AN EXPLORATION OF HELP-SEEKING PATHWAYS FOLLOWED BY PATIENTS SEEKING MENTAL HEALTH CARE SERVICES IN POLOKWANE-MANKWENG HOSPITAL COMPLEX

by

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DEDICATION

This work is dedicated in memory of my late father, Mr Setuma Hendrick Ngoepe, for believing in me and for his words of wisdom that will always echo throughout my life. This dedication extends to my late husband, Mike, for inspiring me to pursue a career in Psychology. May their souls rest in the peace of Christ Jesus!

DECLARATION

I declare that **AN EXPLORATION OF HELP-SEEKING PATHWAYS FOLLOWED BY PATIENTS SEEKING MENTAL HEALTH CARE SERVICES IN POLOKWANE-MANKWENG HOSPITAL COMPLEX** hereby submitted to the University of Limpopo, for the degree of Master of Arts in Clinical Psychology has not previously been submitted by me for a degree at this or any other university; that is, it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

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ABSTRACT

A number of studies have indicated that help-seeking pathways followed by individuals suffering from mental disorders and other conditions of ill-health are not random, but are structured by a range of psychosocial and cultural factors. The quality and seriousness of the distress provide the impetus to the pathway, but its direction and duration is shaped by the convergence of psychosocial and cultural factors.

This study explored the help-seeking pathways followed by patients receiving mental health care services in Polokwane-Mankweng Hospital Complex (PMHC) in Limpopo Province (South Africa). A qualitative approach was followed and participants were selected through purposive sampling. Ten participants (5 males and 5 females) who are receiving mental health care services at PMHC and were apsychotic at the time were recruited to the study. Data were collected using semi-structured interviews and analyzed using content analysis.

The following psychological themes emerged from the study: participants' subjective notions of the events or factors that could have led to their mental illness; their explanations of mental illness; the reasons for entering the mental health care system; the pathways they followed before receiving mental health services in the hospital; concurrent use of hospital mental health services and other services; their experiences of living with mental illness; and, the role of significant others in this regard. The study revealed that various agencies and providers of health care are visited by individuals suffering from mental illness and that there is also some evidence of concurrent use of these services, i.e., Western and African. The findings emphasize that help-seeking pathways are mainly determined by the perceived causes of the illness, which are derived from cultural ideologies.

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CHAPTER 1: INTRODUCTION

1.1.   Introduction

Mental disorders make a substantial independent contribution to the burden of disease worldwide. According to the World Health Organization's (WHO) Global Burden of Disease report, it has been suggested that neuropsychiatric conditions account for up to a quarter of all disability (cited in Prince, 2007). The report further indicated that the most common neuropsychiatric conditions contributing to the global burden of disease are mental disorders, especially affective disorders, substance-use disorders, schizophrenia and dementia. From the aforementioned information, it can be deduced that a higher percentage of people globally do suffer from mental disorders. Whilst many people suffering from mental disorders in the developing world do consult at psychiatric care facilities (i.e., they receive services from mental health experts such as psychologists and psychiatrists), there are indications that most people in the developing world never seek services from these facilities as confirmed in studies by Ganasen, Parker, Hugo, Stein, Emsley and Seedat (2008) and the World Health Organization's Mental Health in Haiti (2010). In many communities in the developing world, people suffering from mental disorders may turn to general medical practitioners, while some consult with traditional healers or other alternative health care service providers (Kovess-Masfety et al., 2007; Nonye & Oseloka, 2009).

A number of studies have indicated that help-seeking pathways followed by individuals suffering from mental disorders and other conditions of ill-health are not random, but are structured by a range of psychosocial and cultural factors (Razali & Yasin, 2008). According to Rogler and Cortes (1993), help-seeking pathways are viewed as the sequence of contacts between individuals and health care providers prompted by the distressed person's efforts and his/her significant others. The quality and seriousness of the distress provide the impetus to the pathway (Greenley & Mechanic, 1976; Horwitz, 1977), but its direction (sequence of contacts) and duration (time lapse between problems and contacts) is shaped by the convergence of psychosocial and cultural factors (Greenley & Mechanic, 1976; Horwitz, 1977; Lin, Tardiff, Donetz, & Goresky, 1978; Link & Dohrenwend, 1980).

These pathways commonly involve multiple agencies or providers of care such as traditional healers, primary care physicians, providers of alternative medicine, general practitioners and other social agencies (Ryan, 1998).

In South Africa, some studies conducted on the referral system of patients to psychiatric facilities serving the greater Cape Town metropolitan area have suggested that up to 60.7% of referrals were from persons not trained in mental care (Berard, Sennett & Ahmed, 1998). Although there is some recognition of the importance of these non-Western trained health care providers, there is little information about this alternative health care resource. Studies conducted by Abdool Karim, Zigubu-Page and Arendse, (1994); Nyamongo (2002); World Health Organization (1995); and anthropologists suggest that the use of traditional healers and other alternative health care providers is widespread in the developing world, with a large percentage of psychiatric patients being seen by traditional healers at the beginning of their illness (Razali & Yasin, 2008). This suggests that patients with mental disorders may be consulting providers of alternative health care before, after or during their consultations with Western-trained mental health care providers. For example, studies conducted by Madu, Baguma and Pritz (1997); Mufamadi (2001); Peltzer (2001; 2009) and Sodi (1998) have indicated that there is considerable use of indigenous and faith healing systems in the treatment of mental disorders and other conditions of ill-health by community members in Limpopo Province. It is these kinds of studies that have motivated the present researcher to look at help-seeking pathways that have been followed by individuals and families in Limpopo Province to deal with mental disorders.

1.2. Aim of the study

This study was aimed at investigating the help-seeking pathways followed by patients seeking mental health care services within the Polokwane-Mankweng Hospital Complex.

1.3. Objectives of the study

The following objectives were identified for the study:
- To explore the patients' subjective notions of the events or factors that could have led to their mental illness;

- To understand and describe the patients' own explanations and experiences of mental illness;
- To understand and describe the patients' reasons for entering the mental health care system;
- To understand and describe the patients' subjective experiences of being in the mental health care system;
- To explore the agencies and other providers of health care that were used by the patients before they entered the mental health care system, and
- To explore the agencies and other providers of health care that the patients could be using currently whilst they are in the mental health care system.

1.4. Definition of concepts

- **Mental disorder -** The American Psychiatric Association (APA) defines mental disorder as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering, death, pain, disability, or important loss of freedom. In the present study, both the concepts "mental illness" and "mental disorder" will have the same meaning.

- **Pathway to care -** can be defined as the sequence of contacts with individuals and organizations prompted by the effort to alleviate psychological distress and the help that is supplied through such contacts (Rogler & Cortes, 1993).

- **Mental health care system -** refers to an established way of ensuring that the medical and allied health professionals offer the services through prevention, treatment, and management of illness and the preservation of mental and physical well-being.

- **The help-seeking pathway -** is defined, according to Lin, Inui, Kleinman and Womack (1982), as an event occurring between the point when the problems are first recognized (onset) and the point when the subject receives adequate

treatment, that is, enters the mental health care system and remains in treatment for more than one session (**treatment point**). Frequently, between these two points, the subject has brief contacts with various care providers that may not result in significant treatment action. These are defined as **contact points.**

- **Help-seeking episode or stage -** is defined as the action taken by an individual to seek one particular form of help or the action taken by a care provider to offer one particular form of help for one particular type of problem (Hirst, Cort, Richardson & Watson, 1996).

- **A traditional healer-** an educated or lay person who claims to have the ability or healing power to cure ailments, or a particular skill to treat specific types of complaints or afflictions and who might have gained a reputation in his/her own community or elsewhere. He/she may base his/her powers or practice on religion, the supernatural, experience, apprenticeship or family heritage (Ahmed, Bremer, Magzoub & Nouri, 1999).

- **Traditional medicine -** the knowledge, skills and practice of holistic health care recognized and accepted for its role in the maintenance of health and the treatment of diseases. It is based on indigenous theories, beliefs and experiences that are handed down from generation to generation (WHO, 2000).

- **Spiritual or faith healer -** a professed christian who belongs to one of the independent African churches, who believes that his/her healing power comes directly from God, through ecstatic states or trance-contact with spirits, or sometimes a combination of both the ancestral spirit and christian holy spirit possession (Karim et al., 1994).

- **Witchcraft** - an innate quality and an involuntary personal trait that is often hereditary and provides a theory of failure, misfortune and death (Staugard, 1985).

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

In this chapter, I start by discussing the nature and types of mental health care services in South Africa. This will be followed by a discussion of some selected studies on help-seeking behaviour and pathways for a number of health-related problems. In the last part of the literature review, I will focus on the theories that are relevant to help-seeking behaviours, and pathways to health care will be discussed. These theories include the biomedical model of help-seeking behaviour, behavioural model of health services use, the health belief model, the distress-appraisal-action model, theory of planned behaviour, the four-stage process of 'finding a way' and the pathway models.

2.2. Mental health care services in South Africa

Previous South African legislation relating to mental health (the Mental Health Act No. 18 of 1973) (MHA 1973) focused on control and treatment of patients. Like most international mental health legislations before 2000, the overriding concern was the welfare and safety of the community. Human rights of patients were not a priority and were not addressed, as "protection of society" was given priority over the rights of the individual. A reasonable degree of suspicion of mental disorder was sufficient to have a stranger, neighbour or relative "certified" to a psychiatric institution. Certification was wide open to abuse – jealousies, vendettas and prejudices often lay behind the certification of so-called "patients" and the withdrawal of their personal liberty (Burns, 2008).

At times, this form of detention was used for political ends to incarcerate and silence individuals or "dissidents". Once certified, patients had virtually no recourse to assistance from the law and could languish in hospital, against their will, for weeks or months. Patients had no meaningful right of appeal or representation. Against this backdrop of human rights infringements, psychiatrists were forced to be doctor and gaoler (Burns, 2008). Furthermore, the Act reinforced the separation of mental health care from general health care. Psychiatric services were stand-alone and not integrated into primary health care. Generalist medical practitioners were not required to take any responsibility for mental health. This resulted in many cases of

behaviourally disturbed patients, who were desperately ill with serious medical disorders such as meningitis, delirium and metabolic disturbances, slipping through the net and being sent to psychiatric institutions that lacked optimal medical care. Fatalities occurred, with patients dying of sepsis or metabolic disorders in the seclusion rooms of psychiatric hospitals (Burns, 2008).

Psychiatric services were also centralised in urban-based tertiary psychiatric institutions, far from the homes and communities of most patients. Mental illness in a rural village or remote town often meant transfer over great distances and lengthy incarceration far from home, family and place of employment. There was little or no care within the community. Patients entering the health services system with acute mental disorders experienced a form of systemic traumatization or structural violence. Whether intentionally or not, the structure of the system disempowered, alienated and stigmatized the mentally ill. While individual intentions were usually good and humane, the structural evils inherent in mental health services and legislation meant that admission was a traumatic and damaging experience. Psychiatric service provision under the Mental Health Act No.18 of 1973 was not truly based on the ethical principles of autonomy, beneficence, non-maleficence and justice (Burns, 2008).

The historical focus in South Africa was to provide mental health care in psychiatric hospitals, rather than in general medical or community settings (Van Heerden, 2008). De-institutionalization has occurred in recent decades, but development of adequate community-based services has lagged in catering for the immense need of community outpatients. The new South African mental health legislation was promulgated in 2002 and implemented in December 2004. Emanating from a new culture focusing on human rights within South Africa after the pivotal year of 1994, (when the country became democratic) it was one of the legislations enacted to rid the country of its apartheid legacy. And with its history of mental health treatment, South Africa was in dire need of an act that reflected the new spirit. The main aims of the Mental Health Care Act, No.17 of 2002 are to promote the human rights of people with mental disabilities, to improve mental health services through a primary health care approach, to emphasize community care and to protect the safety of the public (Mental Health Care Act, 2002).

