

**Mental Health Literacy: Knowledge and beliefs about mental illness amongst indigenous African residents of Dihlabeng Local Municipality in the Free State**

By

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### **Declaration**

I, Nonhlanhla Faith-Crescentia Matsoele declare that this dissertation hereby submitted by me for the Magister Artium degree (Clinical Psychology) at the University of the Free State is my own independent work and has not previously been submitted by me to another university/faculty. I furthermore cede copyright of this dissertation in favour of the University of the Free State.

\_\_Nonhlanhla Matsoele\_\_

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## Abstract

For many years mental illness has been on the rise globally, internationally and locally. This could be attributed to a lack of mental health literacy, which contributes significantly to the disease burden and leads to healthcare delays, poor adherence to treatment and patient 'dropout' from healthcare services. This is true for many indigenous African societies who conceptualise mental illness based on their explanatory models of illness rather than according to western psychiatric nosology. While research seeks to explore and improve mental health literacy among the population, such studies remain limited in Africa. Therefore, this research study aimed to investigate mental health literacy among the indigenous African residents of Dihlabeng Local Municipality in the Free State.

This study explored conceptions about three mental disorders, namely, depression, schizophrenia, and alcohol use disorder, as well as beliefs about their treatment. A quantitative design using a survey method was utilised, and a sample was drawn from two towns in Dihlabeng Local Municipality (Bethlehem and Fouriesburg). 240 indigenous Africans were recruited by the use of a randomised public recruitment strategy using a sample size calculator and they completed a self-administered questionnaire. Data were analysed using Statistical Package for Social Sciences (SPSS) for Windows, Version 28.0.

In consolidating the findings of this study, the results revealed several explanatory models, which included western and traditional explanations. Most participants did not use scientifically approved terms to conceptualise mental disorders but phrases relative to their respective contexts. The bulk of the participants conceptualised disorders as psychological. The results also showed the orderly manner in which the community's conceptualisation of mental illness was categorised in terms of psychological, social, medical, traditional and religious concepts. The traditional conceptualisation provided an exciting finding for schizophrenia.

In addition, perceptions of mental illness were significantly related to participants' treatment beliefs. In terms of treatment, more participants were inclined to seek professional help and have someone who would listen to/talk to/support them. Interestingly, participants who expressed belief in seeking professional help for mental illness also reported professional-oriented (medical, social and psychological) causes of mental illness. In contrast, those who

expressed beliefs in traditional forms of treatment for schizophrenia reported on traditional causes of mental illness.

Lastly, the study also revealed a positive relationship between etiological and treatment beliefs for mental disorders among the participants, indicating a positive relationship between what participants believe to be the causes of mental illness. Their belief influences their preference of how best to treat mental illness. The outcomes of this study signify the importance of mental health literacy campaigns, a collaboration between traditional and medical practitioners, and increasing mental health services in communities. Further explorations of mental health literacy, specifically from an African indigenous perspective, are recommended for future research.

**Keywords:** African worldview, mental health literacy, alcohol use disorder, depression, schizophrenia

## 1. Introduction

The prevalence of mental illness is increasing internationally (Polanczyk et al., 2015) and South Africa (Herman et al., 2009). According to the Global Burden of Disease Collaborative Network (2018), approximately 970 million people worldwide have a mental illness. The prevalence rate of mental disorders in South Africa was 12.78% in 2019 (Onuh et al., 2021), with a lifetime prevalence of common mental illness in South Africa being 30.3% (Bhana et al., 2019). In a 12-month survey of mental disorders in South Africa, the most common mental disorders were anxiety (15.8%), followed by substance use (13.3%) and mood disorders (9.8%). Neuropsychiatric disorders rank third in terms of their contribution to the burden of disease after human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and other infectious diseases (Jacob & Coetzee, 2018).

Mental health refers to a state of well-being in which an individual recognises their abilities, can cope with the everyday stresses of life, work productively and contribute to their community (WHO, 2019). On the other hand, mental illness is a syndrome characterised by a clinically significant disturbance in a person's cognition, emotional regulation, or behaviour that reflects a dysfunction in the psychological, biological or developmental processes underlying psychological functioning (American Psychiatric Association [APA], 2013). However, Walker (2006) cautions that what may be dysfunctional to a particular group of people may be normal to others. Furthermore, their cultural worldviews influence people's conceptions of mental illness. Therefore, the cultural and developmental contexts of all health issues need to be considered before assigning the constructs of health or illness (Walker, 2006).

