviewer:** Do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes, I do, but okay, I do know someone that who has been affected by mental illness, but I think as Africans who believe in traditional whatever and everything, I think that's what caused his or her mental illness.

**Interviewer:** Have you had any experiences with mental illness that you would like to share?

**Interviewee:** No.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** Crazy.

**Interviewer:** Any other words?

**Interviewee:** Sick, weak.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** Mental illness? I think no, there's nothing.

**Interviewer:** OK Thank you for your time.

#### Participant SA 4

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**Interviewer:** Good afternoon, the first question that I have is what do you think mental illness is and what is your understanding thereof?

**Interviewee:** Mental illness?

**Interviewer:** Yes

**Interviewee:** Mental illness is, I think it's a disorder it's not a disease, I don't think it's curable.

**Interviewer:** You don't think it's curable? Why do you think of mental illness in this way?

**Interviewee:** What do I think?

**Interviewer:** Why do you think of mental illness as a disorder that is incurable?

**Interviewee:** Because most of the people that I know they were born with the disorder, I cannot just call it a disease yes.

**Interviewer:** Ok why do you, or what do you believe contributes to the causes of mental illness?

**Interviewee:** I think the problem is, I think the problem happens during the, the process of developing inside, ya maybe there was some errors. Ya that leads to mental disorders.

**Interviewer:** OK, when they were developing inside the womb?

**Interviewee:** Yes.

**Interviewer:** OK, anything else that you'd like to mention? Concerning what you believe causes mental illness?

**Interviewee:** Some people, they were not born like that, it happens on the way. So we black people believe that they've been bewitched yes.

**Interviewer:** Ok, do you think mental illness can be treated?

**Interviewee:** No, I don't think so.

**Interviewer:** Ok what do you know about the treatment of mental illness?

**Interviewee:** I never seen someone been who, I've never seen, seen someone being curable from that disorder, that's why I don't like it to call it a disease.

**Interviewer:** Ok, what are your perceptions of the mentally ill? How do you view them? The mentally ill?

**Interviewee:** How do I view them like?

**Interviewer:** Yes, just viewing them like, your own view, according to your own view, how are they as individuals?

**Interviewee:** Some of them they are scary ya, but some of them you can live with them, ya it depends on how she acts.

**Interviewer:** Ok, what are your thoughts relating to individuals with mental illness?

**Interviewee:** I do not know.

**Interviewer:** You don't have anything to say?

**Interviewee:** Ya.

**Interviewer:** Ok, do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes, I know them.

**Interviewer:** You know them?

**Interviewee:** Yes.

**Interviewer:** OK have you ever had any experience with mental illness that you'd like to share?

**Interviewee:** Yes, because it is this lady where I come from, I come from Phalaborwa, she used to walk in the street with a whip.

**Interviewer:** With a whip? OK.

**Interviewee:** Whenever she finds you she would beat you with that whip, but sometimes she's cool, she can even greet you on the way ya.

**Interviewer:** OK.

**Interviewee:** It depends on the weather.

**Interviewer:** OK, what words would you use to describe someone affected by mental illness?

**Interviewee:** What words?

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** I'll just say she's mentally disturbed.

**Interviewer:** Is there anything you would like to add regarding the topic under discussion?

**Interviewee:** No.

**Interviewer:** OK Thank you very much for your time.

## Participant ML1

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**Interviewer:** Do you think, the first question is what do you think mental illness is and what is your understanding thereof?

**Interviewee:** I think people, when they are behaving unhuman like that's mental, mental illness.

**Interviewer:** When they are behaving?

**Interviewee:** Unhuman.

**Interviewer:** Ok, anything else?

**Interviewee:** No, I don't have anything on my mind.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** I think whatever they are doing at that particular time, doesn't correspond with the normal way of living,

**Interviewer:** OK. What do you believe is contributes to the causes of mental illness?

**Interviewee:** Causes? Using drugs too much, overdosing with drugs, get injured.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** In some cases, not always.

