PERCEPTIONS OF LEARNERS IN SELECTED RURAL SECONDARY SCHOOLS TOWARDS MENTAL ILLNESS: THE CASE OF GA-DIKGALE COMMUNITY, LIMPOPO PROVINCE

By

LEPHAI IRENE DAISY MAKGATO

DISSERTATION

Submitted in fulfilment of the requirements for the degree of

MASTER OF ARTS

in

PSYCHOLOGY

in the

FACULTY OF HUMANITIES
(School of Social Sciences)

at the

UNIVERSITY OF LIMPOPO

SUPERVISOR: Prof Tholene Sodi
CO-SUPERVISOR: Dr Mpsanyana Makgahlela
CO-SUPERVISOR: Prof Hilde Bastiaens

2020

DEDICATION

To my family, BaTau ba mahlo a mahubedu!

Power to us

DECLARATION

I declare that **Perceptions of Learners in Selected Rural Secondary Schools Towards Mental Illness: The Case of Ga-Dikgale Community, Limpopo Province,** hereby submitted to the University of Limpopo, for the degree of Master of Arts in Psychology has not previously been submitted by me for a degree at or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

_____ _____

Surname, Initials (title) Date

ACKNOWLEDGEMENTS

Without the support and encouragement of a great many people, I couldn‘t have managed to complete this dissertation, I wish to extend my gratitude to:

- To God, the Creator and Almighty, all the praises belong to you.
- My Supervisor, Professor Tholene Sodi, for his dedication, patience, and professionalism displayed while supervising this journey from the start to finish;
- My Co-Supervisor, Dr Mpsanyana Makgahlela; for his unwavering support, encouragement and dedication to this dissertation;
- The Department of Education, Schools and best of all the participants, without whom the objectives of this work could not have been met;
- My mother, Joyce for her support, understanding, encouragement and for having my back always;
- To my grandmother, aunts and siblings (Mathipa, Khutso & Tshegofatso) for their support, inspiration and encouragement;
- To Mathipa, for helping with transcribing when I was too tired to do so;
- Professor Tebogo Mothiba for being my mentor and providing academic support and assisting with analysis of this dissertation;
- Lastly, the VLIR-UOS (Flemish University Council) scholarship, for the financial support and all the wonderful people working for the project and the opportunities afforded me through this funding; and
- To everyone who played any role, even though your name was not mentioned, in helping to make this study a success. This would not have been possible without your contribution.

THANK YOU!!!

Abstract

The growing number of young people in schools presenting with mental illness is increasingly becoming a disconcerting issue locally and globally. This qualitative study sought to explore the perceptions of mental illness by learners drawn from four secondary schools in Ga-Dikgale rural community (Limpopo Province). Twenty-seven learners (males = 14; females = 13) were selected through purposive sampling and requested to participate in the study. Semi-structured individual interviews and focus group discussions (*n* = 2) were conducted. The following three themes emerged from the data: a) Knowledge of mental illness, its causes and symptoms b) Knowledge on the management and types of interventions needed for mental illness c) Challenges associated with mentally ill people. The themes and sub-themes emerging suggested deep seated Afrocentric cultural perceptions which tended to shape learners' views and understanding of mental illness. Some paradoxical explanations with regard to mental illness also emerged. Based on the findings of the study, it is recommended that mental health literacy campaigns be conducted in schools.

Table of Contents

CHAPTER 1: INTRODUCTION

1.1 Background to the study

Worldwide, ten to twenty percent of children and adolescents experience mental disorders or have been in need of services for mental, emotional, or behavioural problems (World Health Organisation, 2017). Half of all mental illnesses are reported to begin by the age of 14 years, and three-quarters by mid-20s (World Health Organisation, 2017). Together with substance use disorders, mental illness is reported to be one of the leading causes of disability globally (23%) while accounting for 19% of disability in Sub-Saharan Africa (Whiteford et al., 2013). In South Africa, the prevalence of mental disorders in adolescence has been estimated to be between 15–17% (Whiteford et al., 2013). Demographically, adolescents who live in households and attend schools which are socially and economically disadvantaged are deemed to be at a greater risk of mental disorders (Whiteford et al., 2013).

The conception and management of mental illness is a cultural affair, and varies across contexts and people of different age groups (Orngu, 2014). This is captured by Bulbulia and Laher (2013) who state that the conceptualisation of mental illness is largely influenced by people's varying belief systems and cultures. On the one hand, it has long been observed that children of different ages perceive and interpret characteristics of mentally ill people differently (Toth, 2014). In the same vein, the authors suggest that culture in the context of socio-economic status, that is, for rural and urban areas, have a bearing or an influence on children's perception of mental illness (Toth, 2014). It is therefore a possibility that this urban/rural divide may play a role in influencing how youngsters in these contexts view mental illness (Kern, Amod, Seabi, & Vorster, 2015).

Mental illness can cause a great deal of suffering to those afflicted and affected irrespective of age. For young people, it is usually both a painful and traumatic experience, as it has a negative impact on family dynamics and puts considerable pressure on relationships (Flisher et al., 2012). Although, mental health care services are available in most communities people suffering from mental illness often are reluctant to seek such services because often are stigmatised (Longkumer & Borooah,

2013). What compounds the problem is that mental illness is still one of the most widely misunderstood health conditions in most African contexts (Whiteford et al., 2013). In view of this misconception, many people, adolescents included, suffer in silence (Flisher et al., 2012). It therefore becomes imperative that studies be conducted on all persons including children and adolescents of varying demographic backgrounds with a view to promote mental health care and access. It is this observation that motivated the researcher to embark on this study in order to gain an understading of learners in rural schools on matters pertaining to mental illness.

1.2 Research problem

Although it can be argued that about one hundred percent of the population has mental health issues, it is the presently growing number of mental health cases, reported at approximately 21,4% among young people in schools, which has become an increasingly disconcerting issue. Severe mental illness has been reported in 4% of the youth population, and continues to grow. Evidently mental health is a declining factor for youth globally, with reports of increased chances of 37 percent of teenagers experiencing major depression between the years 2005 and 2014 (Lindsay, 2019). According to the same study as reported by Lindsay (2019), mental illness has been proven to not only negatively affect the quality of life of the sufferer but has also been shown to impact school performance.

It is in consideration of the impact of mental illness on quality of life and school performance that calls for the implementation of programmes that will increase awareness and promote mental health have been made (McCann, Renzaho, Mugavin, & Lubman, 2017). In spite of evidence from a few studies on the considerable levels of mental health problems in schools, little has been done to understand how youth, particularly those in rural secondary schools, perceive mental illness (Nguendo-Yongsi, 2015; Kern et al., 2015). In view of the paucity of literature on the mental health issues pertaining to young people in rural areas of Limpopo Province, the present study aimed to bridge the identified gap. It was in response to this challenge that the present study sought to explore the perceptions of young people in rural secondary schools towards mental illness.

1.3 Operational definition of concepts

- **Perception:** Perception can be defined as recognition and interpretation of sensory information from our environment. It also includes how we respond to information (Williams, 2017). For the purpose of this study, perception is understood to mean the interpretations and connotation that learners attach to mental illness.
- **Learners:** In the context of the present study, learners means young people of school going age, from 14 to 19 years of age attending secondary schools.
- **Mental illness:** Also referred to as mental disorder, mental illness refers to a health condition involving changes in thinking, emotion or behaviour, or a combination of these; it is associated with distress in normal functioning (American Psychiatric Association, 2015). From the African nosology, Azibo (1983) defines mental order as opposed to disorder, as the correct psychological and behavioural functioning, that is inculcated by culture, history and principles derived from the African social reality. For the present study, mental illness was understood to mean all diagnosable mental disorders involving changes in behaviour, thinking and emotion.
- **Rural schools:** For the present study, rural schools referred to schools which are not based in town but are rather based in villages within Ga-Dikgale area.

1.4 Purpose of the study

1.4.1 Aim of the study

The aim of the study was to explore the perceptions of secondary school learners in Ga-Dikgale rural community towards mental illness.

1.4.2 Objectives of the study

- To determine learners' understanding of mental illness.
- To identify and describe symptoms of mental illness as perceived by the secondary school learners.
- To determine learners' views regarding the causes of mental illness.

- To describe learners' views regarding appropriate treatment for mental illness.

1.4.3 Research questions of the study

- How do learners understand mental illness?
- How do secondary school learners perceive mental illness?
- What are learners' views regarding mental illness?
- What are learners' views regarding the appropriate treatment for mental illness?

1.5 Significance of research study

The study contributed to getting a deeper understanding of the perceptions of secondary school learners in rural areas with regards to mental illness. It also uncovered how they conceptualised and their understanding of what causes it. It also explored the knowledge of learners in secondary schools in Ga-Dikgale towards mental illness. Information from this study also assisted in providing more insight in informing programmes that will be geared towards mental health in schools.

CHAPTER 2: LITERATURE REVIEW

2.1 Youth and mental health

Based on the definition of the World Health Organisation (2018), mental health is a state of mental well-being and not only the absence of clinical mental illness, but also a sense of belonging and adapting to life's tensions. It defines a person's ability to cope with normal stressors and still be able to lead a happy and efficient lifestyle which allows them to make meaningful contributions to the society they live in. It is essentially considered as a primary and principal component of health needed by any individual for a sustainable life (WHO, 2018).

Positive mental health and well-being are viewed as being the basis required for an individual's well-being, meaningful engagement in society and functioning. Mental health is essential for personal and social abilities as human beings to think, feel excitement, interact with each other and promotes personal development (Hall, McKinstry & Hyett, 2016; WHO, 2018), earn money, and enjoy life. Accordingly, promoting and maintaining mental health can be considered an important and vital concern for individuals, societies, and communities around the world (Hall et al., 2016). This also includes the mental health and wellbeing of young people in our societies, who make up 42% of the population (WHO, 2018). Young people are more often than not affected by mental illness, with 1 in 8 having being clinically diagnosed with some form of mental illness (WHO, 2018). Despite the increasing statistics of mental illnesses across different age groups, the phenomenon still holds some negative undertones in many societies and mental health education is still not considered as a vital tool (Secker, Armstrong, & Hill, 1999).

In light of these issues, many studies have focused on mental health promotion as opposed to the conceptualization and perceptions behind many young people's attitudes towards mental illness. Until recently, most research on school-based mental health education interventions has been focusing on reducing stigma and altering negative attitudes, with an added aim of improving efficiency in help seeking behaviour for mental health problems in youth (Lindsay, 2019; Singletarya et al., 2015).

Other studies for instance, one that was conducted by Forum and Wright (2007) in Melbourne, revealed that youth in that society had a belief that proper interventions to control and prevent mental illnesses could be effective (Forum & Wright, 2007). The consensus from both the young people and their parents about the type of interventions that were more likely to be of assistance. The views seemed to apply across the range of disorders that were presented (Forum & Wright, 2007). It was also expressed that these proper interventions were necessary to cope with daily life pressures (Chinekesh et al., 2018).

2.2 Young people's conceptualisation of mental illness

Mental illness is conceived differently from one culture to another. What is considered normal in one society may be seen as abnormal in another. The same applies with age; how young people and adults perceive mental illness is always different (Bohnenkamp & Stephan, 2015). Seemingly, attitudes toward mentally ill persons vary among individuals, ethnicities, cultures, race and creed. Cultural and religious teachings often influence beliefs about the origins and nature of mental illness, and shape attitudes towards the mentally ill (Orngu, 2014). It is therefore imperative that knowledge with regards to mental illness is perceived in a positive manner especially among young people (Bohnenkamp & Stephan, 2015).

According to Singletarya et al. (2015), not much is known about young people's perceptions on mental health, even health in general, with regards to themselves and others. It has however long been suggted that how they perceive the concept of mental health differs from those of adults and policy makers. In order to fully understand the perspective of positive mental health for young people, it is imperative to involve them in qualitative research. Young people are the experts in their own experiences and their perceptions may differ markedly from how adults, including health professionals, view their experiences (Hall et al., 2016)

According to Secker et al. (as cited in Toth, 2014) it was found that young people were able to make judgements about what was `normal' behaviour and what was not based on either their own personal experiences, or of those around them. This shed some light on significant insight on ways which shape young people's understandings

of mental illness. As such, behaviour that could not be categorised as “normal', or by extension socially acceptable, was classed as ‘abnormal' and therefore labelled as mental illness. Another study by Nguendo-Yongsi (2015) reported responses from 50.6% of students were not afraid of mentally ill people and would not avoid them. The overall attitudes of students were positive and respectful toward individuals with mental disorders. Social distance results revealed a pattern of negative attitudes by a majority of participants. It was noted that, the substantial minority who showed negative attitudes suggest a significant undercurrent of negative views about mental illness despite the presence of many positive attitudes (Nguendo-Yongsi, 2015).