According to Bhui and Bhugra (2007), culture is a way of life that includes the values, practises, customs and beliefs that form an intricate system. As such, culture encompasses all human-constructed ideas, including those of mental illness (Bhui & Bhugra, 2007). More specifically, indigenous beliefs about illness influence people's perceptions, experiences and ways of coping. Indigenous views play a fundamental role in conceptualising psychopathology's aetiology, presentation and treatment outcomes (Mosotho et al., 2011). Kometsi et al. (2020) stated that people are not ignorant of mental illness and conceptualise mental illness based on indigenous explanatory models informed by their worldview.

According to the Africentric worldview, individuals' perceptions of reality depend on their cultural beliefs, ideas, values, conceptions of time, and cause and effect (Thabede, 2008). Therefore, using the biomedical perspective alone is insufficient for clinicians to understand people's experiences of mental illness from their worldview, as this can determine individuals' behaviour, treatment and response to treatment, argues (Kometsi et al., 2020). According to Jorm (2012), improved mental health literacy can indicate the likelihood that individuals will access, understand and use the information to promote and maintain good mental health.

The term mental health literacy was first coined by Jorm et al. (2005) and refers to the knowledge and beliefs about mental disorders that promote the prevention, recognition and treatment of disorders. According to Jorm et al. (2005), this knowledge and beliefs should include accurate and appropriate information about mental disorders, such as their aetiology, risk factors, recognition, conceptualisation, and methods of treatment and help. Evidence shows that most of the public does not correctly recognise the symptoms of mental illness (Altweck et al., 2015). Improved knowledge about mental health and awareness of how to seek help and treatment leads to the prevention of mental health problems. This can promote early detection of mental disorders, which improves mental health outcomes and increase the use of health services (Furnham & Swami, 2018). Kometsi et al. (2020) argue that inadequate mental health literacy is a serious barrier to care for patients with mental illness.

Swartz and Kilian (2014) point out that the provision of mental health services remains inadequate, with only one in four people with a common mental disorder receiving treatment (Petersen et al., 2016). Apart from providing mental health services, Jorm (1997) argues that better mental health in the community depends on the mental health literacy of the population. According to Henderson et al. (2013), a lack of mental health literacy contributes significantly to developing countries' disease burden. In addition, inadequate mental health literacy can support negative beliefs and stigmatising attitudes towards mental illness (Chipps et al., 2015). According to Kutcher et al. (2016), this can lead to mental health patients delaying appropriate health care, poor adherence to treatment and dropout from services.

While research continues to seek to explore and improve mental health literacy among the population, Atilola (2016) argues that such studies remain limited in Africa. Therefore, this research aims to contribute to South African mental health literacy studies.

### **1.1. Research aim and objectives**

The proposed study investigates mental health literacy among the indigenous African residents of Dihlabeng Local Municipality in the Free State. The following objectives are derived from the aims of this study.

1. To investigate participants' conceptualisation of mental illness.
2. To investigate the participants' knowledge and beliefs about the aetiology and treatment of mental disorders.
3. To investigate the relationship between aetiological and treatment beliefs.

### **1.2. Rationale and contribution of the study**

This study will add value to research on mental health literacy among indigenous Africans, particularly regarding the conceptualisation of mental illness, knowledge, and beliefs about the aetiology and treatment of mental disorders, as well as the relationship between aetiological and treatment beliefs. The study will further contribute to understanding the presentation of mental illness from indigenous South African's explanatory model of illness, an area of study in South Africa. It may contribute new insights into less explored areas of mental health literacy, particularly from an African perspective.

## 2. Literature Review

### 2.1. The prevalence of mental illness

Globally, mental illness is rising (Jacob & Coetzee, 2018). The World Health Organisation (WHO) estimates that in most countries, more than one-third of people meet the criteria for a mental illness during their lifetime (WHO, 2011). The Institute for Health Metrics and Evaluation (2018) reports that nearly 970 million people worldwide experience mental or behavioural disorders. Globally, 264 million people suffer from depression, 50 million from dementia, 45 million from bipolar disorder and 20 million from schizophrenia and psychosis (WHO, 2019). The prevalence of common mental disorders in developing countries was reported by Kutcher et al. (2016) to be similar to those in developed countries.