The state of affairs in the 21st century indicates that health services in South Africa are rendered in public and private contexts. According to Van Rensburg (2007), functions of psychiatric hospitals and assessment units include multi-tiered parallel programmes such as voluntary, assisted and involuntary mental health care, care of state patients, care of mentally ill prisoners and assessment of persons referred by court for psychiatric observation. Studies conducted in the Western Cape by Van Heerden (2008), revealed that there are, however, some challenges identified across various levels of care. These, among others include the following:

- Assessing the burden of psychiatric disease in the population, leading to mental illness being under-represented.
- Community-based services for patients with mental illness appeared to have lacked attention in the past (a decrease in funding for chronic hospital services), which is impacting negatively on the current situation by accelerating the discharge of long-stay patients from large psychiatric institutions.
- Models that adequately integrate mental health and general medical services at the primary care level appear to still be under-developed and the situation is characterized by poorly equipped community centres and district hospitals, shortage of staff and the sense of unwillingness of the understaffed personnel to take on their mental health responsibilities (Van Rensburg, 2007).

Against the background of the aforementioned state of affairs, studies were conducted in Durban (South Africa) on consumer evaluation of the delivery and aspects of services provided and it was highlighted that clients were satisfied with the health care services delivered (Almeida & Adejumo, 2004).

Before the April 1994 elections, the African National Congress (ANC) proposed the following in its National Health Plan: "Traditional healing will become an integral and recognized part of health care in South Africa. Consumers will be allowed to choose whom to consult for their health care, and legislation will be changed to facilitate controlled use of traditional practitioners" (African National Congress, 1994a). Soon after the elections, the new Government of National Unity formalized this policy in its

Reconstruction and Development Plan (RDP): "There are deep divisions, fuelled by mutual suspicion and lack of communication, between traditional and other complementary healers and medical and social workers. This is not in the interest of people who use all types of healers. The Reconstruction and Development Programme (RDP) must aim to improve communication, understanding and cooperation between different types of healers" (African National Congress, 1994b).

Traditional African health practice has recently been mainstreamed in South Africa by the promulgation of the Traditional Health Practitioners Act, No. 22 of 2007 (Traditional Health Practitioners Act, 2007). This has taken place against the background of the significant change that has occurred in political, social and personal spheres of life in South Africa since achieving a democratic dispensation in 1994 (Van Rensburg, 2009).

Traditionally, Africans believe that all things in the universe are connected ontologically to one another. Beings and objects are organized hierarchically, whereby objects and beings occupy the lowest level of hierarchy. According to Mbiti, (1991), beings are divided into two levels, namely, the intermediate world (consisting of human beings) and that of integrated ancestors (who are capable of communicating with God on behalf of their relatives). Beings and objects are endowed with a life force, which is regarded as the energy or power and is the essence of all phenomena, material and immaterial. These forces are, however, constantly interacting with each other, making it possible for some unknown forces to intervene in the order of events (Baloyi, 2008; Mkhize, 2004; Myers, 1988). This may serve as the rationale for Africans to deny the possibility of events as happening by accident.

As is evident in South Africa and other African countries, traditional and faith healers play an important role in health care (Peltzer, 1987; 1998; 1999; Shai-Mahoko, 1996; Sodi, 1998). This is based on the suggestion that for many South Africans, the first choice of treatment is the traditional healer (Farrand, 1984; Louw & Pretorius, 1995; Mabunda, 1999; Swartz, 1986).

In his study on faith healing for mental and social disorders in the rural community of Eisleben in Limpopo Province, Peltzer (1999) indicated that there are two major independent movements that practice faith healing, namely the Apostolics and Zionists, which he pointed out, as contributing towards health care in South Africa. In another study conducted in the Mankweng area also in Limpopo Province (South Africa), Peltzer (2001) found that both traditional and faith healers seem to treat a variety of problems and illnesses and seem to operate at an equal level in dealing with witchcraft/sorcery related problems, physical disorders and mental disorders. Based on the background of the study, the researcher came to the conclusion that mental health care services should be able to take into account the beliefs of those it is serving. In other words, the patients' beliefs about the causes of their problems should be acknowledged. The implications that such beliefs might have on service provision should also be considered. The results from the study were in support of the recommendations from previous studies by De Adrande (2011); Madu et al., (1997); Moodley and Stewart, (2011) that mental health services of developing countries may be sustained more effectively by integrating traditional and modern approaches to therapy. The results further pointed to conclusions arrived at previously by some researchers (Devish, 1996) that the healing churches in Southern Africa resemble a melting pot, bringing together fragments of Western/Christian traditions and some basic tenets of African cultures.

2.3. Illness help-seeking behaviour and pathways

Studies of pathways to care and responses to illness by social scientists mushroomed in the 1950s and 1960s on the back of pioneering work by Clausen and Yarrow (1955) and Hollingshead and Redlich (1958), among others. Interest in the processes shaping how, when and why individuals present to health services and enter the role of patient developed from the observation that the nature and severity of symptoms alone does not determine when and what type of help is sought (Armstrong, 1994). This observation shifts attention from clinical presentation to the social context of help-seeking. The central feature of much social science research is the emphasis on help-seeking, which is viewed as a socially and culturally shaped process.

Since the 1960s, a vast body of research has accumulated, attempting to link socio-cultural variables to individuals' likelihood of perceiving an event as a symptom and to their mode of responding to symptoms. Factors that appear to affect this process include health knowledge, cultural background and socio-demographic characteristics. It is often suggested that the social and cultural background not only determines the choice of illness behaviour, but already asserts its influence in the first phase of recognition and identification of symptoms (Alberts, Sanderman, Gerstenbluth & Van den Heuvel, 1998).

The term "illness behaviour" was used by Chrisman (1977) to describe how people behave when they become ill. In a broad sense, it covers a set of sequential behaviours, including how they recognize, perceive and interpret the discomfort or suffering and react against it; how they seek help, attention, or treatment from others; how they communicate and present their problems or illness to their families, healers and others; how their role changes when they are sick, including how they are cared for by family members, friends, or others; how they react to therapy prescribed or the treatment offered by healers, including compliance and adherence to treatment; and how they accept or react to the results of treatment and the prognosis of their disorders. Thus, illness behaviour includes several identifiable elements that are involved in the process of illness. From a cultural perspective, it is important to know how cultural factors contribute to patients' behaviour and to their behaviour in seeking help, including how they utilize the healing systems that are available. It is believed that illness behaviour is shaped by culture to a great extent and that such behaviour varies considerably among societies with different cultural backgrounds (Chrisman, 1977).

Gilliland et al. (1999) described health care-seeking behaviour as the action taken by individuals in response to a stimulus (such as the perception of a symptom) that they decide is indicative of a condition needing evaluation by a health professional. This behaviour is influenced by personal, physical, and psychological characteristics and by socio-cultural and environmental factors. Health care-seeking involves a series of stages or phases, beginning with the patient becoming aware of a need and ending with medical assessment and treatment, if warranted. Delay can occur at any stage,

including delay in patient care-seeking and delay in treatment once contact is made with the health care system (Gilliland et al., 1999).

Gilliland et al. (1999) highlighted the fact that structural-environmental issues are in most cases associated with treatment delay. While these issues may play a role in treatment delay (that is, access to care, poor emergency medical service and doctor-instituted delays in diagnosis or treatment), the largest component of delay for acute problems seem to occur before the patient contacts the health care system (Boydell et al., 2006; Gilliland et al., 1999). Several studies have noted that, besides inadequate availability of health care services in many areas, especially the less developing countries, certain disease-specific and non-disease-specific cultural beliefs may influence people's health care-seeking behaviour (Feyisetan, Asa & Ebigbola, 1997; Kroeger, 1983; Rudell, Bhui, & Priebe, 2008). Leventhal and Nerenz (1985) mentioned that when individuals face psychological problems, they represent the problem along five dimensions, which include identity (label), perceived cause, time line (how long it will last), consequences (physical, social and psychological) and curability/controllability. These representations are drawn from social norms about the illness. There are also three types of attribution that people make to mental illness such as psychological, somatic or normalization of the illness. All these are embedded in culture. Culture is therefore a strong determinant of people's perceptions of illness, its perceived causes and treatment options as compared to other personal attributes.

A key concept utilized by social scientists in the study of how people come to use health services is that of "illness behaviour", developed by Mechanic (1968). Broadly, illness behaviour refers to the ways in which individuals, and significant others, perceive, evaluate and act upon the symptoms of illness. On the basis of the research available at the time, Mechanic (1968) identified ten variables known to influence illness behaviour, including the nature and quality of symptoms, their visibility, the extent to which they disrupt routines, cultural beliefs about illness and knowledge of available treatments. This was not an exhaustive list, as Mechanic (1968) made clear, but there are common threads running through the ten variables that highlight a small number of key factors that have been found to exert a significant influence on illness behaviour. These are: (a) the nature of symptoms; (b)

the influence of cultural factors, particularly beliefs about illness; (c) the impact of symptoms on family and social functioning; (d) the response of significant others, and (e) the range of treatment responses available. What this work emphasizes above all is that response to illness does not occur in a social or cultural vacuum, meaning that the role of significant others is particularly important. Relating to this, Mechanic (1968) stressed the need for research to distinguish between self-defined and other-defined illness, a distinction particularly pertinent to psychotic mental illness in which the sufferer may often deny the illness. In their study on patients' patterns of utilization of health services, Hulka and Wheat (1985), noted that evidence exists for a dose-response relationship between need and use: the stronger the need (i.e. the more severe the perceived symptoms), the more important it is in determining health services use.

In South Africa, health services are offered through multiple, sometimes overlapping channels, echoing what is true in many parts of the developing world (Ahmed, Adams, Chowdhury & Bhuiya, 2000; Baume, Helitzer & Kachur, 2000; Develay, Sauerborn, & Diesfeld, 1996). Case, Menendez and Ardington (2005) examined patterns of health seeking behaviour prior to death (from any form of medical condition) among individuals who lived in the Umkhanyakude District of Northern KwaZulu-Natal. These researchers found that traditional healers were consulted by almost half of the sample. It was further found that almost all of those who consulted traditional healers also consulted a Western medical practitioner. It was deduced from these findings that the services provided by traditional healers appear to be complementary to, rather than substitute for, those provided by public and private doctors. The use of traditional healers was found to be high, with half of all adults who fell ill before death seeking care from an *inyanga,* a *sangoma* or an *umthandazi* (Case et al., 2005). Forty-six percent of individuals also purchased non-prescribed medications and also made use of home-cures and vitamins.

Pronyk, Makhubele, Hargreaves, Tollman and Hausler (2001) conducted a study in the Bushbuckridge region of South Africa's Limpopo Province on assessing the health seeking behaviour of patients suffering from tuberculosis. A considerable proportion (15.4%) first sought treatment at a traditional or spiritual healer, such as the Zionist Christian Church or local traditional healers. In 25% of patients self-

referred to hospital, family members were seen to be an important source of influence to seek treatment regardless of the final place where treatment was sought. It is, however, notable that approximately one-quarter of these patients consulted traditional healers at some time during their illness.

In another study conducted on patients from African residential areas and public places around Pietermaritzburg, South Africa by Zondo (2008), the findings indicated that help-seeking pathways include consultation with family members, then the diviner, *inyanga* or doctor. These can also be consulted simultaneously, depending on the perceived cause of the illness. As the health-seeking behaviour of patients plays a pivotal role in the outcome of any disease, it is important to understand the treatment options employed by mentally ill patients and their reasons for doing so. Nonye and Oseloka (2009) conducted a study to establish the treatment seeking behaviour of patients suffering from mental illnesses in South-Eastern Nigeria. The study showed that psychiatric consultation is not usually initially employed, especially in rural areas. The study further indicated that the most common first contact for treatment of mental illnesses is the prayer house (34.5%), followed by a psychiatric hospital. The majority of patients in the study attributed their ailments to supernatural causes, which explains why visiting a spiritual house was their first option.

Given the findings of this study, it is important to understand the choices that people make for treating mental illness to ensure proper utilization of available mental health services and better management and control of mental disorders. Patients' most common reason for the choice of place of first visit was confidence that they would be cured there.