It has also been reported that young people tended to sympathise more with mentally ill people of the same age or gender or those who shared the same characteristics. In light that young people could identify more with individuals experiencing mental illness of the same characteristics as them, this in turn has an important role in conceptualising mental illness. As such, this could assist mental health workers in helping youth to understand and contextualise their experiences (Secker et al., 1999). Despite, many young people identifying with their peers who were suffering from mental illnesses, some alluded that those suffering from mental illness are overly sensitive and weak individuals who let themselves be affected. One in four even regarded themselves as having less in common with persons suffering from mental illness (Nguendo-Yongsi, 2015).

Regarding the sources of knowledge about mental illnesses it was reported that media played a major role in providing information lacking from experiences from which youth could draw legitimate judgements. Television was the cited as the main source of information for most young people pertaining knowledge on mental illness (Secker et al., 1999). However, the process of identification seen in the young people's accounts meant that their attitudes towards those they label mentally ill were not necessarily negative (Secker et al., 1999).

In explaining the negative attitudes towards the mentally ill, an individual’s beliefs may be very influential in shaping their perceptions and ultimately their attitudes. It can therefore be said that the negative attitudes expressed by some young people usually emanate from their beliefs and limited knowledge about mental illness. For instance,

about half of the youths who participated in Oluwole, Obadeji and Dada's (2017) study believed that most if not all mentally ill people have a low IQ or are mentally retarded. Although some believed that it was possible to treat mental illnesses outside of the hospital setting, four-fifth of the respondents were of the opinion that mentally ill people should control their symptoms through the use of prescribed medication (Oluwole, Obadeji, & Dada, 2017).

A majority of young people seem to harbour negative attitudes people with mental illness and often thought of them as being incapable of functioning normally, or meeting normal societal standards or requirements such as working regular jobs. They are perceived as public nuisance and menaces within the society because of their apparently violent behaviour. This is supported by Nguendo-Yongsi (2015) study, which reported that 72.4% of the participants were not willing to work on the same project with a mentally ill person. Some were even against the idea of mentally distressed students attending regular classes (Nguendo-Yongsi, 2015), let alone working in the same environment as them (Oluwole, Obadeji, & Dada, 2017). Fear of interacting with mentally ill persons was expressed, also most also reported uncertainty when encountering them (Oluwole, Obadeji, & Dada, 2017).

Although some experienced bouts of fear when approached by a mentally ill person, they insisted that they should not be avoided (Nguendo-Yongsi, 2015). Most of the studies conducted about young people perception of mental illnesses, suggest that conceptualisations are steadily changing. There are apparent differences in results from earlier studies suggesting that youth nowadays possess a slightly more tolerant attitude as compared to the general population (Nguendo-Yongsi, 2015).

Despite some misgivings and negativity about mental illness from a potentially problematic smaller group; it could be deduced that young people generally have a positive attitude towards mental illness. As in most of the studies conducted, most maintained a respectful view stance towards people with mental illness (Nguendo-Yongsi, 2015). Over the years research conducted on young people has suggested that in order to achieve health promotion principles, individual learning opportunities need to be given in such a way that will take youth's own view point. This will help in

creating a supportive environment for mentally ill person and for the development of a more positive attitude towards the mentally ill (Secker et al., 1999).

2.3 Young people's knowledge of causes and symptoms of mental illness

The need for the public to have greater mental health literacy is highlighted by the high lifetime prevalence of mental disorders; (up to 50%) which means that virtually everyone will either develop a mental disorder or have close contact with someone who does (Tibebe & Tesfay, 2015). In most developing countries, dimensions of mental health literacy are totally different from those in Western countries, supernatural causes of mental disorders are more widely held and traditional sources of help, such as spiritual healers, preferred over medical advice (Tibebe & Tesfay, 2015). In a study conducted in Ethiopia, Zambia and Nigeria to assess how mental health problems were perceived by community, a significant number of people implicated supernatural powers as causing mental health problems (Tibebe & Tesfay, 2015). This is supported by Oluwole, Obadeji, and Dada (2017), who reported that reported 49% of Nigerian participants had a standing belief in supernatural factors as being the cause of mental illnesses. They further posit that other studies conducted in other developing countries like Ethiopia, Malaysia and Pakistan reported that a significant number of participants believed that the most significant causes of ill mental health were supernatural (Oluwole, Obadeji, & Dada, 2017).

In relation to young people Nguendo-Yongsi (2015) posits that there are still some gaps in students' knowledge about mental illness, particularly with respect to the causes of specific disorders as those students who are from academic level, do not seem to have a good understanding of the signs of specific disorders. They may then be slow to recognise illnesses experienced by themselves or by their peers, leading to delays in help seeking. It might also be possible that students will be confused by or misunderstand psychiatric labels that may be used to describe themselves or others (Nguendo-Yongsi, 2015).

Environmental dynamics, among which stress is included, were also perceived by most young people as one other significant causal factor in mental distress (Oluwole, Obadeji, & Dada, 2017). Apart from stress, other environmental factors believed to be

contributory to mental illness are physical, emotional or psychological stress. To support this notions, Oluwole, Obadeji, and Dada (2017) further reported that a study conducted in an urban setting in South Africa showed results which indicated that most young people's perceptions of the causes of mental illness, tend to lean a little more towards stress related factors and medical etiology. Even less respondents attached supernatural meanings to mental illness, and only a handful cited supernatural factors as the cause of mental illness (Oluwole, Obadeji, & Dada, 2017).

However, worthy to note is the cultural differences in most of the studies. It can be argued that most African and Asian countries or cultures with deeply rooted traditional cultures and customs tend to attribute mental illness as being caused by supernatural factors whereas countries which were more westernised and scientifically inclined believed that chemical imbalances in the body were the causes of mental illness. One case in point to support the notion of differences in perceptions on how mental illness is caused, is a study conducted in Agaro, Ethiopia assessing how mental health issues was perceived by a community. The results indicated that a majority of people associated supernatural forces as the main cause of mental illnesses which is in agreement with other studies conducted in other parts of Africa. Such traditional views in which supernatural powers are believed to control the sanity of an individual's mind are widespread in all ethnic or religious groups across the African continent (Tibebe & Tesfay, 2015).

Another study done with young people in Vietnam and the United States (US) about their perceptions on mental illness had three main findings; firstly perception on causes of mental illness differed by country. Vietnamese participants reportedly believed that mental illness was caused by life stresses while their US counterparts believed that chemical imbalances were the most likely cause. Furthermore, Vietnamese participants seemed to have images that individuals with mental illness were a danger to the community and had to be kept out of it, while US participants were of the opinion that mental illness was the same as other illnesses and thus should be treated as such. Lastly, Vietnamese participants tended to prefer seeking help and support from family or friends and therefore did not see any need to seek help elsewhere (Kamimura et al., 2018).

2.4 Stigma and treatment of mental illness as understood by young people

Mental health is an essential component of health and wellbeing and so early identification and treatment of mental disorders is important. This will happen only when people have adequate knowledge and positive attitudes regarding mental disorders (McCann et al., 2017). Treatment stigma has led to major barriers to accessing health care and illness management. Stigma has been linked with problems relating to knowledge and attitudes while discrimination has largely been related to behaviour, however, their overall effects on the people with mental illness can be far reaching and can have dire consequences (Egbe et al., 2014).

There are mainly two types of stigma which exist, namely; public (externalized stigma) and self-stigma (internalized stigma). Although these types of stigma maybe interlinked and in many cases one can lead to the other, the negative consequences have a far more reaching impact on the people experiencing them. More often than not, mentally ill people not only have to carry the burden of their illness, they also have to deal with the social, cognitive and economic consequences of stigma they experience from both themselves and people around them. Stigma can bring about feelings of low self-esteem, social difficulties (isolation and anxiety), poor social support and economic difficulties. This may in turn lead to strained relations, low self-esteem, and poverty which most likely serve as a barrier to seeking or accessing healthcare services (Egbe et al., 2014). The negative stereotypes towards mentally ill people sometimes instigated by the public and portrayed by the media as a menace to the society, violent, dependent, not fit to be in love relationships, psychologically volatile and economically ‘useless’ are some of the challenges which mentally ill people come across in the societies in which they live (Egbe et al., 2014).

Tibebe and Tesfay (2015) reported that a study in Zambia revealed that stigmatisation and discrimination was mostly prevalent towards those affected by mental illness and this was an omnipresent factor in the society. These issues which are faced by the mentally ill are often intensified by a poor or restricted access to adequate health care services. In a bid to improve lives of the mentally ill, Egbe et al. (2014) suggest ridding the healthcare system of inequalities and also identified that the reduction of stigma is

another important factor which could assist in alleviating and improving the lives of the mentally ill (Egbe et al., 2014).

Since people with mental illness have a lot to grapple with, it is therefore imperative that healthcare facilities from whence they seek assistance, be as accommodating and non-judgmental as humanly possible. Personality characteristics, individual beliefs and situational circumstances are usually significant determinants of people's attitudes towards people with mental illness. Despite contrary information, society's view of mental illness have an impact on practical professional responses to the mentally ill individual. As such, health care providers being the first point of contact, should portray a positive attitude when interacting with those affected by mental illness (Egbe et al., 2014; Tibebe & Tesfay, 2015).

Stigma is the most frequently alluded to barrier which prevents most people from seeking treatment (Hartman et al., 2013). It has a disabling effect on one's sense of self, including a reduced self-esteem, diminished self-value and confidence. This is supported by a significant number of studies which have shown linkages between stigma, non-help seeking behaviour and non-adherence to treatments (Casañas et al., 2018). It can be argued that public stigma may be inherent or socially learned as evidenced by research done with young children which showed that although they generally have poor conception of mental illness. They, however, seemed to already possess stigmatising attitudes which was demonstrated by their tendency to avoid mentally ill people (Hartman et al., 2013).

A systematic review of barriers and facilitators for help-seeking in young people found that one of the key barriers was stigma (Casañas et al., 2018) and despite the many improvements and advances in accessibility and quality of treatments, a considerable number of mentally ill people still opt to not seek treatment. Young people are mostly at an age whereby peer approval and inclusion are central to their social and cognitive functioning. However, the emergence of mental health problems more often than not, would lead to negative encounters and rejecting views from peers (Nguendo-Yongsi, 2015). Although public stigma initially contributes to the experience of self-stigma, it is self-stigma which is a more prominent indicator of an individual's willingness or reluctance to pursue professional help (Hartman et al., 2013).

Negative stereotypes which portray people with mental illnesses as unfit to lead normal lives are some of the challenges that they have to face from the society (Egbe et al., 2014). More work needs to be done to educate young people about the psychobiological underpinnings of psychiatric disorders and the value of effective treatments. A better understanding of these disorders amongst the public would presumably lessen stigmatisation and encourage the use of currently available and effective interventions (McCann et al., 2017).

Positive and negative attitudes expressed toward and social acceptance or rejection of individuals with a mental illness may also be perpetuated by an individual's acculturation (Nguendo-Yongsi, 2015). The differences in perceptions of individuals with mental illness by country was done by Kamimura et al. (2018) in their study with Vietnamese and United States (US) participants from urban settings. The study's findings suggested that mental illness stigma was stronger in Vietnamese participants and more so in developing countries as compared to more developed countries such as the US. It was also suggested that urban residents have more perceived stigma and discrimination towards mentally ill people than their rural counterparts in Vietnam, this is common in developing countries (Kamimura et al., 2018). This is further supported by studies (Nguendo-Yongsi, 2015; Wahl, Susin, Lax, Kaplan, & Zatina, 2012), that reported that respondents who were more knowledgeable tended to possess less stigma towards mentally ill people as compared to their counterparts.

2.5 Theoretical Framework

2.5.1 Biopsychosocial Model

The present study adopted the Biopsychosocial Model as a theoretical framework. According to Frankel, Quill and McDaniel (2003), the Biopsychosocial Model emphasises the importance of understanding human health and illness in their fullest contexts. This approach systematically considers people's genetic makeup (biological), mental health and personality (psychological), and sociocultural aspects (social factors) and their complex interactions in understanding health, illness, and health care delivery.