**Interviewer:** In some cases, not always? OK What do you know about the treatment of mental illness?

**Interviewee:** I just hear that they got pills, I don't know how those pills are working, how I don't know, but they get the pills they behave normally.

**Interviewer:** Ok. What are your perceptions of the mentally ill?

**Interviewee:** My perception of the mentally ill? How can I say, I never thought of anything?

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** My thoughts relating? Yoh I can't say anything because I'm scared of people who are mentally ill.

**Interviewer:** Do you know someone; do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes.

**Interviewer:** OK, who is he to you?

**Interviewee:** It's just someone from the community.

**Interviewer:** OK, someone from the community. Have you had any experiences with mental illness that you would like to share?

**Interviewee:** No.

**Interviewer:** None?

**Interviewee:** Because which I know they are violent, I like to play far from people who are mentally ill.

**Interviewer:** Ok. What words would you use to describe someone affected by mental illness?

**Interviewee:** I don't have.

**Interviewer:** Even a single word, just a word.

**Interviewee:** I don't have.

**Interviewer:** You don't have OK. Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** No

**Interviewer:** None? OK Thank you for your time.

**Participant ML2**

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**Interviewer:** OK, what I'm gonna ask is what do you think mental illness is and what is your understanding thereof?

**Interviewee:** I think Mental illness is a state of being mentally ill.

**Interviewer:** OK, a state of being mentally ill?

**Interviewee:** Yes.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** Because the person is like mentally disorder, it's not like, eish, they are the same as us, but mentally they are not, yes.

**Interviewer:** Ok what do you believe contributes to the causes of mental illness?

**Interviewee:** Causes is I think abuse, some get that mental illness through accident and yes.

**Interviewer:** Ok, do you think mental illness can be treated?

**Interviewee:** I don't know.

**Interviewer:** You don't know?

**Interviewee:** I do not.

**Interviewer:** What do you know about the treatment of mental illness? What have you heard anything about how they treat mentally ill people?

**Interviewee:** I heard an uncle who was mentally ill, he used to go to like a clinic to get the medication, I don't know ya.

**Interviewer:** Ok, what are your perceptions of the mentally ill?

**Interviewee:** People who are mentally ill?

**Interviewer:** Yes, how do you perceive them?

**Interviewee:** I see them as human beings.

**Interviewer:** Ok.

**Interviewee:** They are the same as us, I don't see any problems with them.

**Interviewer:** Ok, what are your thoughts relating to individuals with mental illness?

**Interviewee:** My thoughts?

**Interviewer:** Yes, your own thoughts.

**Interviewee:** They are good people, all they need is to be treated like we should each other equally, they also deserve that. They've got rights to be treated equally, so we should treat them as people, as human beings.

**Interviewer:** Ok, do you personally know someone who has been affected by mental illness?

**Interviewee:** My uncle.

**Interviewer:** Do have you had any experience with mental illness that you'd like to share?

**Interviewee:** Mental illness?

**Interviewer:** Maybe with your uncle or what happened?

**Interviewee:** I know that they say he was born with mental illness, born like that.

**Interviewer:** Born like that? OK, what words would you use to describe someone affected by mental illness?

**Interviewee:** I cannot describe them, they are, I don't know, they are nice, all they need is to be treated with care, love should be taken around them.

**Interviewer:** Is there anything you would like to add regarding this topic?

**Interviewee:** No.

**Interviewer:** OK Thank you for your time.

### Participant ML3

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**Interviewer:** The first question is what do you think mental illness is and what is your understanding thereof?

**Interviewee:** Mental illness it is a condition which a multiple people suffer from which affects normally the brain and people, a lot of people actually do not understand it because they do not follow the other thing, the illness, the mental illness, and they do, not really something people should be negative towards because this is a disease or maybe a condition which people are born with or maybe turn to be exposed to along the way during the growing period.