Nonye and Oseloka (2009) highlighted that there is an urgent need to increase community awareness about the scope and existence of mental health services and the amenability of mental illnesses to orthodox care, which should lead to positive attitudes that will enhance timely visits to a psychiatrist, as well as prompt treatment of conditions. The most common reason for the eventual visit to a neuropsychiatric hospital was advice by friends/relatives (44.8%), which demonstrates the role of social networks in decision-making regarding the selection of modality of treatment among mentally ill patients, and is consistent with other reports.

Perceptions about illness issues, such as diagnosis, cause and treatment are social constructs and thus reflect societal values and norms (Castillo, 1997; Kleinman, 2004; Ryder, Yang & Heini, 2002; Swartz, 1998). These norms and values differ across contexts because of differences in cultural assumptions about illness. All societies have to respond to illness in the course of their development. Societies have long utilized their indigenous knowledge to formulate meaning around illness and also to find ways of managing illnesses. Such contextual differences in norms and values have implications for the classification, diagnosis, and management of illness. The research findings from Castillo (1997) indicate that help-seeking pathways are social in nature and are based on perceived causality. According to the findings, for traditional healers, Western trained counsellors and health care users, help-seeking pathways were linked to the perceived cause(s) of the illness. Before an integrated view of illness and illness management can be formulated, African beliefs and practices, which were previously not acknowledged, need to be made explicit. The indigenous perceptions of illness cannot be divorced from the understanding of the self in relation to its context. This then makes illness a medical, social and cultural construct (Castillo, 1997; Helman, 2000; Matsumoto, 2001; Ngubane, 1977).

According to WHO (2010), regardless of the type of illness, family members are usually the first to be consulted regarding treatment and advice. In the study conducted by the World Health Organization (following the Haitian earthquake in 2010), it was found that Haitians from the lower class generally sought for help for mental problems from an *oungan* (a male Vodou priest). They would visit a mental health professional if a visit to an *oungan* has been unsuccessful. Some may simultaneously use both an *oungan* and a mental health professional (WHO, 2010).

In another study conducted by Al-Busaidi (2010) on the attitudes and beliefs towards help-seeking for emotional distress, it was highlighted that previous studies have established that several factors interact to determine help-seeking behaviour. These factors include stigma and embarrassment, difficulty in discussing mental health problems, doctor-patient relationship, trust in health care professionals, the presentation of illness, previous experiences of illness, and overestimation of one's coping abilities. In addition, social and cultural norms and beliefs have been shown

to play an important role in the way people perceive health and illness and use available resources.

People from different cultures may differ in their help-seeking behaviour due to several reasons. Firstly, there may be variation in the way people experience the problem as a specific diagnosis or just symptoms. Secondly, different cultures can ascribe different meanings to symptoms. Thirdly, culture may influence the extent to which people are willing to disclose certain symptoms, especially because of perceived stigma. Finally, cultures influence the way symptoms are expressed and communicated when in contact with health care facilities and professionals. A study on the role of family member advice as a reason to seek health care in Oman showed that the advice of family members remains a strong mechanism for care-seeking (Al-Busaidi, 2010).

Based on the results from the aforementioned studies, one can deduce that there is a structured path that is followed by individuals suffering from mental disorders and other conditions of ill-health. The process in all cases starts with recognition of symptoms, followed by emotional as well as cognitive meanings of those symptoms - i.e. individuals make formulations of what could be the problem, and as the symptoms persist, they share with a significant other, and this marks the beginning of the help-seeking process (Good, 1987).

2. 4. Theoretical perspectives

The pathway to care has been postulated by previous research as a multifaceted journey, commencing with ignorance and confusion (Webster & Harrison, 2008). Help-seeking pathways include the remedial steps that an individual assumes to restore health. Help-seeking pathways are based on the subjective interpretation and the meaning attributed to the symptoms (Castillo, 1997; MacKain, 2003). They also include learnt behaviours of how to deal with the symptoms. Help-seeking behaviours will therefore differ across contexts and cultures (Castillo, 1997; Faulker, Faulker & Hesterberg, 2007; Lim & Lu, 2005; Lu, Lim & Mezzich, 1995). For example, in traditional Western society, help-seeking pathways are simple, limited and predictable because of their cultural interpretation of illness.

Often, individuals assume responsibility for their own health and will individually consult Western health institutions. There is less consultation within the family, which increases the likelihood of symptoms being managed early. The trend seems to be changing, though, as more Western individuals are accessing alternative health systems such as homeopathy (Kaptchuk, David, & Eisenberg, 1998). This is because cultural norms are fluid and change with environmental changes. In non-Western contexts, help-seeking pathways are complex, involving negotiations between the patients and their social network about the appropriate treatment, depending on the perceived cause. Due to the complex nature of how illness is perceived, help-seeking pathways are not predictable and linear; they may include back and forward movement between Western and traditional health care systems. For instance, studies conducted in South Africa show how African people will simultaneously access the services of Western and traditional healers for the same symptoms based on the cultural conception that an illness is both physical and spiritual. These services, for the most part, are used to complement each other (Berg, 2003).

2.4.1. The Biomedical Help-seeking Model

The biomedical approach assumes that illness is a measurable pathological condition of the body caused by identifiable physical or chemical events (Boorse, 1975; O'Neil, 2006). Therefore, illness with no structural biological evidence is dismissed. Effective treatment changes the physical state of the body in such a way as to correct the physical cause of illness. For example, depression will be diagnosed through biological indicators such as measurements of neurotransmitters, changes in brain chemistry and overall decrease in brain activity (Bland, 1997; Keller, 2003). The biomedical approach, although very effective in diagnosing and treating the disease aspect of distress, ignores a large component of distress which is the illness aspect. The illness aspect of distress is mainly socially constructed; it sets the standard of what abnormality is, provides a script on the sick role, and shapes the perceived cause of illness which then translates into help-seeking behaviours. Moreover, it predicts the efficacy of the therapeutic encounter. The biomedical approach is limited even when applied in Western cultures because it neglects the subjective nature of illness and the cultural and contextual influences.

Traditionally, the biomedical model of help-seeking behaviour postulated a straightforward linear course: disease gives rise to illness; symptoms are the manifestations of such illness and form the focus of the sufferer's search for expert help. Professional (medical) assessment of symptoms then leads to the appropriate treatment, to which the patient responds. This "naive model" of help-seeking behaviour is now considered a seriously inadequate description (Watson, 1985). For example, not all symptoms lead to consultations with medical professionals.

2.4.2. Behavioural Model of Health Services Use

This model proposes that differential use of health services depends on three categories of variables, predisposing, enabling, and need factors (Anderson, 1968). Predisposing factors, such as age, gender, religion, prior experience, education, attitudes to health services, health insurance and social network support, suggest that personal attributes may predispose individuals to seek care. Enabling factors represent triggers and barriers to care, which tend to be structural or organizational, such as health insurance coverage and having a regular source of care. Need factors are measured by the perception of severity of illness, or number of sick days. According to this model, the need for health care, i.e., the perceived symptoms, is the primary factor in determining use of services. The social and cultural background of the individual (the predisposing factors) and enabling factors, such as financial and community resources, are of secondary importance (Anderson, 1968).

2.4.3. The Health Belief Model

The Health Belief Model focuses on two aspects of an individual's representation of health and behaviour: threat perception and behavioural evaluation. Threat perception depends on perceived susceptibility to illness and anticipated severity of the consequences of the illness. Behavioural evaluation consists of beliefs concerning the benefits of health behaviours and the costs or barriers to behaviour. In addition, the model proposes "cues to action" which can trigger health behaviour such as perceptions of symptoms, social influence and health education campaigns (Becker, 1974).

2.4.4. The Distress-Appraisal-Action Model

Watson proposed a circular sequential model, based on Lazarus' (1966) view of person-environment relations. In this view, help-seeking behaviour is characterized by one or more Distress-Appraisal-Action cycles, where initial appraisals involving the self, significant others and other "lay consultants" may precede medical consultation. The help-seeking process, which is the pathway involving a sequence of medical and non-medical contacts, ends when the distress, or the problem perceived as causing it, has been alleviated.

2.4.5. Theory of Planned Behaviour

The theory of planned behaviour is centred on factors which lead to a specific intention to act, or Behavioural Intention, which is situated between the attitudes and behaviour (Ajzen, 1991). According to this theory, Behavioural Intention is determined by:

- Attitudes towards behaviour, determined by the belief that a specific behaviour will have a concrete consequence and the evaluation or valorization of this consequence.

- Subjective norms or the belief in whether other relevant persons will approve one's behaviour, plus the personal motivation to fulfil with the expectations of others.

- Perceived behavioural control, determined by the belief about access to the resources needed in order to act successfully, plus the perceived success of these resources (information, abilities, skills, dependence or independence from others, barriers, opportunities etc.)

- Socio-demographic variables and personality traits which condition attitudes, subjective norms and perceived behavioural control.

An outstanding aspect of the theory of planned behaviour is the central role of social network support. The theory may serve as a background for determining how

attitudes and beliefs function in the help-seeking process (Ajzen, 1991). At the most basic level of explanation, it postulates that behaviour is a function of salient beliefs, relevant to the behaviour in question. Salient beliefs are the antecedents of attitudes, subjective norms and perceived behavioural control – three conceptually independent determinants of intention, which result in the behaviour or action in question.

The subjective norm is composed of a normative expectation, that is, the individual's perception of how significant others think they should perform and the motivation to comply. In other words, to care about what significant others think. The normative expectations of the patient's significant others are oriented to the ideas currently prevalent in the society.

2.4.6. The Four-Stage Process of 'Finding A Way'

"Finding a way" indicates the life-changing process that participants undergo in response to and as a result of the onset of mental health problems. The process has four stages. At each stage, barriers or facilitating factors (intervening conditions), which are to be found in the participants' social, personal and health-care environments, could delay or speed progress. Not all participants experience each stage in the process, but all, at some point, experience barriers which impede their progress to care and factors which facilitate their movement from one step to the next. These could occur at any stage of the process depending on the life circumstances of the participants (Webster & Harrison, 2008).

Stage 1: First sign

In the first stage, an individual does not know what is wrong. He/she experiences emotions such as sadness, fear, loneliness and self-blame. In the midst of this emotional turmoil, the individual has to find a way through the first sign (causal conditions) of symptoms he/she finds difficult to understand. Some behavioural changes such as denial, social withdrawal and substance use may occur. The way an individual handles the causal condition depends on the social context, i.e. the extent to which his/her feelings and changed behaviour are recognized by the individual's family or friends, to a lesser extent.

Stage 2: Recognition

An individual recognizes that something is wrong through the awareness either of the increasing intensity of the symptoms, or the increased difficulty in coping with life. The individual begins to develop coping strategies, or might continue to deny that something is wrong. The dawn of recognition, the consequences of the causal conditions, is characterized by the development of a sense of change in an individual. However, growth in personal attitudes and coping strategies are elements of this recognition phase.

Stage 3: Understanding

This stage is characterized by strategies for action, i.e., gaining control and taking responsibility. As the individuals gain understanding of what is going on with them, the perceptions about their illness change. They gain control and take responsibility, thereby finding courage and commitment during this stage, which further leads to acceptance. Taking responsibility or showing commitment involves a sense of obligation to engage on a course of treatment intervention to alleviate the symptoms.

Stage 4: Resolution

This is the final stage in the process, which might also be referred to as the consequences of the strategies, both intended and unintended. For some people this might mean that they have been able to find positive support, while others experience a feeling of being defeated by the illness, and the end result is accessing care either voluntarily, or involuntarily. Webster and Harrison (2008) identified "barriers and facilitators" to care which refers to the processes and factors which people identify in their accounts as accelerating or impeding their progress to care. The latter allows movement from one stage to the next, while the former yields the opposite results. Both factors are to some extent, peculiar to each person and depend on their unique circumstances.

2.4.7. Theoretical framework for the present study: The Pathway Model

This is the theoretical framework that guided the researcher in the present study. The Pathway Model is centred on the path that people follow until they use different health services (home treatment, traditional healer, biomedical facility). This model stresses the importance of "significant others" in the decision-making process of

seeking treatment (Good, 1987). The "significant others" are part of the "therapy managing group", a concept elaborated by Janzen (1978) which is the key for understanding decision-making in therapeutic processes. This idea challenges the strong emphasis on the individual and stresses the pivotal role of extended groups of relatives and friends in illness negotiation and management. In the course of the illness episode, the involvement of support groups in illness management can successively change. Pathway models therefore, acknowledge these dynamics of illness and decision-making.