In Africa, mental health difficulties appear to increase (WHO, 2018). Although between 2000 and 2015, the African population spread by 49%, the years lost to disability as a product of mental and substance use disorders increased by 52%. In 2015, 17.9 million years were lost to ill health because of mental health struggles (Sankoh et al., 2018). Such illnesses were almost as significant a cause of years lost to disability as were infectious and parasitic diseases (WHO, 2018). A community study from rural Uganda obtained the following statistics on prevalence: Depression 9.3%, Anxiety 8.5%, Bipolar disorder 4.9%, and Schizophrenia 1.5%. In a study of the Kabarole district of Uganda, Kasoro and others discovered that 30.7% of adults had psychiatric illnesses (Abbo et al., 2009). In Ethiopia, schizophrenia and depression are rated as the top ten contributors to the disease burden (Abera et al., 2014). Nigeria has a global human rights crisis in mental health (Ugochukwu et al., 2020). Statistics suggest that roughly 80% of people with severe mental health needs do not receive care. This crisis is also seen in South Africa, which has more than twice the lifetime prevalence of mental and substance use disorders than in Nigeria (12.0%) (Jack et al., 2014).

In 2018, data presented by the South African College of Applied Psychology proposed that one in six South Africans experiences depression, anxiety, or a substance use disorder, 40% of South Africans living with HIV develop a comorbid mental illness, 41% of pregnant women experience depression, approximately 60% of South Africans might be suffering from post-traumatic stress, while only 27% of South Africans with severe mental disorders receive treatment. Despite the rates of mental disorders in South Africa, Mkhize and Kometsi (2008)

argue that society still lacks access to mental health services and inadequate mental health service provision (Swartz & Kilian, 2014).

Africa has the highest number of low-and middle-income countries, and the disease burden of mental health disorders lies more heavily than in the rest of the world (De Kock & Pillay, 2018). However, more than 85% of people experiencing mental health disorders do not receive treatment (De Kock & Pillay, 2018). The fact that only 27% of those with severe mental disorders receive treatment is a sign of how mental illness has been overlooked by the health system in South Africa (Nguse & Wassenaar, 2021).

## **2.2.Factors that impact access to treatment of mental illness**

Despite various effective treatments worldwide, more than 70% of people with mental and behavioural disorders do not receive professional mental health treatment (Henderson et al., 2013). Furthermore, approximately 76% of people with severe mental illness in low-income countries do not receive treatment for 12 months (Petersen et al., 2017). Therefore, it is essential to review factors that may impact access to treatment for those with mental illness to address the existing problems (Sarikhani et al., 2021). While there are numerous factors, those relevant to the scope of the current study are lack of resources, lack of income or finances, and stigma.

### **2.2.1. Lack of resources**

According to Louw (2019), there is a lack of mental health professionals and training facilities for psychiatrists, clinical psychologists, psychiatric nurses, and occupational therapists in South Africa. Docrat et al. (2019) found that there is an average of 0.31 public psychiatrists per 100 000 uninsured population in the public sector, with the Western Cape reporting the highest availability of psychiatrists at 0.89 psychiatrists per 100 000 uninsured population and Mpumalanga reporting the lowest rate at 0.08 psychiatrists per 100 000 uninsured population. Furthermore, there remains a critical shortage of child psychiatrists; only three of South Africa's nine provinces, Western Cape, Free State, and Gauteng, have child psychiatrists working in the public sector (Docrat et al., 2019). In addition, there were 0.97 psychologists, senior clinical psychologists, and principal psychologists in the public sector per 100 000 uninsured residents (Kim et al., 2020). The availability of medical support staff crucial to rehabilitative care and support services was also low: 1.53 occupational therapists in the

public sector, 1.07 speech therapists and audiologists in the public sector, and 1.83 social workers per 100 000 uninsured residents (Kim et al., 2020). Due to a lack of resources, the Department of Health is struggling with a shortage of treatment facilities to serve the mentally ill population (Louw, 2019).