**Interviewer:** Why do you think of mental illness in this way? What, why do you think of mental illness in this way that you have just explained?

**Interviewee:** It's because I've interacted with a lot of mental, a lot of people suffering from mental illness. I also have relatives who are suffering from it, so I understand it a lot more, like more, I understand it better.

**Interviewer:** OK. What do you believe contributes to the causes of mental illness?

**Interviewee:** In most cases it might be a depression, mostly it might be due to substance abuses, but it differs in situations, so it might be that a person you see, it might be that someone was born with the condition.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** Yes, it can be treated but, I don't think it can be cured because it is very much difficult to cure mental disorder or illness, but it can be treated through institutions, mental institutions or medication

**Interviewer:** What do you know about the treatment of mental illness?

**Interviewee:** I don't know much about it, I don't know much, don't know much.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** I think that mental illness should be perceived as a abnormal thing because this is a situation that a people come across, like ya, in the daily basis, we do come across people suffering from mental illness, we do interact with those people on our daily basis. So I think those people need to be perceived as normal people and be treated normally so.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** I would say that individuals suffering from mental illness, might, must actually congregate with people who are still, or perceived as normal people, so they can be able to interact and understand each other, this will help educate those who have less, those who are less educated about the disorder.

**Interviewer:** OK. Alright, do you know, do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes, I know plenty of them and I have relatives suffering from mental disorders and I used to have someone I would say a friend, I lost contact with, who suffered from mental disorder, mental illness and wasn't born with a condition but due to substance abuse, he developed the mental disorder, mental illness.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** Unique, special yes, those like the people suffering from mental illness are just unique, that's two words.

**Interviewer:** Is there anything else you would like to add regarding the topic?

**Interviewee:** I would just like to wrap up by saying that people suffering from mental illness should be treated fairly, and should not be discriminated. There is nothing wrong with mental conditions, there is no way, there is no wrong way or right way of being normal, like every person should be perceived as normal, yes.

**Interviewer:** OK Thank you for your time.

## Participant ML4

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**Interviewer:** Ok so the first question is what do you think mental illness is and what is your understanding thereof?

**Interviewee:** I think mental illness, OK I'll talk about the person neh, a person who has a problem with mind or yes a problem with mind, mind disturbance, maybe the person, I don't

know, I heard people saying that it happened that the person is the blood on the mind, and the mind is mixed blah blah blah blah yes. I don't know .

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** What do I think?

**Interviewer:** Of mental illness, in the way you have just described now?

**Interviewee:** What do I think it is?

**Interviewer:** Why is it that you gave me a definition of mental illness?

**Interviewee:** I did.

**Interviewer:** Why do you think of mental illness in this way?

**Interviewee:** Because they don't think like us, there are a lot of things that are differing from us, the way they talk, they talk some things that doesn't make sense some of the time and then which means the mind is disturbed, it's what I think like, we are not the same, it might be the same, but something is wrong with their mind.

**Interviewer:** OK. What do you believe contributes to the causes of mental illness?

**Interviewee:** The causes? Some, I don't know, some they are born with it, which I don't know what happened while they were inside their mother's womb. Some of them it's because of the accident, some people are hit by something on their head and then the blood, and the mind get mixed, yes some get accidents from then within a week that person starts to have a mental problem.

**Interviewer:** Do you think mental illness can be treated?

**Interviewee:** Yes, I think it can be treated, yes I think.

**Interviewer:** What do you know about the treatment of mental illness?

**Interviewee:** Some they take them to a particular school where they train them, train them, tame their minds because there's another person that I he was having a mental problem, so they took that person to a particular, I don't know if it's a school, it's a hospital for mental, for those people, so they were training them, training them and then at the end, they ask them questions to check their minds are fine and then they were fine. Some of them, they were fine. Another thing, is through doctors , doctors they can go and check your mind if your mind can be able to be fixed or to be fine again, they can give you treatment. It's possible maybe, even operation that I know, but treatment.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** Perceptions.