Most of the studies which use pathway models investigate the path until the first contact with a health facility. More recently, there has been an increasing emphasis on successive therapy choices. What usually happens, according to the model is that an individual perceives him/herself as being ill (perception of illness). The significant others are informed and become involved in the decision-making process of what should be done (significant others). The discussion yields a choice of therapy an individual will follow (therapy choice). Based on the outcome of the discussion with significant others, an individual may visit a traditional practitioner, resort to self-treatment, or seek biomedical practitioners. It is important to note that an individual can move from one sector to another, that is, from self-treatment to biomedical practitioners and to a traditional practitioner, for example.

CHAPTER 3: METHODOLOGY

3.1. Introduction

This section focuses on the methodology employed in this study, which consists of the tools and techniques upon which the entire research is based. These include the data collection methods, instruments, sampling and sample size, procedure used to collect data, and methods for data analysis. In this section, the researcher concludes with a brief overview of ethical issues that were considered in conducting the study.

3.2. Research design

In this study, a qualitative research approach, that of a phenomenological nature was used. Qualitative research has been recognized as a legitimate way to obtain knowledge that might not be accessible by other methods and to provide extensive data on how people interpret and act on their symptoms (Smith, Pope & Botha, 2005). The phenomenological approach is also aimed at understanding and interpreting the meaning that subjects give to their everyday lives (De Vos, Strydom, Fouche & Delport, 2005). The approach, however, generates non-numerical data (Holloway, 1997). To qualitative researchers, behaviour is intentional and creative, and can only be explained and not predicted (De Vos, 1998). It is, therefore, defined as a "multi-perspective" approach (utilizing different qualitative techniques and data collection methods) to social interaction in terms of the meanings that the subjects attach to it (De Vos, 1998).

3.3. Sampling and setting

The participants in this study were selected through purposive sampling, which is a type of a non-probability sampling technique. In purposive sampling, cases are chosen because they illustrate some feature or process that is of interest for a particular study (Silverman, 2000) and researchers will be having a clear criterion in mind and have rationale for their decisions (Creswell, 1998). Neumann (1977) mentions that purposeful sampling is appropriate when one is looking to gain an in-depth understanding of people's experiences and for content analysis.

The population in the study comprised persons who are receiving psychiatric services at Polokwane-Mankweng Hospital Complex and have been diagnosed as

suffering from a mental disorder. Participants were recruited to the study using the booking list for the Psychiatry Clinic of the Out Patient Department. The first 10 individuals diagnosed with a mental disorder but being apsychotic at the time of this study were approached and requested to participate in the study.

The Polokwane-Mankweng Hospital Complex (PMHC) is a combination of two hospitals, Pietersburg Hospital campus and Mankweng Hospital campus. Pietersburg Hospital campus is situated in Polokwane City, while Mankweng Hospital campus is located in Mankweng Township (30 kilometres north-east of Polokwane). The role of the PMHC is to provide tertiary services to all Level 1 (District) and Level 2 (Regional) hospitals in Limpopo Province. It has a bed capacity of 1016 patients. The following are some of the clinical departments and services available: Radiology, Surgery, Medical (under which psychiatry falls) and Health Care Support (which includes psychological services). Some of the services that are not available in one campus are, however, provided by the sister campus. For example, all acute and short-stay psychiatric patients are admitted to Mankweng Hospital campus, with follow-up visits at either side of the complex, or local clinic, depending on the patients' place of residence (PMHC, n.d.)

3.4. Data collection

An interview guide was developed as a tool to gather data. According to Rubin and Babbie (2001), an interview guide ensures that the interviewer covers the same material and keeps focused on the same predetermined topics and issues, while at the same time remaining conversational and free to probe into unanticipated circumstances and responses. The interview guide was self-developed based on the relevant literature and research (See Appendices 1(a), (b)). The interview guide focused on exploring the pathways followed by these participants, their subjective understanding and experiences of mental illness and events and factors that could have led to their illness and the treatment seeking process.

Semi-structured one-to-one interviews were conducted at a location suitable to the participants. Participants were allowed to choose from two options, namely, their home or the consulting offices of the hospital. All the participants opted to being

interviewed at their respective homes. According to Smith et al. (cited in De Vos et al., 2005), semi-structured one-to-one interviews give both the researcher and participant more flexibility and is suitable where the researcher is particularly interested in complexity or process, or where an issue is controversial or personal. The fundamental assumption in this method is to converse with the aim of exploring the general topics in order to uncover the respondents' meaning and perspective. By using this method, the researcher respects the respondents' own framing and structuring of responses. The phenomenon studied should unfold in accordance with the participant's way of viewing the phenomenon and not the researcher's view (Kahn & Cannell, 1957).

For each of the major steps in the health-seeking process, retrospective information was collected on the onset of the illness, the presenting problem, the sequence of contacts with various care providers, the approximate timing of consultations, or the length of time spent on each contact point and treatment or services offered. Interviews were used to tap into the participants' subjective meaning and experiences of the phenomena, the nature of the presenting problem and help-seeking pathways. This was an important aspect of the research as it revealed the social meaning and interpretation of illness. In addition, through the responses one could get a sense of how people with mental illness are treated, and assess if there is a need for familial interventions. Data were captured by use of tape recordings and written notes, in accordance with Collins' (1998) recommendations that the events recounted and experiences described are made more substantial and real through recording and writing of notes.

3.5. Data analysis

According to Marshall and Rossman (1999), data collection and analysis typically go hand in hand in order to build a coherent interpretation of the data. This means that ideas for making sense of the data emerge while still in the field of collecting data. The researcher looked at frequently recurring patterns of responses and themes. The collected data were organized (Creswell, 1998) and interviews or notes transcribed.

The interviews were conducted in the participants' home language, namely, Sepedi so as to ensure that they fully understood the content of the interviewing process and thus relate their experiences adequately. Based on the aforementioned state of affairs, the data were translated from Sepedi into English by a Sepedi-speaking language expert. Back-translation was also done to ensure that there was consistency in meaning of both the English and Sepedi versions of the data. The tape recording was then given to the researcher's supervisor to listen to and to repeat the above process for the sake of validation. The data were analyzed as follows:

3.5.1. Organising (Managing) Data
This is a phase in which the collected data were organized into file folders and computer files. This also involved converting these files and folders to appropriate text units (Creswell, 1998) and transcribing interviews or notes.

3.5.2. Reading and writing memos
During this phase, the researcher read the transcripts in their entirety several times, so as to try and get a sense of the interview as a whole, before attempting to break it into parts. During this process, the researcher listed the data available, performed some necessary editing to make filed notes retrievable and generally "clean up" what seemed overwhelming and unmanageable. Memos were written in the margins of field notes or transcripts. These were in the form of short phrases, ideas or key concepts that occur to the reader (Creswell, 1998).

3.5.3. Generating categories, themes and patterns
From what the researcher did in the previous phase, salient themes were identified, and recurring ideas or language and patterns of belief that link people and situations together and the meanings held by participants in the setting were categorized. Here are the psychological themes that emerged: a). Participants' subjective notions of the events or factors that could have led to their mental illness; b).Participants' own explanations of mental illness; c). Reasons for entering the mental health care system; d). Pathways followed by the participants before receiving mental health services in the hospital; e). Concurrent use of hospital mental health services and other services; f). Experiences of living with mental illness. This was also an

opportunity for the researcher to step back and form broader opinions of what was taking place.

3.5.4. Testing emergent understandings

Part of this phase entailed evaluating the data for their usefulness and centrality, that is, the researcher determined how useful the data collected were in illuminating the questions being explored and how central they were to the story that had unfolded about the phenomenon being studied.

3.5.5. Writing the report

This was the final phase which is regarded as the primary mode for reporting the results of the research. During this step, the researcher presented data (a packaging of what was found) in text form.

3.6. Reliability, validity and objectivity

Qualitative research has often been criticized for being subjective and therefore rather hard to replicate. Thus, findings are sometimes considered to be lacking reliability. Reason and Rowan (1981) assert that validity in qualitative research lies in the emphasis on the personal encounter with the experience and encounter with persons. Another critique often launched against qualitative research is that it is subjective, thus running the risk of projection and collusion that may have a negative impact on both reliability and validity of the study. Craftsmanship is an important tool in qualitative research as it ensures validity and safeguards against imposition by the researcher (Denzil & Lincoln, 2000). Craftsmanship is described as the researcher's qualification, his/her competent observation and the ability to accurately record and transcribe the data. In this study, the interviews were recorded. The tapes were played and recorded word for word. The transcripts were read over a couple of times to get the gist of the data. Small summary notes were then written on the margins of the prescribed interviews. Mischler (1990) refers to this process as the trustworthiness of the procedure whereby the raw data are transcribed into manageable data and results.

3.6.1. Credibility

In qualitative research, credibility is maintained by an inquiry that ensures that the subject is accurately identified and described (de Vos, 2002). The researcher adequately placed boundaries around the study, by adequately stating the parameters such as the variables, the population and theoretical framework (Lincoln & Guba, 1985).

3.6.2. Transferability

Transferability refers to the applicability of one set of findings to another context (de Vos, 2002). In this study, the researcher used multiple methods of data collection namely, interviews and recordings. This has led to more valid, reliable and diverse construction of realities and it can be viewed as a way of strengthening the study's usefulness for other settings.

3.6.3. Conformability

Lincoln and Guba (1985, as cited in Marshall & Rossman, 1999) emphasize the need to ask whether or not the findings of the study could be confirmed by another. The researcher involved several peer researchers to assist with interpretation of the data at different times or location, so as to improve the analysis and understanding of construction of others.

3.7. ETHICAL CONSIDERATIONS

3.7.1. Informed consent

Participants were informed about the research. This helped to ensure that they fully understood the investigation and were consequently able to make voluntary decisions about their participation (Hakim, 2000, as cited in De Vos et al. 2005). The researcher informed the participants that they could terminate their participation in this study at any point, should they not want to continue, and clearly indicated that this decision would not in any way affect them negatively (see Appendices 3 (a), (b)).

3.7.2. Confidentiality/anonymity and privacy

As it is the responsibility of the researcher to ensure that the privacy and identity of the research participants is safeguarded, the information obtained was handled in a confidential manner.

3.7.3. Respect for persons

The researcher ensured that the dignity of all the research participants was respected by ensuring that they were not used simply as a means to achieve research objectives, but to benefit from the knowledge derived from the study.

3.7.4. Debriefing of respondents

In the initial plan, the researcher gave an allowance for the possibility of debriefing sessions to be held, should a need arise. These sessions were meant to provide participants with the opportunity to work through their experiences and the aftermath of these experiences. During the interviewing process, using her skills and expertise as a training clinician, the researcher was able to assess the situation. The emotional problems that seemed to have been generated by the research experience were dealt with or corrected after the interview (Babbie, 2001). Some participants were referred accordingly, for example, to psychologists and social workers.

3.7.5. Permission to conduct the study

Prior to commencement of the research, the researcher obtained permission from the ethics committee of the university and also from the Limpopo Provincial Department of Health and Social Development (see Appendix 4).

CHAPTER 4: RESULTS

4.1. Introduction

In this chapter, the researcher will first present the demographic profile of the participants. This will be followed by phenomenological explication of the protocols obtained from the participants so as to extract the psychological themes that emerge. In this regard the following themes identified will be presented: a). Participants' subjective notions of the events or factors that could have led to their mental illness; b). Participants' own explanations of mental illness; c). Reasons for entering the mental health care system; d). Pathways followed by the participants before receiving mental health services in the hospital; e). Concurrent use of hospital mental health services and other services; f). Experiences of living with mental illness. The chapter will conclude by giving a summary of the results of the study.