In addition, mental health services are scarce in rural areas of South Africa (Vergunst, 2018). The inaccessibility of mental health specialists in various locations is a recurring barrier to accessing mental health services (Sarikhani et al., 2021). This situation was described as "dehumanising" in the 2015 South African Campaign for Rural Mental Health report (Vergunst, 2018). Evidence implies that only 27% of South Africans with severe mental disorders receive treatment (Nguse & Wassenaar, 2021). This may be due to the centralisation of mental health services in urban centres, specifically tertiary hospitals, resulting in rural communities being neglected (Petersen et al., 2012).

In contrast to those with more rural districts, provinces with more urban districts have a high percentage of mental healthcare professionals working in the public sector (De Kock & Pillay, 2018). Geographic inequalities of this nature are continually reinforced and intensified by the movement of healthcare specialists, particularly from rural to urban centres. The geographical distribution of the healthcare workforce governs accessible services and their quantity and quality (Van Rensburg, 2016). People in need of healthcare are, of necessity, referred to the nearest city, which has a cost and transport implications.

Many patients cannot afford to travel to access care due to their already existing burden of low socio-economic status (Syed et al., 2013). These imbalances contribute to problems of equity or efficiency and effectiveness of services, plus the satisfaction of users (Dussault & Franceschini, 2006). Therefore, the consequences of the lack of mental health facilities in terms of providing care for patients with mental health disorders in rural areas are extensive. The effects of a lack of mental health care are personal suffering, premature mortality, poor physical health, experiences of stigma and discrimination, poverty, and abuse (Abera et al., 2014).

### **2.2.2. Lack of income/finances**

A correlation between poverty and mental health has been noted, with mental illness more prevalent among the poor (Mungai & Bayat, 2019). Due to the high unemployment rate, many

South African households rely solely on social grants as their only source of income (Ragie et al., 2020). Healthcare facilities are often out of reach for many patients who lack personal transportation or access to affordable public transportation (Syed et al., 2013). The facilities usually within reach include high consultation fees, making them inaccessible for most South Africans. The high transportation costs and the distances involved lead to patients presenting late with mental disease because they seek help from informal sources that are considered affordable (Syed et al., 2013). This theme supports the argument in the theory of planned behaviour that external control factors, such as finances, can impact professional help-seeking behaviour (Ajzen, 2020). Not only does the poverty increase the risk of mental illness, but it also includes a discriminatory factor that further increases the risk of stigmatising attitudes in communities due to the inaccessibility of treatment (Shrivastava et al., 2012).

### **2.2.3. Stigma**

Thornicroft et al. (2007) argue that stigmatising people with mental disorders can result in a family's reluctance to take them for treatment at specialised mental health care facilities, fearing that they will be labelled negatively based on association. Stigmatising public attitudes negatively impacts the prevention, treatment, rehabilitation, and quality of life of those affected by mental disorders (Barke et al., 2011). Society and mental health professionals similarly stigmatize people with mental health disorders (Kaur et al., 2021). The most consistent stereotype expressed by health professionals was that of mentally ill patients presenting as aggressive, violent, dangerous, and lacking self-control (Shrivastava et al., 2012). In addition, some health professionals do not consider specific categories of mental illness, such as alcohol use disorder, anxiety, and depression, as psychiatric diagnoses because they are so common (Koschorke et al., 2021). Consistent with undermining certain mental illnesses, some professionals deem mental illness incurable (Koschorke et al., 2021). This is due to the belief that pharmacological treatment is ineffective as most patients are on lifelong treatment (Carvajal, 2022). Mohamed-Kaloo and Laher (2014) maintain that limited mental health literacy among health professionals perpetuates the stigmatisation of mentally ill patients in global communities.

### **2.3.Mental health literacy**

Mental health literacy is the knowledge and beliefs about mental health disorders that can be applied to preventing, recognising, and treating mental disorders (Jorm et al., 1997). This

knowledge and belief should incorporate accurate and adequate information regarding mental disorders, such as their aetiology, risk factors, recognition, conceptualisation, treatment, and help-seeking methods. Mental health literacy also promotes early identification of mental disorders by presenting knowledge of signs and symptoms contributing to preventing mental health issues (Bonabi et al., 2016). In addition, understanding mental disorders increase awareness of how to seek help and treatment from health services (psychological and pharmacological) to maintain positive health (Brijnath et al., 2016). Finally, mental health literacy should be based on practical knowledge that can be effectively integrated into existing social and organisational structures, such as schools and community organizations (Kutcher et al., 2016). Therefore, mental health literacy is critical because it seeks to empower people to take appropriate action to maintain their mental health or assist others in need (Jorm & Kitchener, 2011).