The Biopsychosocial perspective posits that not one of these mentioned factors is sufficient to create health or mental illness, but the interaction between different factors

determines the course of one's development of mental illness (Cardaso, 2013). In order to truly understand someone's mental health, we must take into account all of the factors affecting people both positively and negatively (Frankel, Quill, & McDaniel, 2003). In line with the model's basic tenats, the researcher was able to understand how learners made sense of the phenomenon of mental illness. The researcher appreciated the multi-dimensional proposition of this model since it assisted in the holistic understanding of leaners' views and understanding of mental illness.

CHAPTER 3: METHODOLOGY

3.1 Introduction

In this chapter, the research methodology employed in the study would be outlined. This includes a discussion on the study paradigm, the research design, sampling strategy used, and data collection methods. Data analytical strategy employed to derive meaning, and ethical considerations are covered last.

3.2 Research paradigm: Interpretivism

The study adopted the interpretivist paradigm. Interpretive researchers assume that realities are socially constructed through things such as consciousness, shared meanings and language (Saunders, Lewis, & Thornhill, 2012). Thus, interpretive oriented researchers pursue research projects focusing on the meaning individuals or groups attach to a social or human problem (Saunders, Lewis, & Thornhill, 2012). Added on, it is vital that an interpretivist researcher be a social actor in order to appreciate the differences between people (Saunders, Lewis, & Thornhill, 2012). Being guided by this paradigm, the researcher was able to understand how learners ascribed meaning or constructed knowledge as it relates to mental illness. The learners were the primary sources of information from which the contextual account of their perceptions was the premise for the study (Fouche & Delport, 2005). Knowledge shared by participants was treated as relative to culture, age, and context in order to gain an in-depth understanding from a social and experiential point of view (Fouche & Delport, 2005).

3.3 Research methodology and design

According to Creswell (2014), qualitative studies seek to explore and understand the meaning individuals or groups ascribe to a social or human problem. Therefore, the central goal of qualitative researchers is to gather an in-depth understanding of human behaviour and the reasons that govern such behaviour. It also seeks to explore human experiences through in-depth inquiry and observations of participants in their natural setting (Fouche & Delport, 2005). This is done in the form of narrations, and analysed through interpretation, coding, and categorisation (Fouche & Delport, 2005). Qualitative research comprises of diverse designs of which all are concerned with how

humans socially construct knowledge related to phenomena of interest (Saunders, Lewis, & Thornhill, 2012). For the present study, since the study sought to explore and describe the perceptions of secondary school learners, an exploratory-descriptive contextual research design was found to be appropriate. As recommended by Creswell (2014), this design helps the researcher an opportunity to gain insight and accurately describe participants' perceptions of a phenomenon whilst avoiding detaching them from the wider setting which they are associated with (Creswell, 2014). Similarly, the researcher in the present study adopted an exploratory-descriptive contextual research design for the same reasons.

3.4 Setting, population and sampling

The study was conducted in Ga-Dikgale community of the Limpopo Province. Ga-Dikgale is a rural community 45km North of Polokwane and comprises of villages under the leadership of Chief Dikgale of the Dikgale Tribal Authority. According to the last census conducted by Statistics South Africa, the average household lives just a little above the poverty line with an average income of R38 200 per annum. The level of education for the majority of the population is secondary schooling (Statistics South Africa, 2015). The population of interest was learners in secondary schools found in the Dikgale community. In this community, there are fourteen secondary schools scattered across ten villages. The participating schools were sampled through the cluster sampling strategy whereby four out of the ten schools were sampled for inclusion. Sampled schools were those located in Sebayeng, Ga-Moloisi, Ga-Mokgopo and Makotopong villages.

Upon sampling participating schools, a purposive sampling strategy was employed to generate the study sample. Accordingly, a total of 14 participants were sampled to participate only in individual interviews. Another 13 (one with six & another with seven learners) were sampled to participate in two Focus Group Discussions (FGDs) from two of the participating schools. Those learners who participated in individual interviews were excluded from participating in FGDs in order for the researcher to get a broad range of views. In total, learners who participated in the study were twenty-seven. The inclusion criteria for all study participants was being male and female learners aged 14 to 19 years, and enrolled in the participating schools.

3.5 Data collection instruments and procedure

Data were collected from the fourteen (14) selected individual participants, employing semi-structured individual interviews (see Appendix 1a for Interview guide – English version, and Appendix 1b for Interview guide – Sepedi version). With regard to the two focus groups, the researcher used a semi-structured Focus Group Discussion (FGDs) guide (see Appendix 2a for Interview guide – English version, and Appendix 2b for Interview guide – Sepedi version) to collect data. Like with semi-structured individual interviews (Nyumba, Wilson, Derrick, & Mukherjee, 2017), focus group discussions are frequently used as data gathering tools to gain an in-depth understanding of social issues. However, with FGDs the aim is to obtain data from a purposely selected group of individuals rather than from a representative sample derived statistically from a broader population (Nyumba et al., 2017). The two methods of data-collection were triangulated to enrich the data collected in order to achieve study credibility (Fouche & Delport, 2005).

With regard to the study procedure, upon institutional and governmental ethical considerations and clearance (see subsection 3.7 below) the researcher requested permission from each participant to audio record the interviews. Upon gaining verbal consents from each of the participants interviewing could commence. Interviewing was in the Sepedi language which was the language that all participants were comfortable to be interviewed in. The principal researcher was assisted by a research assistant who also acted as a moderator during FGDs. During the interactions the researchers also took field notes. All data were later transcribed verbatim and later sent to a language practitioner for translations into the English language.

3.6 Data analysis

Thematic content analysis was employed to derive meaning from both the data collected during individual interviews and FGDs. Thematic content analysis seeks to identify, analyse, and report patterns (themes) within data as well as minimally organising and describing the data set in detai (Braun & Clarke, 2006). The present study adopted the analytical method developed by Braun and Clark (2006), following the following six phases:

Phase 1: Familiarisation with data

The initial phase in thematic analysis is for researchers to familiarise themselves with the data (Braun & Clarke, 2006). What this essentially means, is that, a researcher should listen to audio recordings multiple times, and also read through the derived transcripts several times (Braun & Clarke, 2006). Similarly, in this study, the researcher listened to each of the audio recordings, and made necessary alterations after to the transcriptions and translations after listening to the audio multiple times read through each derived transcript to fully familiarise themselves with the data. Additionally, the researcher managed to get a sense of the whole by reading all the transcripts carefully. This assisted the researcher with developing initial ideas about the data segments and what they might mean before the next phase was initiated.

Phase 2: Generating themes

The second phase in this study was to generate an initial list of codes from the data set. The researcher scaled down the data collected to codes based on the existence or frequency of concepts used in the verbatim transcriptions. This systematic way of organising and gaining meaningful parts of data in relation to the research question was used to generate codes (Braun & Clarke, 2006). The researcher then listed all concepts that emerged during the scaling down. Similar concepts were grouped together, and those that did not have association were clustered separately. Notes were written on paper margins and the researcher started recording thoughts about the data on the margins of the paper where verbatim transcripts appear.

Phase 3: Searching for themes

The researcher started by searching for themes and taking into consideration what works and what did not work within themes; this enabled the researcher to begin the analysis of potential codes. During this phase, Braun and Clarke (2006) recommend that the researcher begin by examining how codes combine to form over-arching themes in the data. Thereafter, the researcher made a list of themes and focused on broader patterns in the data, combining coded data with proposed themes. The researcher read through the transcrips again and analysed them. This time the researcher asked herself questions about the data, based on the codes (mental picture codes when reading through) which existed from the frequency of the concepts. The

questions were “Which words describe it?” “What is this about?” and “What is the underlying meaning?”

Phase 4: Reviewing of themes

For this study, the researcher searched for data that supports or refuted the proposed theory. This allowed for further expansion on and revision of themes as they developed. Braun and Clarke (2006) recommend that at this point, the researcher should have a set of potential themes, as this phase is where the reworking of initial themes takes place. Some existing themes may collapse into each other; others may need to be condensed into smaller units. The researcher started to abbreviate the topics that has emerged as codes. These codes needed to be written next to the appropriate segments of the transcription. Differentiation of the codes by including all meaningful instances of a specific code’s data were done. All these codes were written on the margins of the paper against the data they represent with a different pen colour as to the one in Step 3.

Phase 5: Defining and naming themes

During this phase, the researcher defined and refined existing themes that were presented in the final analysis which assisted in analysing the data within each theme. During this phase, identification of the themes' essences related to how each specific theme affect the entire picture of the data (Braun & Clarke, 2006). Analysis during this stage was characterised by identifying which aspects of data were being captured, what was interesting about the themes, and why themes were interesting. The researcher developed themes and sub-themes from coded data and the associated texts and reduced the total list by grouping topics that relate to one another to create meaning of the themes and sub-themes.

Phase 6: Producing the report

After reviewing the final themes, the researcher in this study began with the process of writing the final report. While in the process of writing the final report, the researcher decided on themes that made meaningful contributions to answering research questions which were refined later as final themes. The researcher presented the dialogue connected with each theme in support of increasing dependability through a thick description of the results (Braun & Clarke, 2006). The researcher in this step

rework from the beginning to check the work for duplication and to refined codes, topics and themes where necessary.

Using the list of all codes she checked for duplication. The researcher grouped similar codes and recoded others were necessary so that they fit in the description. The data belonging to each theme were assembled in one column and preliminary analysis was performed, which was followed by the meeting between the researcher and co-coder to reach consensus on themes and sub-themes that each one has come up with independently.

3.7 Quality criteria

For quality purposes, principles of credibility, dependability, confirmability and transferability had to be paid attention to as suggested by Lincoln and Guba (1985):

3.7.1 Credibility

This criterion is more concerned with establishing that the results of the qualitative study are believable from the participant's vantage point, as they are the only ones who can rightly judge the credibility of the results (Trochim, 2006). As a way of getting rich data, the study employed the triangulation technique by using more than one data collection method. Individual interviews and focus group discussions were utilised to ensure the credibility of the study. The semi-structured interview guide allowed the participants to flow in their responses without restriction and also gave the researcher room to probe within limit. The researcher engaged with the participants a day before data collection and introduced herself and the study, as a way of establishing some familiarity with the participants and environment. A period of a month was spent engaging with the participants in order to acquire the relevant data necessary for the study.

3.7.2 Dependability

The idea of dependability in qualitative research puts emphasis on the need for the researcher to account for the ever changing context in which research occurs (Trochim, 2006). Similarly, the researcher in the present study reported on changes in settings that occurred during the course of the study. The researcher had to make

changes to the focus group discussions question as it did not elicit the desired responses or participation from the participants. For uniformity, the questions used for the focus group discussions were the same as the one used for the individual interviews. The participants were all interviewed in their respective schools which served as a neutral setting for them and felt comfortable.

3.7.3 Confirmability

Confirmability refers to the degree to which the results of a study can be confirmed by others. This criterion is there to verify that the findings are shaped by participants more than researchers (Statistic Solutions, 2017). The researcher documented all the procedures undertaken, and continued to check and recheck data throughout the study to ensure confirmability. For this study, the element of bias was eliminated through the use of the same semi-structured interview guide for all participants for both the individual interviews and focus group discussion. An independent analyser was also invited to assist in interpreting and analysing the data.

3.7.4 Transferability

Transferability is evidence that the results of a study can be applied in other contexts (Trochim, 2006). For the purpose of this study, the researcher described the research context and assumptions that were central to the research. This criterion was ensured through the use of a description of the methodology and sampling techniques used to conduct the study. Although the sample was limited to a specific area and limited population, the results cannot be generalised to other populations. However, data were collected until saturation was reached.

3.8 Ethical considerations

3.8.1 Permission to conduct study

The researcher sought ethical clearance from the Turfloop Research Ethics Committee before the study was conducted. Gatekeeper permission was also sought from the Limpopo Provincial Department of Basic Education which subsequently gave permission to approach circuit managers. The two circuit managers from Kgakotlou and Dimamo were approached to request permission, which was granted, to gain access to the schools identified for the purpose of the study. Principals of the identified

schools were also approached to give the researcher access to the learners in their schools. The participants were addressed and the study was explained to them, those who were interested to participate were given Consent Forms. The learners then gave the Consent Forms to their parents or guardians to sign for permission for them to participate in the study. Only learners who returned the signed Consent Forms were allowed to participate. Verbal assent to take part in the study was also sought from the learners before data was collected (Appendix 3a & 3b are the English and Sepedi versions of the consent letters for parents/caregivers, requesting permission to interview the participants).