4.2. Demographic profile of participants

Table 1: Demographic details

Participant's No.	Age	Home Language	Residential area	Religion
1	18	Sepedi	Ga-Mailula	Traditional
2	57	Sepedi	Ga-Molepo	Traditional
3	52	Sepedi	Ga-Molepo	ZCC
4	34	Sepedi	Botlokwa	Catholic
5	59	Sepedi	Ga-Molepo	Traditional
6	26	Sepedi	Ga-Dikgale	ZCC
7	35	Sepedi	Mankweng	ZCC
8	27	Sepedi	Ga-Mothiba	Catholic
9	32	Sepedi	Ga-Makanye	ZCC
10	30	Sepedi	Ga-Molepo	Born-Again

The sample of this study comprised ten (10) participants who are receiving mental health care services in Polokwane-Mankweng Hospital Complex (PMHC) and have been diagnosed as suffering from a mental disorder. There were 5 males (50%) and 5 females (50%). Their ages ranged from 18-32 (50%), 33-47(20%) to 48-62 (30%) years. Their mean age was 37 (SD: 14.0). Participants were included in the sample because they had some experiences to share regarding the pathways they followed in seeking for intervention for their illness. The distribution by ethnicity showed that all (100%) the participants were Sepedi-speaking. They were all living with mental illness, and the period varied from one individual to the next, but the average is approximately 12 years. The longest period was 33 years, while the shortest was a couple of months.

4.3. Phenomenological explication

4.3.1. Participants' subjective notions of the events or factors that could have led to their mental illness

The findings from the study suggest that people suffering from mental illness have their own perceptions about the events or factors that could have led to their illness. These perceptions appear to be culturally defined, and they include amongst others, substance use, witchcraft and social stressors. The following quotations from the interviews corroborate their experiences:

"Actually, there's nothing else that made me ill. … Smoking drugs and drinking alcohol is where my illness emanated from." [Participant 1]

"In my opinion it's … alcohol … and all these things - cigarettes." [Participant 8]

In the quotations given, substance use/abuse is suggested to have given rise to mental illness of the two participants quoted in the above extract. Another factor mentioned to be the cause of mental illness in some participants was witchcraft. According to the explanations given, there seems to be an element of jealousy that prevails behind the practice of witchcraft against the targeted individual, such as ensuring that the individual's potential is skewed or hindered in some way. This is highlighted in the following two explanations:

"After writing the notes, someone asked for my book so that he could go and copy at home, only to find that his aim was to bewitch that book. [In order] For you to become mad, so that you should not beat them ..." [Participant 5]

"I had some illness some time ago ... in the stomach, it was some form of poisoning-(seješo). It wasn't coming out even when I … consulted with traditional healers… I wasn't getting any better. … Let me say I was worried, about it – the fact that it will kill me if it doesn't come out. ... That affected me mentally… Africans… are the ones who stand on our way. I worked for nine months in Jo-burg. Then I became ill and came back home." [Participant 3]

Everyday stressors that individuals are faced with have been attributed to the onset of mental illness or the exacerbation of the existing psychological distress. These include issues such as unemployment, family discord, pre-existing general medical conditions and occupational problems. The participants made comments such as:

"It's stress, sometimes … and being unemployed… Isn't it that I found out that I was ill… It was because of the stress after finding out that I was … I'm ill. So what if the baby can also be ill? Such things. …It'll be another stress. And also another stress because I want to go back [to my husband and] …they (my family) don't allow me… As time went by …then I found that they are refusing, I started to become somehow"... [Participant 7]

"As for me, my problem … is the issue of unemployment. Have you thought of being maintained (dependent)? But when I'm working, I have no problem. But when I'm out of work, I start thinking that I don't have 1,2,3. Even when you look for a job, you do it with some depression saying: Eish! I wish I could be employed and start working on such and such a day. And also the issue of not having a baby." [Participant 10]

"… It might be ... maybe the fact that I expect high things, you see? I suspect that about my work. I told myself that if one draws … something, drawing - your plan … Then tell yourself that at this time I will be this, at this time … it's something like that I was planning. And yet it didn't happen. Then I ultimately lost hope. Disappointed. Like I was … you know I was sure of being appointed for a permanent job. But it

didn't happen. And I was the only one with a B.com Accounting. It (the post) was frozen, then I started being somehow, do you know what I mean?" [Participant 4]

This last comment seems to embrace the cultural notion of physical illness as the cause of mental illness, for example when a state of disharmony exists between the two because of some issues of impurity which might need rituals.

"Mental illness sets in when the blood … when one's blood is not ok". [Participant 6]

4.3.2. Participants' own explanations of mental illness

Almost all the respondents in this study were able to give an explanation of what mental illness is and in their explanations, made use of various descriptive words and phrases related to their own experiences, such as the symptoms they experienced during the course of the distress. The following quotes illustrate some of the examples of the explanations given:

"My understanding of a person suffering from mental illness … is that this person does things that he/she's not aware of. And secondly, he/she does not understand what he/she's doing. Thirdly, you may say something that you end up being unable to finish." [Participant 1]

"Mental illness? It means ... he/she (the individual concerned) is not well, he/she's slow. Then right … it means he/she can't speak to people, he/she's always alone. That's how I understand it." [Participant 8]

"Eish! I don't know what I can say it is. I understand it to be some state of depression … you find that you are unwell and unable to see what you're doing." [Participant 10]

"It's that's you … you walk too much. You may feel dizzy and collapse maybe when it's hot." [Participant 6]

"The way I was, I would wake up and just sit. I would just sit; I wouldn't even take a bath and just be a person. Have you ever seen that? They would do laundry and everything for me." [Participant 7]

"It's to be mad … You may appear as if you are mad, such things. Things like complaining regularly and even speaking to yourself." [Participant 9]

These descriptions tap on factors including poor insight, impairment in social functioning, somatic complaints and disturbance of the thought processes. These explanations serve to, in a way, mirror the state in which each individual participant found him/her-self during the course of their illness. Despite the unique personal experiences shared, these descriptions arrive at one convergent point - of being mentally ill. Of all the respondents, one seems to still have unanswered questions around issues related to the nature and cause of her illness. This individual, however, explained mental illness in terms of her knowledge that existed prior to the onset of her illness, unlike with the rest of the participants:

"I don't know. But because ... eh … I just grew up, attended school and even had my first child. Yes. It was not there. It just started after this first child. I don't know. Some say it's caused by studying a lot. Some say it's the … it's the disturbance of thoughts. I don't know." [Participant 2]

4.3.3. Reasons for entering the mental health care system

From the findings of this study, it is evident that participants moved from one treatment point to the other seeking for services to alleviate their discomfort. Their movement from one service provider to the next is said to be informed by factors such as their perceived lack of improvement, or the fact that their symptoms were worsening. On the other hand, their stay at a specific treatment point is also said to be based on one factor, namely, their perceived improvement or remission of symptoms. Conditions that rendered family members incapable of handling the situation and the severity of the symptoms were given as the reasons for entering the mental health care system as the first treatment point. The following extracts depict some of the participants' reasons for entering the mental health care system:

"Then I just got unwell, also became somehow and that caused me to be taken by the police from here … to Turfloop. I was fighting that day [and] I was admitted for quite some time. From there, that's when I started using these pills". [Participant 5]

"It means I had an attack while here ... I had an attack here … at home in the evening. You see? Then they devised some means … plans for transport, and then they accompanied me to the hospital. They admitted me and stayed for two days before being released." [Participant 9]

"I really became unwell. I started making noise ... and I did all sorts of things. I was able to see all the things I was doing. I once more became unwell that evening and was admitted to the hospital." [Participant 7]

In these quotes, the situations of the participants seem to have created some form of an emergency, warranting the need for them to be taken to the mental health care system urgently. This might have also left the significant others of the individual participants with little, if no time at all, to engage in negotiations between the patients and their social network about the appropriate treatment modality to be employed. For some individuals, their symptoms appeared to have been worsening, leaving them with the need to seek for intervention, as there seemed to have been no sign of spontaneous improvement, as in the case of the participant who presented her situation in the following quote:

"I was at school. I just become unwell. Then she (the mother) observed that I was getting worse that night, then the following morning she took me …. That's when they took me to Mankweng." [Participant 10]

At times, participants or their significant others arrive at a decision in terms of the treatment point to consult first, as soon as there is evidence of the illness. When they realize that their choice does not yield the desired outcome, they engage in further negotiations or do a re-planning and come up with another option of treatment. In the quotations that follow, treatment failure at one or more point(s) is indicated as the reason for entering the mental health care system:

"… I spoke to my sister and said: You know what? … I've had it, I'm enough. How long have you been tossing me around? ... I am going to the clinic to consult. I need a psychologist." [Participant 4]

"After the visit to the church … and realizing that I didn't feel any better … I ultimately just stayed at home for a long time. Aah! For me to be better actually, it means I was just assisted by the hospital. I didn't ... I have not had any ... any other improvements". [Participant 1]

4.3.4. Pathways followed by the participants before receiving mental health services in the hospital

Health care-seeking involves a series of stages or phases, beginning with the patient becoming aware of a need and ending with medical assessment and treatment, if warranted, but it appears to be a socially and culturally shaped process. (Gilliland et al., 1999). From the interviews, it is quite clear that several other agencies and providers of health care have been visited by participants as soon as they became aware of signs suggestive of ill-health. These include amongst others, traditional healers, spiritual healers, medical doctors (general practitioners) and mental health care facilities. Most of the participants in this study reported to have entered the mental health care facility as their initial treatment point.

On the other hand, the remaining few entered other agencies prior to their visit to the mental health care system. The treatment facility entered (chosen) has been described to be informed by the cultural or belief system of the participant or family members. For those that entered the mental health care system as their initial treatment point, the decision was mostly informed by the severity of symptoms, e.g., manifestation of aggressive behaviour. The following extracts illustrate the paths followed by those who started at other agencies:

[Participant 9]

"... There is a certain prophet there in Seshego ... of the Apostolic Church ... they took me to him." **[1st treatment point]**

[From there] "It … it is this church of Zion, wherein they helped me … I was actually using mainly these instructions from the Zionist church [and] I realized that those things are diminishing …" **[2nd treatment point]**

[Participant 1]

*"... As my uncle is someone who often assists people in a traditional way... he did assist me, [as] I [was] supposed to be treated. He ultimately failed.****"*** **[1ˢᵗ treatment point]**

*"Yes. [Thereafter, I went] To the priest of the Apostolic church. They assisted ... helped me. After the visit to the church and realizing that I didn't feel any better … I ultimately just stayed at home."***[2ⁿᵈ treatment point]**

Depending on the magnitude of the discomfort experienced, the nature of the mental illness and the treatment modality employed, some participants find themselves having to visit various treatment points, before their discomfort could be minimized or completely eradicated. This yields the complex nature of the pathway that these participants followed, highlighting that the path is longer in some cases, depending on the response of the illness/symptoms to the intervention at a specific treatment point, as in the following extract:

[Participant 4]

"I applied for leave … and then I came home (to Botlokwa) and Dr Sath (not real name) gave me the medication. Aah! I took it. I didn't complete the course of the treatment. Then, I realised: Aah! This person gave me medication, but it doesn't do anything." **[1ˢᵗ treatment point]**

"When I explained to my cousins, they took me to someone. They said to me that this person only used water, but only to find that he used herbs… traditional herbs." I went there and that person intervened. But these things [his explanation of the illness] don't make sense... I left it at that." **[2ⁿᵈ treatment point]**

"Then, I was home starting from Saturday. Then while seated ... I started to feel lonely. … I cried, then after cleaning the house I went out [and] there I went, running alone on the street … but came back. Then on Monday, I went to a doctor, then he gave me medication … But, I was not able to sleep at the time. I would be talking the whole night [and] wake up people in the house." **[3rd treatment point]**

"… They (my cousins) took me again … to a prophet of the Bazalwane church. I spent the day there … Then on Monday I left and went to work" **[4th treatment point]**

"I spoke to my sister because I didn't know whether this illness could be man-made or what? I needed to do the right thing. I went to Randburg hospital… then when I came back here … then I started taking medication from Mankweng." **[5th treatment point]**

The findings of this study further reveal that in pursuit for intervention for their distress, the number of treatment points visited by participants prior to entering the mental health care facility ranges from 2 to 5. For some participants, as illustrated in the first two quotations above, the path is simple and predictable, while the same cannot be said for the others.