### **2.3.1. The importance of mental health literacy**

Jorm et al. (2005) indicate that higher levels of mental health literacy are associated with less stigma attached to mental illness or directed at those who are mentally ill. Mental health literacy can increase the public's confidence in their ability to recognise mental illness, seek professional help, and assist other people with mental health problems (Hagen et al., 2020). A high level of mental health literacy can significantly contribute to closing the mental health treatment gap (Weiss et al., 2005).

Mental health literacy could have a positive impact on policy creation. An example of the desired impact has occurred in Australia's National Mental Health Plan, which now includes the Key Action of "Work with schools, workplaces, and communities to deliver programs to improve mental health literacy" (Jorm, 2015). Mental health literacy also features in plans for other jurisdictions (BC Mental Health and Substance Use Services, 2013; Queensland Government, 2008). The Australian government has also supported the national monitoring of mental health literacy with subsequent surveys in 2011. This monitoring, provided since 1995, has demonstrated substantial improvements in the population's mental health literacy, and considerably reduced gaps between public and professional views (Reavley & Jorm, 2011). This may be beneficial in the South African context. Implementation of adequate monitoring could reduce the rates of mental illness, and increased mental health literacy could ensure that

individuals have access to, understand, and use information in ways that promote and maintain good mental health (Jorm, 2000).

In addition, mental health literacy is a necessary foundation for mental health promotion and interventions (Bjørnsen et al., 2017). Exposing people to effective mental health literacy programs can be a fundamental first step in addressing various mental health-related interventions (Mcluckie et al., 2014). From a public health perspective, interventions that prevent mental disorders and promote mental well-being are essential for reducing mental disorders' health and social and economic burden (Arango et al., 2018). An ideal setting for interventions would be schools because most children and young people spend a large amount of their time at school, and school staff is often the first connection for children and young people seeking help for mental health concerns (Abdinasir, 2019). Schools can also reach people in communities with marginalised groups who experience higher rates of mental disorders (McGinnity et al., 2005) and improve the overall accessibility of mental health services (Thorley, 2016).

An example would be *Mental Health First Aid*, a training intervention modelled on physical first aid training designed to increase the public's mental health literacy. Numerous evaluation studies have proven that the program improves mental health literacy (Jorm & Kitchener, 2011). In addition, the program has been successful in its rollout, with over 1% of the Australian adult population trained, and the program has spread to over 20 other countries (Jorm & Kitchener, 2011).

Mental health literacy can also tailor measures to meet intervention aims (Nobre et al., 2021). This creates domain-specific assessments, which are critical in evaluating interventions (Simkiss et al., 2020). When an intervention is developed to improve some aspect of mental health literacy, it needs to be evaluated with measures relevant to the intervention's specific aims. A generic measure of health literacy will generally not meet this requirement (Simkiss et al., 2020).

Overall, improved mental health literacy contributes to a better quality of life (Nobre et al., 2021). This is especially true if acquired at a young age, as it has a direct and positive impact on adult life. It enables people to acquire knowledge and define the attitudes and behaviors that will accompany them throughout their lives (Simkiss et al., 2020). Specifically, it provides

individuals with the ability to positively manage their thoughts and emotions to build healthy social and family relationships, all based on a strong, positive sense of identity. Therefore, a good level of mental health literacy is essential to ensure that individuals will be supported to develop a healthy life (Nobre et al., 2021).

### **2.3.2. Consequences of poor mental health literacy**

Lack of mental health literacy poses challenges to the provision of care to patients (Ganasen et al., 2008). According to Henderson et al. (2013), a lack of mental health literacy is a significant cause of disease burden in most countries. Failure to recognise mental illness in oneself, or others, may result in delayed or inappropriate help-seeking (Cotton et al., 2006). The results of a lack of knowledge are that seeking mental health professional services is delayed, usually, until significant impairment or severe clinical symptoms are experienced; regrettably, managing the condition is difficult and costly. Early detection is essential in financial oversight; preventing severe symptoms reduces medical costs for patients and health facilities. Once the condition escalates, and this holds for all chronic conditions, medical intervention is costly. The benefits of early detection are delivering adequate treatment, care and support while avoiding admission to tertiary care institutions (Henderson et al., 2013). This is particularly true in developing countries with grossly inadequate mental healthcare services and a lack of health promotion and prevention of ill health (Ganasen et al., 2008). The inadequate mental healthcare services have led to the use of several mechanisms to compensate for mental illness services, which include information that is often misleading (Choudhry et al., 2016).