3.8.2 Informed consent

Strode, Slack, and Essack (2011) posit that research with children and young people often requires that informed consent be gained from their parents, legal guardians or primary care-givers, and also from the participants themselves in the form of verbal consent. This is in accordance with Section 71(2) (d) National Health Act of 2003. (Republic of South Africa Government Gazette, 2004). One way of achieving this, was through identifying relevant gatekeepers (i.e., schools, childcare facilities) who facilitated researcher access to parents or legal guardians for their consent (Loveridge, 2010). In this study, upon receipt of written permission to collect data by the provincial Department of Education, circuit managers and the participating school principals, the researcher availed informed Consent Forms (see Appendices 3a, 3b, 5a & 5b for the English and Sepedi versions of the letters and forms of consent) to the schools for distribution to learners. The learners were in turn asked to hand over the forms to their parents to read through and grant permission for them to partake in the study. It was only after parental consent had been granted that learners were approached for their verbal assent.

In accordance with South African ethics and legal framework; Section 71(2) (d) in the National Health Act of 2003, which states that if a minor is capable of understanding, then that child is eligible to provide assent. Therefore, only learners whose parents had given consent (and they themselves having granted assent verbally) were included for participation. Only two participants did not return the Consent Forms and had to be replaced.

3.8.3 Voluntary participation

The researcher also explained to the participants that participation in the study was voluntary and they were free to discontinue anytime during the course of the study, this was also outlined in the consent letters and forms given to parents and the participants.

3.8.4 Anonymity

Furthermore, it was explained to the participants that they would remain anonymous as their names will not be used. For the researcher to be able to identify the participants, unique numbers were used for each.

3.8.5 Confidentiality and privacy

The researcher took every care to ensure that the participants' responses are used solely for the purposes of this study. Data were stored in a password protected file and hardrive which is kept in a safe place. All identifying characteristics of the participants were changed and identifying information will be deleted from the file once it is no longer needed.

3.8.6 Aftercare of participants

Professional counselling was offered to any participant who might have experienced discomfort or stress as a result of partaking in the study. All the participants were asked if they needed any psychological or social intervention and all affirmed that they will not be needing it. From the observation of the principal researcher, none of the participants showed any psychological or emotional discomfort or stress during the interviews or group discussions. Results were also made available for participants and Limpopo Department of Basic Education and participants who requested for them.

CHAPTER 4: RESULTS

4.1 Introduction

The present chapter presents study findings. In the initial part,the demographic profile of participants is outlined (see Table 1). The emerging themes and sub-themes are also presented, whilst quotations from the interviews would be used for illustrative purposes.

4.2 Demographic information of participants

Table1: Participants demographic information

Characteristics	#	%
Gender		
Male	14	51,85%
Female	13	48,15%
Age Range		
13-15 years	10	37,04%
16-18 years	13	48,15%
19-21 years	04	14,81%
School Grades		
8	4	14,81%
9	6	22,23%
10	5	18,52%
11	4	14,81%
12	8	29,63%
Denominations		
Christianity	24	88,89%
Traditional African Religion	1	3,7%
African Independent churches	2	7,41%

A total of 27 learners participated in the study. These included 14 that participated in individual interviews and 13 in focus group discussions. The majority of participants were aged between 16-18 years followed by those between the ages of 13-15 years. Their gender distribution was almost even with males being more by one. Most participants were in Grade 12 (*n* = 8), followed by those in Grade 9 (*n* = 7), and the frequency dropped by one grade per grade respectively. In their majority (*n* = 24), the learners endorsed Christianity as their religious affiliation.

4.3 Main themes and subthemes

From the analysed data three main themes emerged namely: 1) Knowledge of mental illness, its causes and symptoms, 2) Knowledge on the management and types of interventions for mental illness, and 3) Challenges associated with mentally ill people. Three sub-themes were further associated with theme 2: i) Professional healthcare services, ii) Traditional healers and iii) Social support and lack of it; these are tabulated below:

Table 2: Themes

Main themes	**Sub-themes**
1. Knowledge of mental illness, its causes and symptoms	
2. Knowledge on the management and types of interventions for mental illness	2.1 Professional healthcare services 2.2 Traditional healers 2.3 Social support and the lack of it
3. Challenges associated with mentally ill people	

4.3.1 Knowledge of mental Illness, its causes and symptoms

In the present study, it was found that learners possessed different understandings of mental illness. Although this was the case, in their majority, participants had a fairly reasonable knowledge of mental illness. Most of the learners ascribed mental illness to biological, psychosocial, and supernatural factors. This include a view that mental illness could be genetically inherited. The following excerpts support this finding:

> *"…for others it's in their genes…Even drugs can mess one's life."*
> (**Participant 21)**
>
> *"My opinion on the illness is that it can be caused by genetic disorders."*
> (**Participant 8)**
>
> *Mental illnesses have many causes. Others may have brain cancer."*
> (**Participant 4**)
>
> "*Mhmm ... some of us have been born with them (illnesses)."*
> (**Participant 15**)
>
> *"According to me, I think some are caused by depression."*
> (**Participant 18**)
>
> *"According to me seems to be thinking too much."*
> **(Participant 27)**

With supernatural and cultural explanations, the following are what the learners had to say:

> *"Some are being punished by their ancestors for not following their orders…some people are defiant and do not do as their ancestors instruct them, so the ancestors punish them."*
>
> (**Participant 3)**

> *"Ah, I think it is caused by witchcraft."*
>
> **(Participant 13)**

> *"…Jealousy can cause a person to bewitch someone to lose their mind… someone might curse you… and truly the cursed person ends up being crazy."*
>
> (**Participant 16)**

> *Eh you can find that your neighbour's child is suffering from mental illness and the parents will ask you to play with him and you end up being exactly like him, yes since the child is mentally disturbed you end up also behaving like him. You will end up like him and have mental illness."*
>
> **(Participant 9)**

In addition, some of the learners identified factors such as substance abuse (drugs) 'thinking too much/stress' and family conflicts to be the cause of mental illness**:**

> *"Sometimes they are caused by things like drugs."*
>
> (**Participant 18)**

> *It normally affects students … because of peer pressure they ended up using drugs (and smoking weed) which negatively affected their minds."*
>
> (**Participant 9**)

> *"Mostly the illness is caused by family problems."*
>
> (**Participant 25)**

> *"According to me seems to be thinking too much, about things which basically when you do think of, sometimes you feel nervous, such as what you will do or might happen to you in future (anxiety)."*
>
> (**Participant 27**)

> *"Mental illness is a disease normally caused by stress."*
>
> (**Participant 7**)

Another finding was that, in their majority the learners were able to identify symptoms indicative of mental illness. The mental illness symptoms that were predominately reported were those of psychosis. These were some of the symptoms reported:

> *"You normally see them laughing alone in the streets or just waving around at invisible things."*
>
> (**Participant 12**)

> *"We see them by picking up papers in the street while talking to themselves and also doing unusual things."*
>
> (**Participant 15**)

> *"In most cases ... they're destroying things without a reason, like the person will go breaking the windows not knowing why."*
>
> (**Participant 25**)

> *"Usually you can identify them easily because they like laughing alone. In everything they do they are slow, when you talk to them they might answer you after a long time."*
>
> (**Participant 6)**

> *"We can see that they are not mentally stable by their physical appearance*."
>
> (**Participant 20**)

It was also interesting to note that a few other learners had the knowledge that people with mental illness had to be treated with respect and dignity.

> *"I'm talking from experience, they are not that bad, as long as…like they are the kind of people who will be good to you as long as you accommodate (are good to) them and not stress them out. I mean it's very rare to find people living with mental illness causing havoc unnecessarily if you treat them good they are harmless."*
>
> **(Participant 22)**

> *"According to me speaking from experience. Living with these mentally disturbed people when you live close to them, and you see that they are not okay mentally, you must care for them and treat them like normal human beings."*
>
> **(Participant 22)**

Based on the earlier excerpts, mental illness is believed to be predominantly caused by genetic disorders**,** substance abuse, bad lifestyle choices, social problems and supernatural factors such as witchcraft or ancestral calling. Mental illness is caused by substance abuse and by the pregnant mother who abuses substances while pregnant which eventually affects the unborn baby's mental health. Teenagers who

are under a lot of peer pressure and have family problems might end up being mentally ill. Jealousy may also cause one to end up bewitching someone to be mentally ill. Failure of one to respond to ancestral calling or not adhering to cultural norms might end up being punished by ancestors. According to the participants, mentally ill people may be identified by the way they behave, dress and interact with people, which is usually very different and odd from the norm.

4.3.2 Knowledge on the management and types of interventions needed for mental illness

Data analysis further revealed that learners had some knowledge on the management of mental illness including the different types of interventions available. Interventions identified were: i) Professional health care services, ii) Traditional healers and iii) Social support and the lack of it. These are further presented below:

i) Professional health care services

Participants pointed out that a professional multidisciplinary team is crucial in dealing with people with mental illness. According to their responses, the different expertise of a multidisciplinary team inclusive of counsellors, psychologists, medical practitioners and social workers would go a long way in creating a mentally stable society. This is supported by the below statements from the participants:

> *"We can help them by getting counsellors or psychologist to help them."*
>
> (**Participant 27)**

> *"We have people like social workers so that if you have problems you can go freely to them…for help."*
>
> (**Participant 22)**

> *"Perhaps the doctor's knowledge, they give you some medication or things that you can use."*
>
> (**Participants 2)**

It was also interesting to note that some of the participants highlighted that not only western trained mental health experts should be included in the multidisciplinary team but also African indigenous healers. This is what one learner had to say: *"I think it's about time both Western and African Doctors come together to make the world better that is what they are talented on"* (Participant 16).

The learners went further to indicate the importance of medication in the management of persons living with mental illness. There was a general understanding that the medication does have benefits for ill persons thus adhering to treatment is crucial. They also indicated that the treatment could help an affected person to lead a normal and functional life and make valuable contributions to the society economically and otherwise.

> *"The pill which he takes (my neighbour) makes his mind to be stable…he tends to be normal because even now he is working doing agricultural stuff, he likes planting things."*
>
> (**Participant 22)**

> *"We can help them by arranging some kind of centres for them so that they will be able to take their medication."*
>
> (**Participant 27**)

> *"Perhaps the doctor's knowledge, they give you some medication or things that you can use."*
>
> (**Participant 2)**

> "… *through medication… eh the more they take their medication… (they) do their most positive."*
>
> (**Participant 8)**

> *"They will just give him some medication and after some time he will be fine."*
>
> (**Participant 26**)

> *"I have a neighbour …Yes, he takes medication from Mankweng (hospital). By just merely looking at him you might think that he's normal, but if he is not taking his medication he becomes violent and eish that is where the problem begins."*
>
> *(**Participant 22)***

The above extracts indicate that one helpful intervention in managing mental illness is through professional healthcare service interventions. A multidisciplinary team, inclusive of medical practitioners, psychologists and counsellors is perceived as crucial in helping to alleviate the burden of mental illnesses. The extracts also point out the importance of adhering to medication as a way of lessening the burden of mental illness and improving one's quality of life.

ii) Traditional healers

The participants highlighted on the importance of interventions from other sources other than professionals. Participants seemed to believe that in order to curb and heal some types of mental illnesses, there is a need to involve indigenous healers and faith healers. Some even had knowledge of the processes that one goes through if they opt for the traditional healing route. Some knew this first-hand since either a relative or someone they know utilised indigenous treatment. The learners also highlighted that Africans have different belief systems that could be utilised to help the mentally ill and ease their plight; as supported by the following excerpts:

> *"I think even the African healers can also help."*
>
> (**Participant 16)**

> *"Most of them are often taken to their traditional doctors to be in contact with their ancestors so that they can cure them*."
>
> (**Participant 21**)

> *"How can I explain this? I had an uncle who was mentally disturbed I think he was bewitched the way I saw it. So they took him to some traditional healer and they assisted him… they heal them using traditional medicine."*
>
> (**Participant 2)**

> "*They can use traditional medicine, or be initiated to be a traditional healer because they might be bothered by ancestral spirits which need to be appeased*."
>
> (**Participant 17**)

> *"We can take him to African doctors to help him."*
>
> (**Participant 24**)

> *"For some they will just take him to the traditional doctor to give him some herbs*."
>
> (**Participant 26**)

The participants went further to report that faith healers from African independent churches were also helpful in dealing with cases of mental illness. This is reflected in the below statements:

> *"It's by going to church, like taking a mentally ill person to church so that they can pray for them to be healed…Yes, they take them to a traditional healer, and they instruct that the person must be taken to a river and bathe there. Mhmm, the traditional healer will then give them medicine to mix with the river water while bathing in there."*
>
> (**Participant 3)**

"Others consult with their traditional healers…, yeah and others will prefer to go to their respective churches because we solve problems differently."
(**Participant 1**)

"Maybe things like religion, even traditional healers.…"
(**Participant 5)**

With regard to treatmet, the learners indicated the use of indigeneous treatment systems as another form of intervention. Traditional healers and African independent faith healers are instrumental in alleviating the plight of the mentally ill. Traditional healers also act as mediators between an individual and his/her ancestors, and helps to harmonise their relationship and do away with the mental illness that came about as a result of failure to listen to instructions. The above excerpts also give an indication that participants also were familiar with the process one goes through during treatment. Churches also assist with the management of mental illness.

iii) Social support and the lack of it

It was interesting to note that the learners had the knowledge that if all role players in the community worked together, this could help in dealing with mental illness. During discussions the importance of collaboration between the police and communities in dealing with violent mentally ill people was reiterated. In essence, they suggested that social support was key in dealing with cases of mental illness in the community.