Although the issue under discussion here is clear, i.e., pathways followed by the participants before receiving mental health services in the hospital, a pattern of treatment-seeking emerged which the researcher cannot ignore. The findings also reveal that for those participants who entered the mental health care system as their initial treatment point, that however, did not limit them from exploring on other treatment modalities after their discharge from the mental health care facility. Here are some examples, to illustrate this pattern:

[Participant 7]

"I started to become unwell during the night when I was with him [the husband]. I once more became unwell that evening and was admitted to the hospital. Aah! There was no problem. I then came back being better". **[1st treatment point]**

"I don't know what actually happened or maybe as they (the family) were consulting here and there, they ended up going somewhere … as soon as I came back they said: Let's go. We are taking you somewhere. We went there while you were still in hospital. Aaah! They took me there… But I observed that there were no changes. I realized that I was starting to be very ill and on my arrival at the healer's place, I'd already become a mad person." **[2nd treatment point]**

[Participant 8]

"I started by fighting with my parents at home, that's when they transferred me to the hospital. They took me to Mankweng first." **[1ˢᵗ treatment point]**

"... I just went to church, to carry out some instructions. It was after my discharge from the hospital. **[2ⁿᵈ treatment point]**

Help-seeking pathways are not always predictable and linear; they may include backward and forward movements between Western and traditional health care systems. (Berg, 2003).The findings of the current study suggest that in some cases, the movement of an individual from one health care system to the next ends up bringing the individual back to where he/she started, as in the following cases:

[Participant 10]

"… They took me to Mankweng. Initially they locked me up on realizing that I didn't want to stay there. Then the following day I was better and they assigned me a bed … in the Family Unit. I did not stay for such a long time." **[1ˢᵗ treatment point]**

"[After that I went] … to the doctor. I consulted a doctor in Pietersburg. Just a general doctor. I went there sometimes, once I realized I was unwell I'd go." **[2ⁿᵈ treatment point]**

"I became unwell, got admitted and that's when I started receiving the treatment from here (Mankweng Hospital).They admitted me, but I didn't spend many days there …" **[Back to 1ˢᵗ treatment point]**

[Participant 2]

"I started while I was in Gauteng, then I was taken to the hospital in Gauteng - Johannesburg Hospital." **[1ˢᵗ treatment point]**

"Then in the other year, they (the family) thought: 'Shouldn't we maybe take her to the traditional healers? She might get better.' I indeed went to the southern side. Then they also tried this way and that way. I still did not improve. **[2ⁿᵈ treatment point]** *"Then while we were there, they also took me back to Johannesburg Hospital."* **[Back to 1ˢᵗ treatment point]**

" … One day the illness reappeared and I … even ended up at Kwa-Zulu Natal. They, too, 'fought' with the illness." **[3ʳᵈ treatment point]** *"Then he (traditional healer) also said he was failing, then I came back home and took these Western ones (medication)."*

4.3.5. Concurrent use of hospital mental health services and other services

From the data described in the previous sections, another area to be explored was whether there are other agencies and providers of health care that these participants could be using while at the same time receiving services from the mental health care system. Indeed, those services are in use and the reason behind that is not related to any form of treatment failure, but rather to other factors. Half of the participants reported to be using other treatment modalities to enhance the current one and also to serve a protective role. This practice appears to be based on what is perceived to be the cause of their illness. For example, someone who regards the cause of his/her illness to be witchcraft-related is more likely to engage in measures to ensure that he/she is protected from the evil forces. The other half conversely, reported to be using exclusively the current system as other systems have failed them before, or because of their understanding of the nature of their mental illness. The following extracts tend to give a glimpse of the experiences shared in explaining what the participants are using or where else they are receiving services other than at the mental health care facility:

"It's just that I have this other medication that I take beside this one. It's Gincon - from Forever … This herbal stuff. The likes of aloe vera ... They even help me with my books. There is a liquid … so that at least my brain should function well and that I don't become somehow. This combination is right. It is right." [Participant 4]

"… Actually I'm helped by the fact that I'm in the Zionist church. Yes. I get my instructions from there." [Participant 3]

"Yes! I do use them (instructions from the church). That one is part of my life. It's part of my life; I use them." [Participant 7]

"Then when I use the instructions (from the Zionist church) often … aah! There's no problem. I take some time without having an attack." [Participant 9]

"... It's just to go to church and on coming back; you wait for your hospital treatment." [Participant 6]

The above comments tend to highlight the issue of concurrent use of hospital mental health services and other services by the participants, whereas those that follow depict an opposite situation of exclusivity in the use of hospital mental health services:

"No. I don't go anywhere else. I take the pills only." [Participant 2]

"Yes. And I won't go anywhere else... I use only the ones from the hospital. There's nothing more I use except those from the hospital." [Participant 1]

"I was only helped by the medication I'm taking. It's only at the hospital." [Participant 8]

4.3.6. Experiences of living with mental illness

The participants' experiences of living with mental illness were explored in relation to the services they are receiving from the mental health care system. Almost all of them reported that they had generally positive experiences of being in the mental health care system, describing the health care intervention strategies implemented as being satisfactory and as a result they felt that nothing needed improvement. The following comments suggest positive experiences of these participants:

"No, they're good…they're good. They satisfy me because I was treated from the beginning… of my illness wherein the doctors … the nurses …including all those involved, were never impatient with me ..." [Participant 1]

"Yeah! They satisfy us." [Participant 3]

"You know the treatment they provide is … I don't even know what they have noticed about me? Even when I can't get medication from the pharmacy …They'll say: 'Write down your phone number and ... we'll call you' - if the medication isn't in stock. Honestly, they treat us well." [Participant 7]

"Mmm … I think they treat us well … Now I realize that I'm getting better. I wasn't able to go alone (to the hospital). I was ill. They advised me to stick to my treatment, and not misuse it". [Participant 8]

These quotations suggest not only the level of satisfaction about the health care services rendered at the mental health care system, as it may seem, but say a lot about preservation of human dignity and empathy from the mental health care providers. This although stated overtly, appears to be the voice behind the participants' appreciations and the compliments stated.

Two of the participants, although reporting to be satisfied, highlighted two issues that they felt they (as the mental health care users) could benefit from. One of them involves the delay experienced at the filing section of the health care system. They thought some form of improvement plan could be put in place. The second one was the process of rehabilitation. There is the perception that a lot is done to ensure that mental health care users are stabilized, but there seems to be inadequate measures to ensure that these individuals are effectively re-integrated back into the society. An example in this instance could be some rehabilitative programmes specifically designed for them, such as training them in skills acquisition. The following responses attest to that:

"They treat us well; it's just that people are different. You may find one that treats you well. Another one as you arrive … he/she may treat you ... isn't that people can't change their attitudes? Others will treat you well. Aah! They are ok. The problem is … when we arrive at the clerks'. It looks like they are the ones who are not serious about attending to patients … because when you arrive and hand in your card, they will leave it lying there for a long time." [Participant 10]

"But I'm ill. Even now, I'm still ill. But, when I tell them at the hospital that I'm still ill …They say: No. You're not in a state of someone who ... is 'picking up papers'- who therefore needs financial assistance. Then I asked … if there wasn't something they (the doctors) could do to help me find employment? They said: '… you have to look for a job yourself. We can't look for employment on your behalf'. But I'm ill. Even now, I'm still ill. Since I don't know when the illness will recur ..." [Participant 1]

While still under this aspect of the participants' experiences of living with mental illness, the issue was tackled beyond their lives within the mental health care system. This was not explicitly done, but the researcher tried to get the meaning behind their lives as individuals living with mental illness based on what they were stating. The findings suggest that these individuals have some experiences to share. Some of the untold issues include the aftermath of the illness itself in relation to the changes it has brought into their lives - either positive or negative, and what it has taken or given to their lives. There is evidence of negative experiences, and the participants hinted these when explaining their feelings of frustration, and disempowerment. The following quotations tend to provide insight into the situation the researcher has just presented:

"What is bothering me is that I'm constantly asking myself as to whether I'm just going to be ... like this, nothing can come out of me ... It's like I am just a person. It does not mean that my life is over. Yes. That's what makes me to sometimes sit and ask myself what is it that I've done wrong in this world? The fact that I became ill means it is over about me. I find it stressful. It's stressing me." [Participant 7]

"The problem was that I was annoyed because everyone took a decision for me. …It was high time for me to start deciding for myself, as this life is mine and not theirs. Then I had to live my life the way I wanted to. I've had it, I'm enough." [Participant 4]

From these comments, one can deduce that the experiences of these individuals living with mental illness are not positive. From both quotations, the participants appear to experience a sense of being devalued as individuals by their significant others. There could be various reasons behind the significant others' intentions - which could still be positive. This situation, however, tends to create a sense of

disempowerment. In some participants, a state of confusion arises when the individual understands that he/she no longer can perform duties he/she used to perform quite easily prior to the onset of the illness, and it becomes a problem when that very individual is expected to do things that "normal" individuals do.

4.3.7. The role of significant others

What also emerged from this study is that mental illness does not only affect the individual sufferer, but their significant others also, as these people are usually the first to be consulted regarding treatment and advice, especially in the decision-making process about the treatment option to be followed. The reasons may vary from one individual to the next, but appears to include the nature of the disease (the fact that it may tend to bring about some form of impairment in cognitive functioning and as a result the family may think it is deemed necessary for them to intervene) and the general African belief of an interdependent self that finds its existence through others.

In further exploring this issue, half of the participants reported to have consulted a relative as soon as they realized that they were not well. For those whose illness had already impaired their cognitive functioning to a level where they could not even realize the change they were going through, their significant others intervened. Here are some of the quotes in that regard:

"I told the family members. I told my mother, and then she went further and told my uncle." [Participant 1]

"I phoned my mother in Pietersburg and said: Hey! Things are tough and she said: 'Go to so and so…' [Participant 4]

"My mother was there in Gauteng. Yes. She was working there in Gauteng. I told her. She spoke to ... my cousins were there in Gauteng. From my elder aunt. They spoke to her." [Participant 2]

The first three quotations represent a situation in which a decision was taken by the individual sufferer to consult the significant others. The same cannot be said about

the following ones, in which the significant others had to step in without any invitation from the individual experiencing the distress:

"I did not tell anyone, they just saw me setting things alight ... I just set it (the shack) alight and when I saw it burning, they came and I ran away. They found me that side (pointing at the nearby mountain) and took me to Groothoek." [Participant 3]

"… I started by experiencing some … changes ... I could not even walk ... they (the family) realized it immediately and … were able to take me to the hospital." [Participant 6]

4.4. Summary of findings

The sample was composed of ten (10) participants aged between 18 and 59 years, who are receiving mental health care services within the PMHC and have been living with mental illness for approximately 12 years (on average). Almost all the participants are from the local community and are Sepedi-speaking. The majority of the sample falls under the Christian religion, with a few subscribing to African traditional religion. According to the findings of this study, the participants seem to hold varying perceptions and beliefs in as far as the causes of mental illness are concerned. These perceptions appear to be culturally defined. Most participants made use of their own experiences in defining what mental illness is, such as the symptoms experienced during the course of the illness.

This study revealed that various service providers are visited, and highlighted that whether the participant stays at a specific treatment point, or moves to the next, is determined by factors such as recovery and perceived lack of improvement, respectively. The path does not always start at other agencies and end up at the mental health care system, but it can as well start at the mental health care system. What usually inform the decision to start at the mental health care system are factors such as the severity of symptoms or the belief system of the individual sufferer and family members. The services from the mental health care system appear to be generally positive, and other agencies and providers of care are also consulted while the sufferers receive services from the mental health care system.

CHAPTER 5: DISCUSSION OF FINDINGS

5.1. Introduction

This chapter presents and discusses the findings of the study in relation to the literature review and other related information. It also reviews the contribution of the study in terms of the aims set out in chapter 1. These findings will be discussed according to the emerging themes identified in the previous chapter. The findings will also be discussed in terms of their implications for psychological theories on help-seeking behaviour.