Poor mental health literacy incorporates poor knowledge about using mental health services (Hernan et al., 2010). This could be due to the lack of knowledge concerning the role of psychologists and psychiatrists in mental health care which might increase doubt about the effectiveness of professional help, leading to a preference for informal support (Yap et al., 2011). Lack of knowledge also contributes to patients' resistance to attending mental health appointments and adherence to recommended illness management. Such patients are more inclined to discuss mental health difficulties with family members and friends rather than with professionals (Wilson & Deane, 2012). Due to this, appropriate professional help is not sought by people with mental illness (Jorm et al., 2005).

In addition, poor mental health literacy in people leads to inappropriate help-seeking behaviour (Angermeyer & Matschinger, 2005). Research indicates that most mental health patients' initial consult is with either general medical practitioners or complementary-alternative medical providers (Kometsi, 2016). A significant problem with this model is the tendency of general practitioners in public or private care settings to underdiagnose mental conditions, resulting in delays in patients consulting with mental healthcare professionals (Seedat et al., 2009). Due to this, people with mental illness receive limited information resulting in inappropriate interventions for dealing with mental illness.

Another growing trend in mental health treatment is for people to use self-help resources (Naslund et al., 2020). However, psychologists have reported self-help interventions in a study by Papworth (2015) to be harmful to patients. In addition, Firth et al. (2019) reported the use of dietary supplements like vitamins and minerals to treat mental illnesses from self-help interventions, even though their role in clinical care is highly controversial. Such findings are a concern because mental health literacy influences numerous aspects of the help-seeking process, such as attitudes toward mental health practitioners, stigma, treatment knowledge and choice, and compliance (Furnham & Swami, 2018).

Poor mental health literacy contributes to widespread stereotypes and prejudice against patients with mental illness (Shah et al., 2022), leading to a perception of people with mental illness as dangerous, incompetent, unpredictable, and to blame for their illness (Marie & Miles, 2008). Discrimination, as described above, poses a significant barrier to mentally ill patients accessing treatment (Phelan & Link, 2004). Specifically, 'if an individual has little capacity to recognise symptoms or has a negative view of mental health problems and mental health services, they are unlikely to refer themselves to a mental health service if they develop a mental health problem' (Choudhry et al., 2016). To remedy the situation, WHO (2019) recommends that community awareness interventions can reduce the stigma and discrimination faced by people with mental disorders. It is thought that improved public mental health literacy would presumably lessen stigmatisation and encourage the use of currently available and effective interventions (Hugo et al., 2003).

## **2.4.Culture and mental illness**

Cultural constructions of mental illness influence people's perceptions, experiences, and coping skills (Gopalkrishnan, 2018) and the boundaries between normality and pathology differ across cultures for certain behaviors (APA, 2013). Deciding that a particular behaviour is atypical and requires clinical care depends on cultural norms adopted by the individual and employed in their environment (Altweck et al., 2015). Swidler (1986) argues that culture offers an interpretive framework that outlines the experience and manifestation of symptoms, signs, and behaviours, which are crucial in diagnosing mental and behavioural problems. Due to cultural specificities, many mental illnesses are expressed in diverse ways (Gopalkrishnan, 2018).

For instance, particular symptoms such as hallucinations and delusions have distinctive meanings in various cultures. Similarly, depression in some cultures is not necessarily expressed in the mood but somatic symptoms (Mosotho et al., 2008). From a Western perspective, depression can also be viewed as a dysfunction in a person's physical or psychological structures. On the other hand, in several sub-Saharan African societies, the conceptualisation of depression also considers cultural, spiritual, and social factors (Sodi, 2009). Interestingly, specific symptoms and syndromes may not be present in some cultures, according to Gopalkrishnan (2018), and their intensity varies (Mosotho et al., 2008). This is possible because culture performs a valuable and vital role in the inclusive development and manifestation of behaviour (Mosotho et al., 2011).