Some of the learners showed an understanding that mentally ill people are harmless as long as they are treated with respect. The leaners had some knowledge that if unprovoked people with mental illness would always have good relations with community members. Furthermore, they held that mentally ill persons are human beings who deserved the same support, privacy, and space as any other person. In spite of these views, some of their responses indicated that communities often do not support but rather ill-treat those mentally unstable.

"They are not that bad. …They are the kind of people who will be good to you as long as you accommodate (are good to) them and not stress them out."
(**Participant 22)**

We must also not laugh at them, we should help them anyway we can… We should give them their space to think."

(**Participant 12)**

"As their family members should…treat them well and not anger him/her, ensuring they are always fine."

(**Participant 19**)

"We live with them well and talk with them the way they talk, being patient with them, so we can understand their mental state."

(**Participant 7)**

"We have to also encourage out friends and families to care about and treat them like everyone and stop leaving them alone."

(Participant 27)

"I think…we as black people, we don't support these people, what we do is to laugh at them because they do unusual things."

(**Participant 25)**

"The only problem is that this people are not supported by the societies where they come from."

(**Participant 13)**

"If you offend him, he might end up doing stuff that you will be forced to call the police, to stop him."

(**Participant 22)**

Furthermore, the results showed that learners advocated for the formation of support groups in order to offer support to persons living with mental illness. The following statements highlight their suggestions:

"We can start support groups."

(**Participant 15)**

"If we can have like groups that will volunteer to help people with mental illnesses to talk… I think by so doing we will be making a huge difference."

(**Participant 16**)

"The mentally ill just need to be taken care of well by us, we need care for them like we would children."

(Participant 17)

"Sometimes even taking them to the sports fields to play with us so that they see that they are not that different from us."

(**Participant 25)**

As reflected in the above extracts, social support is also crucial as a way of assisting mentally ill persons. Community and family support is needed for a person to be

better. According to the responses above, social support groups and sporting activities are important in intergrating mentally ill people in the community and making them feel as part of the family. The lack of social support for the mentally ill is sometimes evident in the way they are treated by the community in which they live in. For them to lead a better life, they need to be treated with respect and dignity.

4.3.3 Challenges associated with mentally ill people

The learners found that mental illness on its own is a challenge to families and persons affected. Additionally, the physical violence accompaniment in mental illness was also identified as another challenge. The violent behaviour was also connected to non-adherence to medication, which was identified as another challenge. Seemingly, they found that mentally ill persons' inability to care for themselves was problematic. The identified challenges were perceived to be detrimental to either the mentally ill individual or people in the community. This finding is substantiated by the following extracts:

> *"Mental illness in itself is a challenge to the sufferers, families and their communities."*
>
> **(Participant 16)**

> *"They just do whatever they want they might even pick up anything anytime and hurt someone with it without being aware."*
>
> (**Participant 1**)

> *"They might take something and throw it at you… my neighbour, he likes throwing things around."*
>
> (**Participant 6**)

> *"Some of them… might hit you if you come across them."*
>
> (**Participant 7**)

> *"They chase after people and throw stones at them. They might ask you for money and if you don't give it to them they will hit you."*
>
> (**Participant 10**)

> *"On the streets they are not safe anything can happen. Children might harm them or they get hit by cars, so they are not safe."*
>
> (**Participant 9)**

On the one hand, some participants viewed how some community members would treat mentally ill people as problematic. Some expressed feelings of frustration, guilt and pain with regards to the ill treatment of mentally ill persons. One of the learners,

went as far as highlighting that to play his part oftentimes he treated the mentally ill in a good way and interacted with them without fear. Further support is herein offered thus:

> *"They (people) end up laughing at that particular person even when they know very well that the person is suffering from mental illness."*
>
> (**Participant 25)**

> *"I feel guilty… to see people laughing at them. It is painful because they are different from us and I don't understand why people laugh at them."*
>
> (**Participant 14)**

> *"Most of the community members are just full of criticism."*
>
> (**Participant 8)**

> *"I treat them in a good way when I come across them, I even greet them without being afraid."*
>
> (**Participant 26)**

However some participants expressed some feelings of discomfort whenever they happened to interact with mentally ill persons. Citing that those mentally ill's unpredictability was what mainly leads to their feelings of anxiety:

> *"Personally I am never comfortable when am surrounded by people with mental illnesses, because you cannot know like what's their next step."*
>
> (**Participant 21)**

> *"When you are close to them you cannot feel safe because you do not know what's on their mind, they might be thinking of hurting someone."*
>
> (**Participant 23)**

The above extracts highlight the challenges associated with mentally ill people, not only for themselves but for their families and communities as well. Some of the challenges arise as a result of non-adherance to prescribed medication. It was also indicated that mentally ill people become violent when they default on their treatment. As such, this becomes a challenge to their families and communities. Some community members ill treat mentally ill peole and seldom interact with them. From the excerpts, it was indicated that anxiety was almost an ever present feeling whenever there was an interaction with mentally ill people as they were unpredictable.

4.4 Summary of findings

Based on the findings of the study it could be put forward that mental illness is still a widely misunderstood phenomenon in rural communities. Participants' perceptions in this study towards mental illness were varied, and it could be deduced that the opinions were representative of the larger community. Data analysis revealed three main themes, with theme 2 yielding three sub-themes. Findings from theme 1 revealed the extent of learners' understanding of mental illness and its causes, while theme 2 explored knowledge on the different types of interventions for mental illness. In theme 3 challenges associated with mentally ill people were highlighted. The overall perceptions and understanding of the participants with regard to mental illness were generally positive, with only a handful expressing negative feelings on the subject.

CHAPTER 5: DISCUSSION

5.1 Introduction

The present chapter discusses the study findings that were presented in the previous chapter. The discussion also intergrates previous empirical findings including the study theroretical framework.

5.2 Knowledge of mental illness, its causes and symptoms

With regards to the knowledge and causes of mental illness and its symptoms, it was found that learners possessed fairly reasonable understandings of mental illness and its causes. Most of the learners ascribed mental illness to biological, psychosocial, and supernatural factors. Their held views seems to be in line with the basic tenets of the Bio-psychosocial model of illness (Cardaso, 2013). Learners' knowledge of mental illness is mostly derived from their own experiences of living in communities, whereby they either have had first hand experience or have seen a mentally ill person in the community.

Some of this knowledge emanates from experiences of having close relatives who are mentally ill or what has been passed down by the elderly in their families. They seem to know and understand that the presence of mental illness prevented an individual from living a fully functional lifestyle. It is understood that mental illnesses impaired one's personal and social functioning. These findings are supported by the recent study conducted on Iranian youth, in which participants defined good mental health as having the ability to cope with day to day personal and societal pressures and still be able to function normally (Chinekesh et al., 2018).

In explaining the causes of mental illnesses, the participants tend to attribute it to supernatural factors, including ancestral calling. They explained that failure to follow instructions from one's ancestors was also a causal factor, from which mental illness might emanate as a form of punishment for a person who strays from ancestral calling. This finding lends support to previous studies which have shown that Sub-Saharan participants tended to lean towards metaphysical and religious attributes as causes of mental illness. In this African communities, psychotic mental disorders are believed

to be some form of punishment from a supernatural being/s, or possession by evil spirits (Mbuthia, Kumar, Falkenström, Kuria & Othieno, 2018; and McCann et al., 2017). According to the participants, factors such as jealousy, hate and desire for revenge propelled witchcraft. Witchcraft, in this instance, seems to be one of the main proponent of supernatural factors that causes mental illnesses. It can therefore be deduced that different belief and knowledge systems play a vital role in how individuals ascribe different meanings on phenomena, given that the participants came from eclectic belief systems.

In addition, the participants also had knowledge on other causal factors of mental illness. These factors could be divided into biological, environmental and lifestyle factors. Bad lifestyle choices were also cited as another cause of mental illness. This is consistent with findings from Chinekesh et al. (2018) that posited tensions in the homestead, traumatic life events, hard economic situations and distinct negative traits or thoughts may trigger mental health problems. In the present study, genetic disorders were also identified as causes of mental illness, and highlighted that some genetic defects can be passed down to a person's offspring.

Some of the learners identified indirectly contributory factors such as substance abuse (alcohol and drugs), other factors identified were social issues, anxiety, genetic predisposition and metaphysical factors, to also could cause mental illness. This is supported by Webster (2015), whose study revealed that in addition to substance abuse, some participants stated poor diet, insufficient exercise and relaxation and learning difficulties. However, it was also argued that some of this factors maybe an indication of social disadvantage in some communities. The premise of the argument being that certain personality traits maybe considered to be self-protecting against mental illness (Webster, 2015).

Although some learners possessed a fairly comprehensible understanding of mental illness, some appeared to lack understanding of mental illness. This was evidenced by their inconsistent reports of what mental illness is. Similar results were reported by Wahl et al. (2012) who stated that the participants in their study showed some understanding of causes of mental illness but lacked knowledge with regards to treatment and other specific aspects of mental illness. However, in comparison to the

participants from the current study, a majority demonstrated a level of uncertainty about whether mental illness had a biological cause (Wahl et al., 2012).

There were significant similarities and differences in comparison with the present study, however, a more conspicuous difference between the two is that, some of the learners in the present study attributed the etiology of mental illness to either spiritual or biological factors. Building on the Biopsychosocial Model, which is the framework for this study, the learners' perceptions of mental illness causation were borne from a biological perspective as suggested by the model; in addition, the spiritual vantage point in the etiology of mental illnesses is a significant factor in how the learners relayed their understanding of the phenomenon.

Mental disorders are diverse, however, in the present study this knowledge was limited. Comparatively for all learners, symptoms indicative of mental illness were those suggesting severe forms of mental illness, i.e., psychosis. Nonetheless, studies from elsewhere reported contrary findings (Chinekesh et al., 2018). This contrary findings may suggest a need for learners to be educated in the various forms of mental illness to arrive at consistent findings

5.3 Knowledge on the management and types of interventions needed for mental illness

The findings in the present study showed that participants had knowledge in the management of mental illnesses. Participants seemed to possess an understanding in the management of mental illness. The management of mental illness was further subdivided into three sub-themes which elaborate the different strategies in which mental illness may be managed. In this theme, the learners discussed how they and the communities interact and relate with mentally ill people. They expressed their opinions in how mentally ill people were generally treated by members of the public.

5.2.1 Professional health care services

Participants in the present study pointed out that a multidisciplinary team is crucial in dealing with mentally ill people. According to the responses given by the participants, the different expertise of a professional multidisciplinary team inclusive of counsellors,

psychologists, medical practitioners and social workers would go a long way in creating a mentally stable society. The responses in the present study are in line with previous studies in which participants cited the importance of medical professionals such as doctors, psychiatrists and nurses in providing relevant medical services for those individuals with mental difficulties (Webster, 2015).

Based on the limited literature which is available, it seems that in terms of management of mental illness young people have a fairly broader knowledge of the support which is available for mental health distresses and how to access such support. The knowledge displayed by young people in the present study is consistent with that of the study Singletarya et al. (2015) conducted on mental health literacy on young people, who seemed knowledgeable on the professional mental health support which comprised of general practitioners, mental health therapists and counsellors (Singletarya et al., 2015).

The findings from the present study indicated that the participants had a basic understanding of what mental illness pertains. The consensus that seemed to emerge during discussions among the focus group participants and individual interviews was that mentally ill people were most problematic when they did not properly take their medication or not take it at all.