5.2. Emerging themes

5.2.1. Participants' subjective notions of the events or factors that could have led to their mental illness

The subjective notions of the participants in the study in terms of the events and factors that could have led to their mental illness indicate that substance use, witchcraft and social stressors were regarded as the cause of their illness. Each specific cause was dependent on the knowledge of the nature of the disease (for example, as learned through health education given at the mental health care system, or knowledge derived from any other agency consulted), one's belief system and particularly own formulations of what could be the cause. Although these individuals have one thing in common, i.e., suffering from a mental disorder, they have their own unique ways of defining what could be the cause of their illness, and these perceptions appear to be culturally defined.

The reason for this state of affairs can be explained in terms of the findings of other studies such as those conducted by Castillo (1997); Kleinman (2004); Ryder et al. (2002); Swartz (1998). In these studies, it is indicated that the perceptions about illness issues, such as diagnosis, cause and treatment are social constructs and thus reflect societal values and norms. These norms and values differ across contexts because of the differences in cultural assumptions about illness (Bojuwoye & Sodi, 2010; de Andrade, 2011; Moodley & Bertrand, 2011; Sodi & Bojuwoye, 2011). As a result, all societies respond to illness in the course of their own development.

The findings further lend support to the views of Leventhal and Nerenz (1985) who stated that culture is a strong determinant of people's perceptions of illness, its perceived causes and treatment options as compared to other personal attributes. In the current study, what was perceived to be the cause of the illness, in a way, shed some light as to the treatment modality to be employed.

5.2.2. Participants' own explanations of mental illness

In this study, participants explained mental illness mostly in terms of their own personal experiences, making use of the symptoms they experienced during the course of their distress. The explanations given varied from general disturbance of the thought processes, poor or lack of insight, impairment in social functioning to somatic complaints.

The findings lend support to the views of Mufamadi (2001) who suggested that there seems to be no clear definition of what is regarded as mental illness. This was based on the fact that most of the participants (traditional healers) in the study defined mental illness in terms of the symptoms exhibited by the patient, thus individualizing the illness. Symptoms such as aggression, uttering incoherently, isolation, shouting, confusion and strange behaviour were considered as common symptoms associated with mental illness. This also corresponds with Buhrman (1982) study which found that traditional healers believe that a person with mental illness will present with various physical and psychological complaints which include restlessness, irritability, aggression and social withdrawal.

5.2.3. Reasons for entering the mental health care system

According to the findings from the study, it is evident that participants moved from one treatment point to the other, whereby this movement was informed by their perceived lack of improvement, or the fact that their symptoms were worsening. On the other hand, their stay at a specific treatment point is also said to be based on one factor, namely, their perceived improvement or remission of symptoms.

The findings from this study are consistent with the previous research findings on patients' patterns of utilization of health services by Hulka and Wheat (1985), where it was noted that evidence exists for a dose-response relationship between need and use: the stronger the need (i.e., the more severe the perceived symptoms), the more

important it is in determining health services use. The findings further support those from the studies by Greenley and Mechanic (1976); Horwitz (1977); Lin et al. (1978); Link and Dohrenwend (1980) that the quality and seriousness of the distress provide the impetus to the pathway, but its direction (sequence of contacts) and duration (time lapse between problems and contacts) is shaped by the convergence of psychosocial and cultural factors. Mechanic's (1968) variables that are known to influence illness behaviour, namely, the nature and quality of symptoms, their visibility and the impact they have on family and social functioning also emerged from this study and appeared to have exerted a significant influence on the choice to enter the mental health care system.

Interestingly, the findings show that the path does not always start at other agencies and end up at the mental health care system, but may as well start at the mental health care system. In that case, the decision to start at the mental health care system appears to be informed by factors such as the severity of the symptoms, for example, manifestation of aggressive behaviour and conditions that rendered the family members incapable of handling the situation. This aspect appears to be in contrast with the results from other African studies that revealed that traditional healers are usually the first source of care people seek when faced with mental health problems, and frequently the only source of care sought (Nsereko et al., 2011) and those that suggested that for many South Africans, the first choice of treatment is the traditional healer (Farrand, 1984; Louw & Pretorius, 1995; Mabunda, 1999; Swartz, 1986).

5.2.4. Pathways followed by the participants before receiving mental health services in the hospital

The findings from the current study show that several other agencies and providers of health care were consulted by participants prior to their visit to the mental health care system including, amongst others, traditional healers, spiritual healers, medical doctors (general practitioners) and mental health care facilities. This concurs with the findings by (Ryan, 1998) where it was revealed that the pathways commonly involve multiple agencies or providers of care such as traditional healers, primary care physicians, providers of alternative medicine, general practitioners and other social

agencies. The treatment facility entered (chosen) has been described to be informed by cultural or belief system of the participant or family.

The study also revealed that the use of traditional and faith healers was shown to be employed by some of the participants. These findings are in line with studies conducted by Karim et al. (1994); Lesolang (2010); Mashamba, Peltzer, Maluleke & Sodi (2011); Nyamongo (2002); Sodi, Mudhovozi, Mashamba, Radzilani-Makatu, Takalani & Mabunda (2011); World Health Organization (1995); and anthropologists that suggest that the use of traditional healers and other alternative health care providers is widespread in the developing world, wherein both the traditional and faith healers seem to operate at an equal level in treating a variety of problems and illnesses including mental disorders. The findings further confirm those of South African studies and other African countries, that highlighted that traditional and faith healers play an important role in health care (Peltzer, 1987; 1998; 1999; Shai-Mahoko, 1996). In other studies conducted in the Limpopo Province by Madu et al. (1997); Mufamadi (2001); Peltzer (2001; 2009) and Sodi (1996; 1998), it was also revealed that there is a considerable use of indigenous and faith healing systems in the treatment of mental disorders and other conditions of ill-health by community members.

Other studies conducted within the province by Peltzer (1999, 2001); Pronyk et al. (2001) on faith healing for mental and social disorders, and assessing the health-seeking behaviour of patients suffering from tuberculosis, respectively, indicated that there are two major independent movements that practice faith healing and appear to be contributing towards health care in South Africa, namely the Apostolics and Zionists. These findings also emerged from the current study.

Most of the participants in this study, however, reported to have entered the mental health care facility as their initial treatment point and the decision was mostly informed by the severity of symptoms, such as the manifestation of aggressive behaviour. Some participants found themselves having to visit quite a number of treatment points (ranging from 2 to 5) before their distress could be minimized or completely alleviated. This suggests that the pathway can be complex and longer in

some cases, depending on the response of the illness/symptoms to the intervention at a specific treatment point.

5.2.5. Concurrent use of hospital mental health services and other services

Previous studies conducted have shown that African people will simultaneously access the services of Western and traditional healers for the same symptoms based on the cultural conception that an illness is both physical and spiritual (Berg, 2003). In South Africa it has been indicated by some studies that the nature of how the illness is perceived appears complex, thus making help-seeking pathways not to be predictable and linear. These pathways may include back and forward movement between Western and traditional health care systems. Another area to be explored for the current study was whether there are other agencies and providers of health care that these participants could be using, while they are in the mental health care system. From the findings, it is evident that other agencies and providers of health care are also being used by some participants. The reasons behind the use of multiple agencies vary from individual to individual and involve enhancement of the current treatment and serving a protective role.

This was also confirmed by research findings by Case et al. (2005) that examined patterns of health-seeking behaviour among individuals in KwaZulu-Natal. These researchers found that traditional healers were consulted by almost half of the sample. It was further found that almost all of those who consulted traditional healers also consulted a Western medical practitioner. From these findings, it was deduced that the services provided by traditional healers appear to be complementary to, rather than substitutes for, those provided by public and private doctors.

The findings from the current study concur with those by Peterson (2004) who suggested that that people use traditional healing and allopathic medicine together and even simultaneously, but sometimes without the knowledge of their doctors. This picture also emerged from the study in the area of perception of illness that people from African background use both Western and traditional health simultaneously because they are perceived to be complementary and as targeting different aspects of the illness (Holdstock, 2000; Swartz, 1998).

5.2.6. Experiences of living with mental illness

In their study on Stakeholder's perceptions of help-seeking behaviour among people with mental health problems in Uganda, Nsereko et al. (2011) indicate that the way in which care is delivered is a major influencing factor in help-seeking behaviour. This was based on the fact that respondents, particularly mental health care users in the study described the manner in which patients were dealt with by conventional mental health care practitioners as "hostile" and unkind, often "calling patients bad names" and "spending very little time" with their patients.

In the current study, the participants' experiences of living with mental illness were explored in relation to the services they were receiving from the mental health care system. Contrary to the afore-mentioned, almost all the participants reported that they had generally positive experiences of being in the mental health care system, describing the health care intervention strategies implemented as being satisfactory. These findings support those from previous studies conducted in Durban (South Africa) by Almeida and Adejumo (2004) on consumer evaluation of the delivery and aspects of services provided.

From the current study, two issues were highlighted by a few participants who felt it could be beneficial to all the health care users in the system, if given attention. These issues are delays experienced at the filing section of the health care system and the lack of rehabilitation programme, especially for the mental health care users. The latter appears to be aligned with some challenges experienced in the study by Nsereko et al. (2011) where there were reports that the patients' social life or welfare and other problems that might affect their wellbeing are rarely looked into by the conventional medical staff.

Furthermore, this aspect of the participants' experiences of living with mental illness was tackled beyond their lives within the mental health care system. The findings suggest that these individuals are living with the aftermath of the illness itself, in relation to the changes it has brought to their lives. There is evidence of negative experiences that were expressed by feelings of frustration, and disempowerment.

These findings were reported in previous studies that many people with serious mental illness are challenged doubly. On the one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are

challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people (Corringan & Warson, 2002).

These were also supported by a study by Murthy (2002), which emphasizes that whichever way you look at the issue at hand, stigmatization of mental illness probably exists everywhere, even though the form and nature of it may differ across cultures

5.2.7. The role of significant others

From this study what also emerged was the psychological theme about the involvement of the significant others of the participants, as these people are usually the first to be consulted regarding treatment and advice especially in the decision-making process about the treatment option to be followed. The reasons behind this state of affairs may vary from one individual to the next, but appears to include the nature of the disease (the fact that it may tend to bring about some form of impairment in cognitive functioning and as a result the family may think it is deemed necessary for them to intervene) and the general African belief of an interdependent self that finds its existence through others.

When exploring on this issue, half of the participants reported to have consulted a relative as soon as they realized that they were not well. For those whose illness have already impaired their cognitive functioning to a level where they couldn't even realize the change they were going through, their significant others intervened and took the lead.

In support of these findings are those from a previous study by WHO (2010), which point out that regardless of the type of the illness, family members are usually the first to be consulted regarding treatment and advice. Similar results were found by Nsamenang, (2000) who observed that as far as help-seeking behaviour of health care users is concerned, consultation starts within the family. The researcher further asserts that this practice is crucial because illness is not only about the individual; it is a family issue.

5.3. Implications for Theory

5.3.1. The Distress-Appraisal-Action Model

According to the Distress-Appraisal-Action Model, help-seeking behaviour is characterized by one or more Distress-Appraisal-Action cycles, where initial appraisals involving the self, significant others and other "lay consultants" may precede medical consultation. The help-seeking process, i.e. the pathway involving a sequence of medical and non-medical contacts, ends when the distress or the problem perceived as causing it has been alleviated (Lazarus, 1966).

The findings from the current study are in line with this model. The cycles highlighted by the model were also observed in the current study. Some participants (specifically those whose loss of contact with reality was gradual at the onset) made their significant others aware of the nature of the discomfort or state of un-wellness they experienced and this in most cases led to them seeking intervention from other providers of health care. The study further revealed another part of the cycle whereby the participants would stay at a specific treatment point only if they realized that there was general improvement or recovery from their symptoms.

The same pattern of reaction, or what the model refers to as the cycles, was also observed amongst the participants whose illness was acute, giving rise to sudden loss of contact with reality. In this instance, the significant others would still try out other alternative forms of intervention and then proceed for medical intervention when their first choice of intervention had failed to yield the desired outcomes.