**Interviewer:** Your, how you regard them?

**Interviewee:** I don't know,

**Interviewer:** How do you view them? How do you view people with mental illness?

**Interviewee:** Like compared to normal ones?

**Interviewer:** Yes.

**Interviewee:** I, not the same, obviously not the same, not the same, but ya because, we are we, they have problems with mind and then we are not, but they are normal, not normal. I don't know but they are not the same.

**Interviewer:** OK, What are your thoughts relating to individuals with mental illness?

**Interviewee:** Individual like how?

**Interviewer:** What do you think about them?

**Interviewee:** I think, I don't know, I think, I don't know what can I think about them. They are human and they need to be helped so that they can be like us and then we have to treat them in a nice way like they are human, just that they have problems with their minds. I think they are, they deserve to be treated the same as normal persons.

**Interviewer:** OK. Do you personally know someone who has been affected by mental illness?

**Interviewee:** I know them, two three people yes. I know them.

**Interviewer:** Have you had any experience with mental illness that you would like to share?

**Interviewee:** With someone or myself?

**Interviewer:** Yes, someone or yourself.

**Interviewee:** Yes , I there is a particular person where I'm staying at the village , he having a mental illness, but you know at the village they don't take it serious and like, actually you take it as a normal thing that happens when you are have mental illness, then they just let it go like that, you have your own life together, own life to behave the way you behave it's the love, love and that , and who they love and don't love, but in our village they focus too much on the person doing funny things and laughing blah blah blah like that, We don't treat them the same but we treat them yes, they don't treat them the same.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** I have no others than what I've said.

**Interviewer:** Is there anything else you would like to add concerning the topic we are talking about?

**Interviewee:** What I can say is that you know, you just have to treat them the same as normal people, to treatment and accommodate and everything they are doing. If they want us to have fun with them, have fun even if you know this fun is heling them.

**Interviewer:** OK Thank you for your time.

## Participant HS4

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**Interviewer:** The first question is what do you think mental illness is and what is your understanding thereof?

**Interviewee:** **Mental illness I think** is the state whereby an individual, um, is **unfit mentally**. In a certain extent whereby they do things and after some, they are not even aware of the things that they have done, or they have **no control over these things that they are doing**.

**Interviewer:** OK, Why do you think of mental illness in this way? Why do you think of mental illness in this way? The way that you have just described it as?

**Interviewee:** Because, um, **I look at many people who have mental illnesses**, those people they don't, they, I see them as they are, how **they can't do anything appropriate or accordingly they**, In the case where I'm doing things, because they just do things out of the blue, they don't even know what they are doing or why they are doing them.

**Interviewer:** OK. What do you believe to contribute to the causes of mental illness?

**Interviewee:** **There are so many things**. There are **injuries, accidents whereby the individual's brain has damaged**. Some are inherited yes, and some are inherited such as Down syndrome, right, and some are, I think maybe because of physical abuse that causes it and mental illness, either emotional, psychological or physical abuse.

**Interviewer:** OK. Do you think mental illness can be treated?

**Interviewee:** Yes, **it can be treated yes**, **managed, it can be managed**.

**Interviewer:** What do you know about the treatment of mental illness?

**Interviewee:** **I have known these individuals are given pills to manage their, like their temper**. I don't know what they do manage, but after they have taken those pills they behave in a normal way and like when they given no help they do those crazy things.

**Interviewer:** What are your perceptions of the mentally ill?

**Interviewee:** What?

**Interviewer:** What are your perceptions of the mentally ill? Ok, In other words how do you view them?

**Interviewee:** **Those ones who are mentally ill, I just view them** as normal people who are not lucky, like I am, so I really don't discriminate. I know **sometimes they are scary when they behave in their ways but my wish is to help them and like educate people on how to treat those people, then they will not discriminate them**, because most of them they do discriminate them, if they are unfit psychologically, they see him or her as **unfit** to the **community**, that's where their own **families** of them, they don't treat them very well, they just see them as a disappointment, so I'd **really like people to educate those who are around people with mental illness on how to treat them and how to socialise with them**.