There is an understanding of the importance of medication and the positive effects adhering to treatment could have on a mentally ill person. That treatment could also help the person to have normalcy and lead a functional life and make valuable contributions to the society even economically. This is in contrast with the beliefs held by participants from Webster's study (2015) which revealed that most of the young people believed that at the first indication of mental illness, those people should be hospitalised, meaning that they should have little or no contact with the outside world (Singletarya et al., 2015). Supporting the notions in Webster's (2015) study, is Wahl et al. (2012) who reported that less than 37% of the learners believed that the use of medication was useful in treatment of mental illness, while the remaining percentage believed that people with mental illness do not get better even with medication (Wahl et al., 2012).

Participants of the present believed a mentally ill individual need not be locked up in a hospital, but should rather be given medication and they will be able to live a normal life. Supported by the Biopsychosocial Theory, the beliefs held by the participants from the two studies address the psychosocial components of the theory, whereby although both groups shared their belief in the value of medication, they differed in their level of tolerance, in that the previous study's participants favoured hospitalisation, whereas participants in this study believed that adherence to prescribed medication led to a normal life (Chinekesh et al., 2018).

Overall most learners seem to recognise the importance and value of medication for mentally ill persons when adhered to and the consequences of defaulting. In addition, differing approaches to treatment is seen as a supplement to medication which could help professionals to choose appropriate and effective treatment action to young people (Chinekesh et al., 2018). Furthermore, young people mostly cited counsellors, family and friends sources of support. As such, psychological therapy and counselling are seen as beneficial as medication to the mentally distressed individual (Webster, 2015).

5.2.2 Traditional healers

As alluded in the second sub-theme, the participants in the present study reiterated the importance of interventions from other sources other than clinical interventions. Participants seem to believe that in order to curb and heal some types of mental illnesses, there is a need to involve indigenous knowledge experts and spiritual mediums. The participants alluded that Africans have different belief systems which could be utilised to help the mentally ill and ease their plight (Bulbulia & Laher, 2013).

Africa being a more traditional and spiritually inclined continent, most participants in the present study tended to attach a spiritual factor to the causes and management of mental illness. The Biopsychosocial Model has a shortfall in this regard, as it does not address the spiritual aspect in explaining the perceptions on mental illness, which according to the results of this study, is of significance. However, the inclusion of this aspect during discussion supports the premise from the model that sociocultural influences, which must be incorporated into the model, shape one's perceptions. This can be seen in the differences between this and previous related studies. It may also

be posited that the lack of this aspect in many studies may be due to many urban communities not believing in the metaphysical etiology of mental illnesses, as supported by Oluwole, Obadeji and Dada (2017) who reported that less respondents in their study attached supernatural meanings to mental illness, and only a handful cited supernatural factors as the cause of mental illness (Oluwole, Obadeji, & Dada, 2017).

A number of the participants highlighted that not only western trained mental health experts should be included in the multidisciplinary team, but African indigenous healers as well. The latter should also be included so as to incorporate and explain different knowledge and belief systems in a bid to curb mental illnesses in the society.

It was also interesting to note that the majority of the participants seemed to favour the inclusion of indigenous knowledge systems as another treatment option (Bulbulia & Laher, 2013). Some even had knowledge of the processes that one goes through if they opt for the traditional healing route. Some know this first-hand as either a relative or someone they know went through the process of treatment. Faith healers from independent African churches were also, according to the participants, helpful in alleviating the burden of mental illness healing mental illnesses. It can therefore be argued that young people are open to varied methods in dealing with mental illness. Based on the responses from the participants, it can be inferred that acceptance for the use of non-clinical methods in treating mental illness are gaining traction in the modern world.

5.2.3 Social support and lack of it

The participants in the study seem to agree that mental illness is a social issue and therefore needs to be treated thus. During discussions the importance of collaborations between police and communities to help in handling violent mentally ill people was mentioned. One participant gave an example of her neighbour who would sometimes turn violent if offended. Assistance from police would often be sought for such violent episodes.

Within the United Kingdom, policies proposes that in order to address the issue of mental health, support needs to be offered on a larger framework at the community-

level in accordance with severity (Singletarya et al., 2015). This notion concurs with the suggestions made by participants in the present study who suggested the collaborations between police and communities to assist in dealing with more severe cases of mental illness (Webster, 2015). According to Wahl et al. (2012), mental health literature suggests that the general public looked favourably on informal support. Communities seemed to value informal support from family and friends as compared to professional help (Kamimura et al., 2018). It can be taken into account the psychosocial aspects at play in establishing a sense of belonging for a mentally ill individual within a community as suggested by the Biopsychosocial Model. The literature, in reference to several studies, seems to posit that the positive perceptions derived from the informal support from the community give rise to a more positive attitude towards mental illness (Kamimura et al., 2018; Wahl et al., 2012).

Some of the learners showed an understanding that mentally ill people are harmless as long as they are treated well and not provoked. From their responses they exhibited that as long as there existed a harmonious relationship laden with respect and understanding between people there won't be any issues. This is in line with Wahl et al. (2012) who reported that more than 90 percent of learners concurred that people with mental illness deserve respect and that more effort should be made to help people with mental illnesses to get better, also that jokes about mental illness were hurtful (Kramers-Olen, 2014; and Wahl et al., 2012). The participants in the present study further alluded that mentally ill people are human beings who deserved the same support, privacy and space as any other person. In the same vein, the responses highlighted that communities should support their mentally ill and discourage any form of abuse towards them. Problems arose as a result of ill treatment of mentally ill people.

The relationship between the sociocultural component and perceptions towards mental illness is prominent in the discussions of the present study in reference to the Biopsychosocial Model. The socialisation and cultural background of the participants supports the model as most of them seem to know and appreciate the importance of social support and the role it plays in the lives of mentally ill people. The participants view both familial and communal support as most important in ensuring the well-being of the mentally ill, and this rings true to many rural communities which tend to have

strong communal bonds. This idea is echoed by Kamimura et al. (2018) who reported that rural Vietnamese participants prefer seeking help and support from family or friends. This is futher supported by Kramers-Olen (2014), who found support groups to be beneficial in the rehabilitation of people with mental illness and an important aspect of recovery for people with schizophrenia (Kramers-Olen, 2014). Participants proposed the formation of support groups and sports as a way of supporting them. Hall et al. (2016) also posit that physical environments and social connections promote mental illness. It can then be argued that for most of the participants, mental illness as a societal issue rather than an individual one.

5.4 Challenges associated with mentally ill people

The results in the present study indicated that participants single out odd behaviour as one of the most consistent defining factor for mentally unstable individuals. During discussions it was revealed by the participants that one could set apart a mentally disturbed person by the way they behaved towards others. Behaviour that deviated from the norm was highlighted as a factor. The physical violence often displayed by the mentally ill and their inability of most of them to care for themselves was viewed as problematic as both factors could be detrimental to either the mentally ill individual or people in the community, this notion is supported by Casañas et al. (2018).

Based on responses from the participants, some contrasts emerged in how communities viewed the mentally ill amongst them. Most participants were unimpressed by people in their communities who did not treat mentally ill people well or laughed at them. This has similar results to Singletarya et al. (2015) whereby some, expressed feelings of frustration, guilt and pain with regards to the ill treatment of mentally ill persons. As a way of counteracting the negative actions towards the mentally ill from other people, one participant indicated that they treated them in a good way and interacted with them without fear.

However, other participants reported having feelings of discomfort when ever they happened to interact with mentally ill persons. Unpredictability of the mentally ill was cited as the main source of the feelings of anxiety. However, it is worthy to note that participants in the present study seemed to understand mental illness as psychosis

only and that other forms of mental illness such as depression actually led to psychotic episodes. This could explain their perceived anxiety of interacting with mentally ill persons.

Historical conceptualisations of mental health difficulties and their treatment have influenced public knowledge and attitudes. Indeed, genetic and medical conceptualisations, restraint and segregation have served to set individuals apart as different. Although compassion has been part of public attitude, such conceptualisations have inspired fear and the common belief that people with mental health difficulties are dangerous and unpredictable. Media and popular culture have fuelled this depicting people with mental health difficulties as dangerous despite low rates of violent acts committed by people with mental health conditions (Secker et al., 1999). It shows that some people still stigmatise mental illness and many would prefer to avoid them as much as possible.

However, Wahl et al. (2012), give a different perspective in their study; wherein a majority (62%) of the participants reported that they were comfortable meeting a mentally ill person neither would they be frightened if approached by one. They further revealed that over 86 percent rejected the idea of avoiding individuals with mental illness (Wahl et al., 2012), this is further supported by Toth (2014) and Nguendo-Yongsi (2015) who reported that students' attitudes was respectful towards people with mental illness (Toth, 2014; and Nguendo-Yongsi, 2015).

Non-adherence to prescribed medication was also perceive as a challenge for both the individual with mental illness, the family and community. It was reported that if one failed to take treatment and adhere to it, they ended up being a danger to themselves and their community. Nguendo-Yongsi (2015) concedes with this in the report from his study, wherein the participants highlighted the importance of treatment and consequences of failure to adhere.

5.5 Concluding remarks

This chapter discussed at length the results which were thoroughly interrogated and compared to related studies which were conducted in other parts of the world. The

three prominent aspects from the findings of the study were with regards to the knowledge and causes of mental illness and its symptoms, it was found that learners possessed fairly reasonable understanding of mental illness and its causes. Most of the learners ascribed the basis of mental illness to biological, psychosocial, and supernatural factors. The second aspect was about the management of mental illness which elaborated the different strategies in which mental illness may be managed. The learners identified professional healthcare services, traditional healers and social support as some measures that may be taken in the management of mental illness. The third aspect was challenges associated with mentally ill people, behaviour that deviated from the norm was highlighted as a factor. The physical violence often displayed by the mentally ill and their inability of most of them to care for themselves was viewed as problematic as both factors could be detrimental to either the mentally ill individual or people in the community.

CHAPTER 6: SUMMARY AND CONCLUSIONS

6.1 Introduction

The previous chapter presented a discussion on the findings of the present study supported by existing literature. This chapter outlines the summary, limitations, recommendations and conclusions of the present study. The recommendation are based on the findings of this study.

6.2 Summary

The present study's aim was to explore the perceptions of secondary school learners in Ga-Dikgale rural community towards mental illness. The objectives of the study were, namely:

- To determine learners' understanding of mental illness.
- To identify and describe symptoms of mental illness as perceived by the secondary school learners;
- To determine learners' views regarding the causes of mental illness; and
- To describe learners' views regarding appropriate treatment for mental illness.

The findings on the present study indicate that learners had a fair understanding of what pertains mental illness, as all participants had at one point come in contact with a mentally ill person. Participants' perceptions in this study towards mental illness were varied and it could be deduced that the opinions were representative of the larger community.

6.3 Implications for theory

Mental illness is a worldwide phenomenon that is interpreted and experienced differently by different people. Irrespective of age, one's perceptions will always be influenced by the cultural background, socialisation and belief systems. As such, the three aspects that make up the Biopsychosocial Theory will always apply when explaining mental illness. However, the tendency for the universalisation of mental illness both in theory and practice runs the risk of suppressing and limiting the explanation of mental illness from various perspectives. The Biopsychosocial Theory

was adopted for the purpose of this study. However, it was found lacking in that it does not address the spiritual or traditional aspects which play a significant role in shaping perceptions about phenomena especially in rural communities. From the results, it is clear that perceptions of the learners had a spiritual focus, in addition ot the biopsychosocial aspects. It is therefore recommended that a theory that takes into cognisance all these aspects be developed. Alternatively, the current Biopsychosocial Theory should be modified to not only suit Eurocentric perspectives, but to also include Afrocentric views on phenomena.

6.4 Implications for practice

As suggested by the study findings, there is a need for professionals in the mental healthcare sector to be more culturally sensitive as guided by the client or patient's background. Regrettably, in practice the Eurocentric perspective still takes much more precedence in most if not all healthcare facilities in South Africa. However, in order to achieve a more culturally sensitive crop of mental health practitioners and professionals, it is recommended that, alongside the eurocentric based curriculum, an afrocentric curriculum be adopted to train professionals who will be able to make use of both perspectives; thus making them better suited to serve their communities. For the current mental healthcare professionals, culture-based training could be provided to sensitise them into creating a more culturally accepting environment for the multicultural communities they serve. It has also been proven that, not only clinical methods are effective when dealing with mental health issues, but that the social and African traditional aspects of treatment or alleviation of mental illness may be helpful and should thus be incorporated.