5.3.2. The Pathway Model

The pathway model centres on the path that people follow until they use different health services (home treatment, traditional healer, biomedical facility). This model stresses the importance of "significant others" in the decision-making process of seeking treatment (Good, 1987). The "significant others" are regarded by Janzen (1978) as part of the "therapy managing group", which is the key for understanding decision-making in therapeutic processes. This idea stresses the pivotal role of extended groups of relatives and friends in illness negotiation and management.

The researcher in the current study is also of the opinion that the significant others play a key role in the decision-making process and management of the illness. This is based on the findings that as soon as an individual realizes that he/she is "unwell", or is observed to be having some form of behaviour that is suggestive of being mentally ill, he/she will tell a significant other, or the significant other who made such a discovery will inform others. This could be a parent or a sibling and the matter is then discussed with other significant others before a decision is taken about the treatment modality to be followed. This model seems to be relevant to this study in the sense that other forms of mental illness have a tendency of impairing one's cognitive functioning, for example the thought processes. In such situations, the significant others are the ones who become actively involved in the decision-making process as to decide on the intervention that the individual will follow. Pathway models therefore, acknowledge these dynamics of illness and decision-making.

CHAPTER 6: SUMMARY AND CONCLUSION

6.1. Summary

This study has investigated the help-seeking pathways followed by patients in Polokwane-Mankweng Hospital Complex suffering from mental disorders. Individuals suffering from mental disorders were, in particular, given the opportunity to talk about their subjective experiences of mental disorders. The study does reveal that there are various factors such as perceptions about what causes mental illness and these perceptions are, by and large, culturally-rooted. The study also illustrates that various agencies and providers of health care are visited by individuals suffering from mental illness and the path appears to vary according to the individual's belief system and the nature of the symptoms. Furthermore, the study also revealed that perceived lack of improvement by either the patient or his/her family served as an impetus for them to move to the next treatment point, and staying at one point was associated with some form of alleviation of the symptoms or distress. With the information obtained from the respondents, it can be deduced that individuals have a different understanding of what mental illness is and explanations vary from one individual to another. The findings also revealed that there is a dual/multiple use of services, i.e., Western and African, and that the sufferers' general experiences about the services provided by the mental health care facility appear generally positive.

Another important aspect discovered by the study is that the family plays an important role as far as help-seeking pathways are concerned. The study has, in a way, created an avenue for learning, especially for health care providers of patients suffering from mental disorders. These findings could assist them to have an understanding of the multifaceted journey patients take in the process of seeking treatment. This avenue can further be extended to the authorities, namely the policy makers in the Department of Health in coming up with culturally-sensitive health care intervention strategies. Finally, the researcher in this study concludes by asserting that all the objectives of the study have been met and also that the findings of the study are supportive of other research findings and theoretical perspectives.

6.2. Limitations of the study

The researcher is aware of the considerable limitations of this study. Firstly, translating the interview data from Sepedi into English might have led to omissions or inappropriate substitutions of the original rich material provided by the participants.

Secondly, this study relied only on the patients' subjective experiences and perceptions of their illness and the pathways followed in order to ease their distress. Other people (for example, their significant others) were not interviewed and as such, the present study gave a one-sided interpretation of the phenomenon.

Thirdly, the present study did not tap on other areas such as the experiences and perceptions of health care providers about the phenomenon under discussion and as such, could be seen as exploratory in nature, pointing to areas that need further research.

Lastly, the results of this study cannot be generalized to the larger South African population since the study was conducted on the sample of patients receiving mental health care services within the two tertiary hospitals of Limpopo Province. If perhaps other district and regional hospitals in the province were included, the scope would have been broadened, thus making it appropriate to generalize the results to the entire province.

6.3. Contributions and Recommendations

The findings of the present study emphasize that help-seeking pathways are mainly determined by the perceived causes of the illness, which are derived from cultural ideologies. Against this background, culture may be viewed as some form of a lens by which people experience, make sense of and react to their illness. Furthermore, it should be noted that individuals might be receiving Westernized mental health care services, but they are not "completely Westernised" (Green, Bradby, Chan & Lee, 2006). Rather, they adopt this approach in order to complement and maximize their available resources.

The current study has made a contribution to the literature on mental illness by providing a qualitative insight into the pathways followed by mental health care users in seeking for treatment and may be summarized as follows:

- The findings of the current study have shed some light into areas of further research. From these findings, further research needs to be conducted. A much bigger sample needs to be used, though, for example in other institutions to enable the generalizability of the findings to the entire province.

- It appears, rather, difficult at the moment for the relationship between traditional healers and Western professionals to be strengthened, but acknowledgement of the existence of each approach might yield some positive outcome in terms of the management of the dual nature of the illness.

Therefore, the following recommendations are made:

- It is crucial to bring this understanding to the fore as it may have a great impact on the diagnosis and treatment of the illness, therapeutic alliance and the clinical outcomes. From the aforementioned, a view to an illness therefore requires a holistic and integrated approach that can cater for both the spiritual and medical element of the distress.
- Policy makers in this regard should understand that irrespective of the social, political and economic changes in the country, culture still forms the basis for subjective experience of distress.
- It would be beneficial to both the mental health care providers and mental health care users if in future, communities and consumers could be included in the development and decision-making of policies, programmes and services. This would lead to ideally culturally-appropriate mental health care services that have been tailored to people's needs and are better used.
- It is also recommended that the issue of psychosocial rehabilitation be looked into and addressed. This is a comprehensive process that will offer individuals who are impaired, disabled or handicapped by a mental disorder to reach their optimal level of independent functioning in the community.

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APPENDICES

Appendix 1(a): Interview guide

1. As an individual who has been diagnosed as suffering from mental illness, I would like you to share with me your own understanding of events and factors that could have led to your mental illness.

2. I also would like you to explain, according to your own understanding and experiences, what mental illness is.

3. After realizing that you were ill, where did you go in order to seek help, that is before going to the hospital?

4. Would you explain to me what led you to come to the mental health care system?

5. Since you have been receiving services from this facility, how would you describe your own experiences of being in the mental health care system?

6. What other agencies and providers of health care are you using currently, while you are receiving services from the mental health care system?

Appendix 1(b): Interview guide in Sepedi

1. Bjale ka motho yo a nago le bolwetši bja monagano, ke kgopela gore le mpotše go ya ka kwešišo ya lena gore ke eng seo se ka ba se dirile gore le lwale monagano.

2. Ke rata gore le hlalose go ya ka tsebo le kwešišo ya lena gore bolwetši bja monagano ke eng?

3. Morago ga go lemoga gore le a lwala, le ile la ya kae e le go nyaka thušo pele le tla bookelong?

4. A ke le nhlalosetše gore ke eng seo se dirileg gore le feleletše le tla mo lefelong le la kabo ya tša maphelo.

5. Ga e sale le humana thušo ya tša kalafo go tšwa lefelong le, nhlalošetšeng ka tšeo le kopanego le tšona bjalo ka mošomiši wa kabo ya ditirelo tša monagano.

6. Ke mafelo afe ao a le thušago mabapi le bolwetši bja lena, ntle le mo bookelong?

Appendix 2 (a): Participant consent letter and form

Department of Psychology

University of Limpopo (Turfloop Campus)

Private Bag X1106

Sovenga

0727

Date_____

Dear Participant,

Thank you for showing interest in this study that focuses on help seeking pathways followed by patients receiving mental health care services in Polokwane-Mankweng Hospital Complex. The purpose of this study is to understand the pathways followed by these individuals and their subjective understanding and experiences of mental illness.

Your responses to this interview will remain strictly confidential. The researcher will attempt not to identify you with the responses you gave during the interview or disclose your name as a participant in the study. Please be advised that your participation in this study is voluntary and that you have the right to terminate your participation at any time.

Kindly answer all the questions as truthful as possible. Your participation in this research is very important. Thank you for your time.

Yours Sincerely

_____   _____

Matlou Shai   Date

Masters Student

_____   _____

Prof. T. Sodi   Date

Supervisor

Appendix 2 (b): Participant Consent letter and form in Sepedi

Department of Psychology

University of Limpopo (Turfloop Campus)

Private Bag X1106

Sovenga

0727

Date_____

Motšeakarolo

Ke leboga go bontšha kgahlego ga lena go lesolo le la go nyakišiša ka ditsela tšeo di latetšwego ke batho bao ba humanago thušo ya tša kalafo ya monagano mo maokeleng a mohlakanelwa a Polokwane-Mankweng. Maikemišetšo a lesolo le ke go kwišiša leeto leo balwetši ba ba le tšerego, maitemogelo le kwešišo ya bona ka bolwetši bja monagano.

Dikarabo tša lena go diputšišo tše di tla tshwarwa ka mokgwa wa sephiri. Monyakišiši o tla leka ka mešegofela gore a seke a le amanya le dikarabo tše le tla di fago, le ge ele go se utulle leina la lena bjalo ka motšeakarolo lesolong le. Le tsebišwa gore go tšea karolo ga lena go lesolo le go dirwa ka boithaopo, le gore le nale tokelo ya go ikgogela morago nako efe goba efe.

Le kgopelwa go araba diputšišo tše ka botshephegi bjo bogolo. Go tšea karolo ga lena go lesolo le go bohlokwa kudu. Ke leboga nako ya lena.

Wa lena

_____   _____

Matlou Shai   Letšatšikgwedi

Masters Student

_____   _____

Prof. T. Sodi   Letšatšikgwedi

Supervisor

Appendix 3 (a): Consent form to be signed by the participant

Consent Form

I_____ hereby agree to participate in a Masters research project that focuses on help seeking pathways followed by patients receiving mental health care services in Polokwane-Mankweng Hospital Complex.

The purpose of this study has been fully explained to me. I further understand that I am participating freely and without being forced in any way to do so. I also understand that I can terminate my participation in this study at any point should I not want to continue and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally. I am aware also that my details as they appear in this consent form will not be linked to the interview schedule and that my answers will remain confidential.

Signature: _____

Date: _____

Appendix 3 (b): Consent form in Sepedi to be signed by the participant

Foromo ya tumelelo

Nna _____ ke dumela go tšea karolo go lesolo la go nyakišiša ka ditsela tšeo di latetšwego ke batho bao ba humanago thušo ya tša kalafo ya monagano mo maokeleng a mohlakanelwa a Polokwane-Mankweng, la dithuto tša Masters.

Ke hlaloseditšwe ka maikemišetšo a lesolo le, ebile ke kwešiša gore ke tšea karolo ka go ithaopa gape ntle le go gapeletšwa. Ke kwešiša gore nka ikgogela morago go tšea karolo lesolong le nako efe le efe ge nka kwa ke sa nyake go tšwela pele, le gore kgato yeo e ka se nkame ga mpe.

Ke kwišiša gore maikemišetšo a lesolo le ga se go nthuša ka bo nna, le gore leina la ka le ge e ka ba ditaba tše di filwego ka nna di ka se utullwe (di tla šireletšwa).

Signature: _____

Letšatšikgwedi: _____

Department of Psychology

University of Limpopo (Turfloop Campus)

Private Bag X1106

Sovenga

0727

Date_____

The chief Executive Officer

Department Of Health and Social Development

Polokwane-Mankweng Hospital Complex

Private Bag X1117

Sovenga

0727

Re: Permission to conduct research within the Polokwane-Mankweng Hospital Complex

I am a registered student in the above- mentioned institution. As part of the requirement for the Master's degree in Psychology, I am doing a research project. The title of the research project is: **An exploration of Help-Seeking Pathways Followed by Patients Receiving Mental Health Care Services in Polokwane-Mankweng Hospital Complex.** The purpose of the study is to explore the pathways followed by these individuals and their subjective understanding and experiences of mental illness.

I hereby apply to be granted permission to conduct this research within the Polokwane-Mankweng Hospital Complex. It is important to point out that the researcher undertakes to maintain confidentiality regarding the identity of the participants in this research project. The participants will be assured about the voluntary nature of this study. Further, the participants   are free to withdraw from the study at any time should they wish to do so.

The method of data collection will be semi-structured one-to-one interviews with individuals receiving mental health care services in the Polokwane-Mankweng Hospital Complex.

Yours Sincerely

_____   _____

Ms Matlou Shai   Date
Masters Student

_____   _____

Prof. Tholene Sodi   Date
Supervisor