**Interviewer:** What are your thoughts relating to individuals with mental illness?

**Interviewee:** **Eish, my thoughts relating to individuals with mental illness?**

**Interviewer:** Yes.

**Interviewee:** They just, I hold nothing against them, I just see them as normal, **unlucky**, people who deserve to be treated the way we are being treated.

**Interviewer:** OK. Do you personally know someone who has been affected by mental illness?

**Interviewee:** Yes.

**Interviewer:** OK. Have you had any experiences with mental illness that you would like to share?

**Interviewee:** Experiences? With an individual with mental illness? Yes, like my aunt, her, I don't know what was wrong with her but I was still young. She just started singing, doing all these crazy things. Like as were young, like what's going on. She went for treatment, now she's fine. And also my uncle, she is also affected by the same thing, but I've just seen not so long ago whereby he was not taking his meds, so he just started going crazy, swearing at people, always shouting and all that ya.

**Interviewer:** What words would you use to describe someone affected by mental illness?

**Interviewee:** words? Like when I'm seeing people affected by mental illness?

**Interviewer:** What words would you use to describe?

**Interviewee:** I'm thinking, I normally think that mentally ill, or they are **mentally unfit**.

**Interviewer:** Is there anything else you would like to add regarding the topic under discussion?

**Interviewee:** No.

**Interviewer:** OK Thank you for your time.

**Appendix C: TREC ethical forms**

**FORM B – PART I**

**PROJECT TITLE: Knowledge and perceptions of University of Limpopo undergraduate students towards mental illness**

**PROJECT LEADER: Ms BL Smit**

**DECLARATION**

I, the signatory, hereby apply for approval to conduct research described in the attached research proposal and declare that:

1. I am fully aware of the guidelines and regulations for ethical research and that I will abide by these guidelines and regulations as set out in documents (available from the Secretary of the Ethics Committee); and
2. I undertake to provide every person who participates in this research project with the relevant information in Part III. Every participant will be requested to sign Part IV.

**Name of Researcher: Ms BL Smit**

**Signature: BL Smit**

**Date: 3.7.2017**

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**For Official use by the Ethics Committee:**

Approved/Not approved

Remarks:.....  
.....  
.....  
.....

Signature of Chairperson:.....

## FORM B – PART 11

**PROJECT TITLE: Knowledge and perceptions of University of Limpopo undergraduate students towards mental illness**

**PROJECT LEADER: Ms BL Smit**

Protocol for conducting research using human participants

1. Department: Psychology
2. Title of project: **Knowledge and perceptions of University of Limpopo undergraduate students towards mental illness**

3. Full name, surname and qualifications of project leader:

Bianca Lima Smit

B.A. Psychology

B.Soc.Sci Honours in Psychology

B.Psych Equivalent Practical Psychometrics

4. List the name(s) of all persons (Researchers and Technical Staff) involved with the project and identify their role(s) in the conduct of the experiment:

Name:	Qualifications:	Responsible for:
Bianca Lima Smit	B.Soc.Sci Honours Psychology	Research

5. Name and address of principal researcher:

Bianca Lima Smit, 1089 Besembessie Street, Montana Park, Pretoria.

6. Procedures to be followed:  
Exploratory interviews will be conducted using a schedule constructed from a combination of guide questions derived from a reading of relevant literature.

Informed consent will be sought from each participant.

7. Nature of discomfort:

The interview could trigger incidents which may cause discomfort or challenging emotions or anxiety and anger. Affected participants will be referred to a clinic on campus for intervention.

8. Description of the advantages that may be expected from the results of the study:

- a. The study could provide an avenue for catharsis to some participants. This could bring about a better, more informed knowledge about mental illness.

Signature of Project Leader: **BL Smit**