6.5 Implications for research

Research on the perceptions with regards to mental health in rural communities is still in its infacy. Therefore, it would be beneficial to both the rural communities, academic institutions and government to develop knowledge structures in this area. In essence, it is necessary that research, especially in South Africa reflect all aspects of the multi cultural societies in which we live. It is therefore recommended that future researchers explore the role played by traditional and spiritual factors in shaping perceptions on mental illnesses that were not covered in this study. Future research could also

expand to other rural communities in South Africa as this study was conducted on a smaller scale with a limited population sample. Another study could be conducted to compare the older and younger generations' perceptions, taking into consideration the effects of globalisation and modernisation on the traditional ways of thinking. This study has also added on the production of knowledge in the field of Psychology.

6.6 Limitations

As no research study is problem free, this section focuses on the limitations and some of the challenges which the researcher came across while conducting the study.

- Although permission was granted by the provincial Department of Basic Education and the respective circuit managers, some of the school principals were reluctant to allow the research to take place in their schools. In order to avoid disturbing learners during lessons, the researcher requested break time and 10 minutes immediately after school or before afternoon study time to conduct the study. Some of the principals refused to give the researcher time when the learners were free.
- Some of the learners' parents did not give permission for their children to participate in the study, while some of the learners did not return the Consent Forms during the interview day. This caused delays as more participants had to be sought to replace those who dropped out of the study.
- Translating data from Sepedi to English meant that the study ran a risk of losing some of the meanings in translation. However, a language expert was sought to translate the data.

6.7 Recommendations

Based on the findings from the present study, it is recommended that:

- Mental health education should be prioritised in institutions of learning, especially rural schools. The same way in which health education has been incorporated in curriculum, so should mental health education. This will play a vital role in not only education but sensitising the youth to mental health issues. The researcher realised, while conducting the study, that most of the learners had limited knowledge pertaining mental health. For some, it was for the first time hearing about the field of psychology and what it was about.

- Mental health campaigns should be rolled out by government, NGOs and civil societies targeting rural communities. The present study suggest that a considerable number of people living in rural areas may not be having access to information, especially about mental illnesses. It was evident during data collection that some learners knew about mental illness through their observation of the mentally ill within their communities. Most of the participants seemed to describe mental illness only in terms of relatively serious conditions such as depression or psychosis.
- Consideration should be given to collaboration between Western and indigenous knowledge systems to promote good mental health in communities. Based on the researcher's observation, the participants appeared to be more open minded in terms of possible collaboration between the two knowledge systems.

6.8 Conclusions

The findings of the study show the extent to which learners from rural schools know about mental illnesses. Based on the findings, it could be suggested that mental illness is still a misunderstood condition in rural communities. Generally, participants were found to be having positive feelings about mental illness.

REFERENCES

American Psychiatric Association. (2015). *Strengthening the Child and Adolescent Mental Health Workforce.* Retrieved from American Psychiatric Association website: http://www.apa.org/about/gr/issues/cyf/child-workforce.aspx

Azibo, D.A. (1983). Some Psychological Concomitants and Consequences of the Black Personality: Mental health implications. *Journal of Non-White Concerns in Personnel and Guidance, 11(2)*,59-66.

Bohnenkamp, J.H., & Stephan, S.H. (2015). Supporting Student Mental Health: The role of the school nurse in coordinated school mental health in care. In N. Bobo,(Ed.), *Psychology in the Schools, 52*(7), 715-727. doi: 10.1002/pits.21851

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Quality Research in Psychology, 3*(2), 77-101.

Bulbulia, T., & Laher, S. (2013). Exploring the Role of Islam in Perceptions of Mental Illness in a Sample of Muslim Psychiatrists Based in Johannesburg. *South African Journal of Psychiatry, 19*(2), 52-54. doi:10.7196/SAJP.396

Cardaso, J. (2013, 07, 16). *The Biopsychosocial Perspective to Mental Health and Illness.* Retrieved from Mental Health website: https://www.socialworkhelper .com/2013/07/16/the-biopsychosocial-perspective-to-mental-health-and-illness/

Casañas, R., Arfuch, V., Castellví, P., Gil, J., Torres, M., Pujol, A., . . . Lalucat-Jo, L. (2018). “EspaiJove.net”- A School-Based Intervention Programme to Promote Mental Health and Eradicate Stigma in the Adolescent Population: Study protocol for a cluster randomised controlled trial. *BMC Public Health, 18*(939), 2-10. doi:10.1186/s12889-018-5855-1

Chinekesh, A., Hosseini, S., Mohammadi, F., Motlagh, M., Eftekhari, M., Djalalinia, S., & Ardalan, G. (2018). An Explanatory Model for the Concept of Mental Health in Iranian Youth. *PMC F1000Res, 7*(52). doi:10.12688/f1000research.12893.2

Creswell, J.W. (2014). *Research Design: Qualitative, quantitative and mixed methods approaches , 4th ed.* London: Sage Publications.

Egbe, C.O., Brooke-Sumner, C., Kathree, T., Selohilwe, O., Thornicroft, G., & Peterson, I. (2014). Psychiatric Stigma and Discrimination in South Africa: perspectives from key stakeholders. *BMC Psychiatry , 14*, 191.doi:https://doi.org/10.1186/1471-244X-14-191

Frankel, R., Quill, T., & McDaniel, S. (Eds.) (2003). *The Biopsychosocial Approach: Past, present, future.* NY: University of Rochester Press.

Fusch, P.I., & Ness, L.R. (2015). Are We There Yet? Data saturation in qualitative research. *The Qualitative Report, 20*(9), 1408-1416. Retrieved from Nova website: http://www.nova.edu/ssss/QR/QR20/9/fusch1.pdf

Flisher, A. J., Dawes, A., Kafaar, Z., Lund, C., Sorsdahl, K., Myers, B., & Seedat, S. (2012). Child and Adolescent Mental Health in South Africa. *Journal of Child & Adolescent Mental Health*, 24(2), 149-161. doi:DOI: 10.2989/17280

Hall, S., McKinstry, C., & Hyett, N. (2016). Youth Perceptions of Positive Mental Health. *British Journal of Occupational Therapy, 79*(8), 475-483. doi:10.1177/0308022616632775

Hartman, L.I., Michel, N.M., Winter, A., Young, R. E., Flett, G.L., & Goldberg, J.O. (2013). Self-Stigma of Mental Illness in High School Youth. *Canadian Journal of School Psychology, 28*(1), 28-42. doi:10.1177/0829573512468846

Jorum, A., & Wright, A. (2007). Beliefs of Young People and Their Parents about the Effectiveness of Interventions for Mental Disorders. *Aust N Z J Psychiatry, 41*(8), 656–66. doi:10.1080/00048670701449179

Kern, A., Amod, Z., Seabi, J., & Vorster, A. (2015, March 11). South African Foundation Phase Teachers' Perceptions of ADHD at Private and Public Schools. *International Journal of Environmental Research and Public Health, 12*, 3042-3059. doi:10.3390/ijerph120303042

Kamimura, A., Trinhb, H.N., Johansena, M., Hurleya, J., Pyea, M., Sina, K., & Nguyen, H. (2018). Perceptions of Mental Health and Mental Health Services among College Students in Vietnam and the United States. *Asian Journal of Psychiatry, 37*, 15-19. doi:10.1016/j.ajp.2018.07.012

Kramers-Olen, A. L. (2014). Psychosocial Rehabilitation and Chronic Mental Illness: International trends and South African issues. *South African Journal of Psychology, 44*(4), 498-513. doi:10.1177/0081246314553339

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Inquiry,* Newbury Park, CA: Sage

Lindsay, S. (2019, January 10). *Addressing Mental Health Issues in School Leads to Improved Performance*. Retrieved from ICA Notes Website: https://www.icanotes.com/2019/01/10/addressing-mental-health-issues-in-school-leads-to-improved-performance/#respond

Longkumer, I., & Borooah, I. P. (2013). Knowledge about and Attitudes toward Mental Disorders among Ngagas in North East India. *IOSR Journal of Humanities and Social Sciences, 15*(4), 41-47.

Loveridge, J. (2010). *Involving Children and Young People in Research in Educational Settings.* Victoria University of Wellington. Jessie Hetherington Centre for Educational Research.

Marshal, M. (1996). Sampling for Qualitative research. *Family Practice Journal, 13*(6), 522-525.

Mbuthia, J.W., Kumar, M., Falkenström, F., Kuria, M.W., & Othieno, C.J. (2018). Attributions and private theories of mental illness among young adults seeking psychiatric treatment in Nairobi: an interpretive phenomenological analysis. *Child and Adolescent Psychiatry and Mental Health, 12*(28), 1-15. doi:10.1186/s13034-018-0229-0

McCann, T.V., Renzaho, A., Mugavin, J., & Lubman, D.I. (2017). Stigma of Mental Illness and Substance Misuse in Sub-Saharan African Migrants: A qualitative study. *International Journal of Mental Health Nursing*, 1-10. doi:10.1111/inm.12401

National Alliance on Mental Illness, (2017, March). *Mental Health by the Numbers.* Retrieved from National Alliance on Mental Illness Website: www.nami.org

Nguendo-Yongsi, H. B. (2015). Knowledge and Social Distance towards Mental Disorders in an Inner-City Population: Case of university students in Cameroon. *Trends in Medical Research, 10*, 87-96. doi:10.3923/tmr.2015.87.96

Oluwole, L. O., Obadeji, A., & Dada, M. U. (2017). Perceptions and Attitudes of Students of Mass Communication towards Mental Illness in Nigerian Tertiary Institution. *Indian Journal of Social Psychiatry*, 315-319. doi:10.4103/0971-9962.193650

Orngu, T.D. (2014). Cultural Perspectives and Attitudes towards Mental Health in Nigeria: Social Workers at a dilemma . In A. Francis, P. LaRosa, L. Sankaran, & S. Rajeev (Eds.), *Social Work Practice in Mental Health: Cross-cultural Perspectives (1st Ed.)*, *(1),* 154-164. Nigeria: Allied Publishers. Retrieved February 2018, from https://books.google.co.za

Republic of South Africa Government Gazette No 26595. (2004, July 23). *No. 61 of 2003: National Health Act*. Cape Town: Parliament of South Africa, The Presidency

Singletarya, J. H., Bartle, C. L., Svirydzenka, N., Suter-Giorgini, N. M., Cashmore, M, A., & Dogra, N. (2015). Young peoples' perceptions on mental and physical health in the context of general wellbeing. *Health Education Journal, 74*(3), 257-269. doi:10.1177/0017896914533219

Saunders, M., Lewis, P., & Thornhill, A. (2012). *Research Methods for Business Students*, 6th edition. Pearson Education Limited.

Statistics Solutions, (2017, November 26). *Dissertation and research consulting*, Retrieved from Statistics Solutions website: www.statisticssolutions.com

Strode, A., Slack, C., & Essack, Z. (2011). Child Consent in South African Law - Implications for researchers, service providers and policy-makers. Letter tothe editor. South African Medical Journal , 101, 604-606

Tibebe, A., & Tesfay, K. (2015). Public Knowledge and Beliefs about Mental Disorders in Developing Countries: A Review. *Journal of Depression and Anxiety, 3*, 1-4.

Toth, E. (2014, April). *A Qualitative Investigation into Children's Perception and Knowledge of Mental Health and Illness* (Master's Thesis). Manchester Metropolitan University, Manchester, United Kingdom. Retrieved February 20, 2018, from https://e-space.mmu.ac.uk/576481/1/Eszter%20TOTH.pdf

Trochim, W. M. (2006). *The Research Methods Knowledge Base,* 2nd ed. Cincinnati: Atomic Dog Publishing.

Unknown. (n.d.). *The Effects of 'Mental Illness' on Carers and Their Families.* Retrieved December 02, 2017, from Healthy future website: http://www.healthy future. health.wa.gov.au/Publications/01_MI_CALD_5.pdf

Wahl, O., Susin, J., Lax, A., Kaplan, L., & Zatina, D. (2012). Knowledge and Attitudes about Mental Illness: A survey of middle school students. *Psychiatric Services, 63*(7), 649-654. doi: 10.1176/appi.ps.201100358

Webster, A. (2015, September). Mental Health: Young people's knowledge, beliefs, attitudes and wishes (Unpublished doctoral thesis). The University of Birmingham, Birmingham, United Kingdom.