Specific culturally determined presentations are difficult to explain with standard diagnostic terminology (Janse van Rensburg, 2009). In such contexts, mental health professionals must deliberate whether a person's experiences, symptoms, and behaviours deviate from sociocultural norms and advance into difficulties linked to adapting within their culture of origin and specific social contexts (APA, 2013). Due to the emphasis on context, it can be concluded that mental illness is relative and depends on the individual's worldview (Opare-Henaku & Utsey, 2017).

## **2.5.African worldview**

The conceptualisation of mental illness depends on the individual's worldview (Opare-Henaku & Utsey, 2017). Barker (1999) defines worldview as how people understand their

relationship with societal institutions: spirituality, nature, other people and objects. The Africentric worldview states that how a person sees reality depends on cultural ideals, beliefs, conceptions of time, values and cause and effect (Thabede, 2008). As much as Africans share commonalities in culture, it is significant to mention that not every African sees the world according to a single African worldview (Kometsi, 2016). It is evident that African culture is not homogeneous (Gopalkrishnan, 2018).

Contact with multiple worldviews entails that there cannot be a simple one-to-one correspondence between a meaning system and its application in real life (Sodi, 1998). Therefore, it is anticipated that various African cultures will have distinct ideas about the causation and treatment of disease and that there will be alterations in how the disease is conceptualised and treated (Honwana, 1998). Thabede (2008) contends that each culture has its own theoretical or explanatory model for health and illness. It also assumes that visible and invisible worlds are intimately connected and influence each other (Nwoye, 2015). This reflects the principle of cosmic unity, meaning that everything is constantly in motion and influences the other (Chuwa, 2014).

According to Maffi (1998), indigenous societies do not see the world as cause and effect mechanically. Instead, they take a holistic view of the world in which the units of analysis are not removed from their context (Nwoye, 2015). In this holistic conception of life, the central tenets are belief in God, the universe, and notions of causality, person, and time from a traditional African perspective (Mbiti, 1969). Traditional African societies, for example, believe that there should be harmony and interdependence between the elements of the cosmos.

### **2.5.1. African conceptualization of health and illness**

African conceptions of health and disease are embedded in the African worldview (Bojuwoye & Moletsane-Kekae, 2018). For Africans, good health entails mental, physical, spiritual, and emotional stability for themselves, family members, and the community. This integrated outlook of health is grounded on the unified African view of reality (Mokgobi, 2014), which is consistent with the World Health Organization (WHO) perspective that views health holistically (WHO, 2019). According to Swartz & Kilian (2014), ethnic African communities in South Africa view coherence between individuals and ancestors as significant to sustaining sound mental health. This harmony exists when the individual and their family

have fulfilled their socio-spiritual commitments to their ancestors. Certain mental disorders are believed to arise when this balanced relationship between the ancestors and those living is disrupted (Sodi & Bojuwoye, 2011). For illnesses resulting from disharmony, treatment by a traditional healer aims to restore the equilibrium between one's family and ancestors (Sodi & Bojuwoye, 2011). Severe mental illness is regarded as metacommunication to be "read" and deduced rather than categorised or classified, as underlined in the Western Diagnostic and Statistical Manual of Mental Disorders 5 (Nwoye, 2015). By identifying such illnesses as "symbolic illnesses" or representations with hidden connotations, indigenous African seniors recognise that they should go beyond the surface expressions of illness to discover "who" is communicating through such illnesses and what these actors aim to convey (Nwoye, 2015). By discovering who or what is behind the hidden meanings of mental illness, African elders can be guided to the root cause of the illness, eventually leading to proper treatment (Sodi, 1998).

### **2.5.2. The African view of mental illness causation**

Africans view the cause of mental illness based on their worldview (Chong et al., 2016), thus leading to many causal attributions (Picco et al., 2016). Mabvurira (2016) stated that indigenous Africans were more likely to attribute the root of mental illnesses to external influences such as possession by ancestral spirits, life stressors, generational curses, witchcraft, and religion. It is believed that the basis of ancestral spirit possession is that individuals do not honour their ancestral spirits by following specific rules and rituals (Mabvurira, 2016). This is corroborated by Sodi (1998), who reports that ancestors, when angered, can inflict illness and bad luck on their living relatives. The ancestors can also cause disease in an individual they want to make a diviner. Such a disease is called *ukuhlanya*. Another observation from the study findings is that stressful situations are also responsible for causing mental illness (Moelsae et al., 2012). This observation is confirmed by Sorsdahl et al. (2010), who identify psychosocial factors, especially stress, as the leading cause of mental disorders. Sorcery, or 'Ubuthakathi' referred to as witchcraft, is also considered a common cause of the disease (Petrus, 2009). It is considered to be performed by anyone and utilised when an individual has a grudge against another. In the Northern Sesotho culture, it is also believed that the transgression of diseases or *senyama* can cause mental illness. This is considered to be instigated by someone evil who locates a disease in the victim's path in the form of medicine (Sodi, 1998). Opare-Henaku and Utsey's (2017) study showed that many individuals considered their illness based on the premise that everything happens for a reason or purpose and that nothing happens by chance.