Whiteford, H., Degenhardt, L., Rehm, J., Baxter, A., Ferrari, A., & Erskine, H., (2013, August). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet, 9*(382), 1575-1586. doi: 10.1016/S0140-6736(13)61611-6

Williams, Y. (2017). *What is Perception in Psychology? - Definition & Theory,* Retrieved September 2017, from Study.com website: http://study.com/academy/lesson/what-is-perception-in-psychology-definition-theory-quiz.html

World Health Organisation. (2018). Retrieved 9 April 2018, from World Health Organisation Website: http://www.who.int/mental_health/maternal-child/child_adolescent/en/

APPENDICES

Appendix 1(A): Semi-Structured Interview Guide (English Version)

OBJECTIVES	**INTERVIEW GUIDE**
1. To determine learners' understanding of mental illness.	a. What is your view about mental illness? b. Can you explain, according to your understanding and experiences, what mental illness is?
2. To get an understanding of youths' knowledge on symptoms of mental illness.	a. What are signs of mental illness?
3. To determine the views of learners with regards to causes of mental illness.	a. What causes mental illness according to your knowledge?
4. To get an understanding of young people's views of different treatment pathways.	a. What is your view with regards to the treatment of mental illness? b. Can you give me the different mental illness treatments that you know of?

Appendix 1(B): Semi-Structured Interview Guide (Sepedi Version)

DIPHIHLELELO	**HLAHLO YA DIPOTŠIŠO**
1. Go sekaseka kwešišo ya barutwana ka ga bolwetši bja monagano.	a. Kgopolo ya gago mabapi le bolwetši bja monagano ke eng? b. Na o ka nhlalosetša go ya ka kwešišo ya gago le maitemogelo a gago gore bolwetši bja monagano ke eng?
2. Go hwetša kwešišo ya baswa ka tsebo ya gore bolwetši bja monagano bo hlolwa ke eng le dika tša bjona.	c. Na dika tša bolwetši bja monagano ke dife?
3. Go ahlaahla pono tša barutwana mabapi le hlolo ya bolwetši bja monagano.	d. Go ya ka tsebo ya gago, bolwetši bja monagano bo hlolwa ke eng?
4. Go hwetša kwešišo ya tsebo ya baswa ka pono ya bona ka mehutahuta ya dikalafo tša bolwetši bja monagano.	f. Na pono ya gago ke eng mabapi le kalafo ya bolwetši bja monagano? g. Na o ka mpha mehuta ya go fapana yeo o e tsebang ya kalafo ya bolwetši bja monagano?

Appendix 2(A): Focus Group Discussion Guide (English Version)

OBJECTIVES	**QUESTION GUIDE**
1. To get an overall perception of mental illness among young people in rural areas.	a. Can we broadly discuss your perceptions, as a young person, about mental illness in your community?

Appendix 2(B): Focus Group Discussion Guide (Sepedi Version)

DIPHIHLELELO	**HLAHLO YA DITSHEKATSHEKO**
1. Go hwetša kgopolo ka botlalo mabapi le bolwetši bja monagano magareng ga baswa dinaga magaeng.	a. Na re ka sekaseka ka bophara, dikgopolo tša lena bjalo ka baswa, mabapi le bolwetši bja monagano setšhabeng sa geno?

Appendix 3(A): Parent Consent Letter (English Version)

Department of Psychology

University of Limpopo

Private X1106

Sovenga

0727

Date__/__/____

Dear Parent

My name is Irene Makgato. I am a student under the direction of Professor Sodi at University of Limpopo.

I am conducting a study about Perceptions of Learners in Selected Rural Secondary Schools in Ga-Dikgale towards Mental Illness and am asking for your child's participation in this research. Your child's participation will involve answering and or discussing a few questions related to the research.

Your child's participation is voluntary and he/she is free to withdraw from participation at any time. If your child chooses not to participate, it will not affect your child's grade, treatment. The results of the research study may be published, but your child's name will not be used.

Should you have any queries or need further clarity on this study or your child's participation in this study, kindly contact myself, Miss I Makgato on 060 716 3744 or my supervisor, Professor T Sodi on 015 268 2318, co-Supervisors Dr M Makgahlela (073 975 6318) or Prof H Bastiaens (+32 3 265 18 25).

Sincerely

Irene Makgato (Student)

By signing below, I give consent for my child to participate in the above-referenced study.

Parent's Name: _____

Child's Name: _____

Parent's Signature: _____

Appendix 3(B): Lengwalo La Tumelelo La Motswadi (Sepedi Version)

Lefapha la Thuto ya menagano

Yunibesithi ya Limpopo

Mokotla wa Phoraebete X1106

Sovenga

0727

Tšatšikgwedi__/__/____

Motswadi yo a hlomphegago

Leina la ka ke Irene Makgato. Ke moithuti Yunibesithing ya Limpopo ka fase ga hlahlo ya Professor T Sodi, gomme ke kgopela ngwana wa lena a tšea karolo thutong ye.
Ke dira dinyakišišo tša thuto mabapi le dikgopolo tša barutwana ba dikolo tše kgethilweng tša sekontari tša dinaga magaeng, mabapi le malwetši a monagano, nageng ya Ga-Dikgale. Ngwana wa lena o tlo ba a araba goba a ahlaahla dipotšišo le barutwana ba bangwe mabapi le nyakišišo ye ya thuto.

Go tšea karolo ga ngwana wa lena mo thutong ye ke ka boithaopo gomme o wa lokologa go ikgogela morago mo nakong efe goba efe magareng ga thuto ge a ikwela bjalo. Ge lena le ngwana wa lena le ka tšea sephetho sa go se sa tšea karolo, dithuto tša gagwe le tshwaro ya gagwe di ka se amege ka mo go šele. Dikarabo tša gagwe di tla swarwa ka sephiring, gomme leina la gagwe le ka se tsebagatšwe.

Ge e ba le na le dipotšišo mabapi le nyakišišo ye ya thuto le kamano ya ngwana wa lena go yona, le ka ikgokaganya le nna, Mohumagatšana I Makgato go 060 716 3744 goba mohlahli wa ka Professor T Sodi go (015 268 2318), bathušamohlahli Dr M Makgahlela (073 975 6318) goba Prof H Bastiaens (+32 3 265 18 25).

Madume a borutho

Irene Makgato (Moithuti)

Ka go saena mo, le fa tumelelo ya gore ngwana wa lena a tšee karolo nyakišišong ye ya thuto.

Leina la motswadi: _____

Leina la ngwana: _____

Mosaeno wa motswadi: _____

Appendix 4(A): Letter of Invitation for Participant (English Version)

Department of Psychology

University of Limpopo

Private X1106

Sovenga

0727

Date__/__/____

Dear Participant

I would like to invite you to participate in this study about the **Perceptions of learners in selected rural secondary schools towards mental illness: The case of Ga-Dikgale community, Limpopo Province.**

The study aims to explore the perceptions of secondary school learners in Ga-Dikgale rural community towards mental illness. As such your participation will be very helpful in determining learners' views with regards to mental illness, its causes and treatment. Your participation will also help in contributing to the body of knowledge with regards to mental illness, thus helping even policy makers and communities at large with regards to the extent of mental health knowledge in the society.

Kindly take note that participation in this study is voluntary and are free to withdraw from participating at any point during the study should you wish to do so. Your

responses will remain confidential; you are therefore at liberty to answer all questions as honestly as possible.

Your responses are valuable and would be of much assistance to the researcher.

Kind regards

_____ __/__/____

Makgato LID (Student) Date

Appendix 4(B): Lengwalo La Taletšo La Motšeakarolo (Sepedi Version)

Lefapha la Thuto ya menagano

Yunibesithi ya Limpopo

Mokotla wa Phoraebete X1106

Sovenga

0727

Tšatšikgwedi__/__/____

Motšeakarolo wa hlomphego

Ke rata go laletša go tšea karolo mo dinyakišišong tša thuto mabapi le **Dikgopolo tša barutwana ba dikolo tše kgethilweng tša sekontari tša dinaga magaeng, mabapi le malwetši a monagano: Taba ya naga ya Ga-Dikgale, Profenseng ya Limpopo.** Thuto ye ke ya nyakišišo ya dikgopolo tša barutwana ba dikolo tša sekontari tša Ga-Dikgale mabapi le malwetši a monagano. Go tšea karolo ga gago mo thutong ye go tla thuša go lemoga le go tseba ka ga tsebo ya barutwana ka ga malwetši a monagano, gore a hlolwa ke eng, le gore a alafša bjang. Go tšea karolo ga gago go tla thuša gape ka go oketša tsebo ka ga malwetši a monagano, ka fao gwa thuša le ba diramelao le setšhaba go tseba gore batho ba tseba go go kakaang ka ga malwetši a.

Ka boikobo lemoga gore go tšea karolo mo nyakišišong ye ke ka boithaopo gomme o lokologa go ikgogela morago mo nakong efe goba efe magareng ga thuto ge o ikwela

bjalo. Dikarabo tša gago di tla swarwa ka sephiring, ka fao lokologa go araba dipotšišo ka moka ka botshepegi ka mokgwa woo o ka kgonago.

Dikarabo tša gago di bohlokwa kudu gomme di tla thuša monyakišiši. Ke a leboga

Madume a borutho

_____ Tšatšikgwedi: __/___/____

Makgato LID (Moithuti)

Appendix 5(A): Parent of Participant Consent Form (English Version)

I _____, allow my child to participate in this research study about the **Perceptions of learners in selected rural secondary schools towards mental illness: The case of Ga-Dikgale community, Limpopo Province.**

The researcher explained the purpose of this study. I fully understand that my child's participation in this study is voluntary and shall not be compensated in any form, I am also aware that should he/she wish to discontinue his/her involvement with the study he/she has the right to withdraw at any point during the study.

I understand that every effort will be taken by the researcher to protect my child's confidentiality and any personal information that might identify him/her will not be published to any other party expect those that are involved in the study.

I have understood the conditions of my child's participation in this study and therefore give full consent for him/her to take part in this study.

Parent signature: _____ Date: __/___/____

Appendix 5(B): Foromo Ya Tumelelo Ya Motswadi Wa Motšeakarolo (Sepedi Version)

Nna _____, ke dumelela ngwana wa ka go tšea karolo mo nyakišišong ya thuto, mabapi le **Dikgopolo tša barutwana ba dikolo tše kgethilweng tša sekontari tša dinaga magaeng, mabapi le malwetši a monagano: Taba ya naga ya Ga-Dikgale, Profenseng ya Limpopo.**

Monyakišiši o hlalositše bohlokwa bja nyakišišong ya thuto ye. Ke kwešiša ka botlalo gore go tšeeng karolo mo dinyakišišong tše, ga ngwanaka ke ka boithaopo gomme a ka lefšwe ka mokgwa ofe goba ofe. Ke a lemoga le gape gore ge a ka ikwela go se sa tšwela pele mo nyakišišong ye ya thuto goba go ikgokaganya le yona, o na le malokelo a go ikgogela morago nakong efe goba efe.

Ke a kwešiša gore monyakišiši o etše hloko go tšhireletša tshedimošo ya ngwanaka, gomme e ka se tsebagatšwe go mang goba mang yo a sa amegego mo thutong ye.
Ke kwešišitše mabaka a beilwego mabapi le go tšeeng karolo ga ngwanaka mo thutong ye gomme ke dumelela ngwanaka go tšea karolo mo nyakišišong ye ya thuto.

Mosaeno wa motswadi: _____ Tšatšikgwedi: __/___/____

Appendix 6(A): Letter Requesting Permission from Limpopo Department of Basic Education

Department of Psychology

University of Limpopo

Private X1106

Sovenga

0727

Date__/__/____

Dear Sir/Madam

Request to conduct research study with learners in secondary schools in Ga-Dikgale area

My name is Makgato Irene and I am a registered Research Psychology Masters student, at the University of Limpopo. I am doing a study about the **Perceptions of learners in selected rural secondary schools towards mental illness: The case of Ga-Dikgale community, Limpopo Province.**

I am therefore requesting for permission to conduct the study at schools in Ga-Dikgale area. Permission is requested to gain access to the schools to interviews and conduct Focus Group Discussions in relation to the study topic. A total of 24 learners will be required to conduct the study.

Should you have any queries or need further clarity, kindly contact myself, Miss Makgato on 060 716 3744 or my supervisor, Professor T Sodi on 082 439 4280/ 015 268 2318 or co-Supervisors Dr M Makgahlela (073 975 6318) or Prof H Bastiaens (+32 3 265 18 25).

Your assistance in this regard will be appreciated.

Regards

_____ Date__/__/____

Makgato LID (Student)

_____ Date__/__/____

Prof T Sodi (Supervisor)

_____ Date__/__/____

Dr MW Makgahlela (Co-Supervisor)

_____ Date__/__/____

Prof H Bastiaens (Co-Supervisor)