Such views imply that people with mental illness deserve their fate in some way, which has significant implications for people's use of medical care. An example in the Zulu culture in South Africa is a group of diseases such as *umkhuhlane*, diseases that 'just happen' (Ngubane, 1977).

These observations imply that the Africentric paradigm, in contrast to the Eurocentric perspective, recognises the likelihood that the basis of psychopathology is not merely in the infirmity of the body, mind or social setting, as emphasised in the west (Engel, 1977), but is sometimes rooted in the spiritual or ancestral upbringing of the individual exhibiting the illness (Engel, 1977). This is because, in the Africa-centered paradigm of mental illness, the unhappiness can be located past the visible-to the invisible world of ancestors, the concept being to find the cause of the crisis and seek treatment at the source of origin (Mkhize, 2003).

### **2.5.3. African treatment of mental illness**

Tangwa (2007) confirms that many South Africans see traditional medicine as more attractive than mainstream medicine. It has established itself as an accessible and affordable means of health care. In addition, it is valued as sensitive to psychological, environmental, and spiritual influences (Pretorius, 2004). According to Stott & Brown (1973), the African medicine man is seen as one who honors, appeases, or exorcises evil. His treatment is often obtained from dreams, and his diagnostic abilities are attributed to psychic powers bestowed by ancestral spirits. Shai-Mahoko (1996) concluded that indigenous healers prevent certain diseases that the Western-trained health personnel cannot treat; they prevent social conflict by performing ritual cleansing and fortifying homesteads; and they repair social relationships by performing sacrificial rites to ancestors (Moagi, 2009).

Indigenous Africans are more prone to consulting traditional healers for mental health issues than other ethnicities (Chipps et al., 2015). Moagi (2009) classifies a traditional healer in the South African setting as an individual who has the gift of obtaining spiritual counsel from the ancestors. Occasionally, such a person is chosen by ancestors from a chronological family background with a solid ancestral lineage. The Traditional Health Practitioners' Act Number 22 of 2007 regulates the happenings of traditional healers in South Africa. It designates that traditional healing involves the practice of a function, service, activity, or process that is grounded on traditional philosophy and involves the use of traditional medicine (Government

Gazette, 2008). South African patients can seek out four categories of traditional healers. These include (Setswe, 1999; Truter, 2007):

- The traditional doctor –*inyanga*, focus on the use of herbal remedies,
- The diviner–*isangoma*, either choose to become fortune teller or is chosen by the ancestors.
- The faith healers – *umprofiti* or *umthandazi*, diagnosis is made primarily through communication with God and
- traditional birth attendants.

Mashamba (2007) notes that dreams, ancestors, and throwing bones are essential in diagnosing disease because this study focuses on the applicability of indigenous African practices to treating mental illness. Therefore, only the roles of the diviner and the faith healer are discussed here.

#### *The diviner*

In most societies in indigenous Africa, the diviner is the competent intermediary (Sodi, 1998). Divination involves consulting the spirit world (Ezekwesili-Ofili & Okaka, 2019). It is a process of obtaining information about a person or a disease state using randomly assembled symbols to attain healing knowledge (Ezekwesili-Ofili & Okaka, 2019). It is a transpersonal practice in which diviners center their wisdom on communication with spiritual forces such as spirits, deities, and ancestors (Olupona, 2004). The "spirit world" is consulted to determine the cause and treatment of the illness or to find out if the sick person has violated an established order (Ezekwesili-Ofili & Okaka, 2019). This is done by throwing bones, shells, money, dice, and other items determined by the diviner and the spirit to embody certain polarities on leather, animal skin, or pieces of wood (Omonzejele, 2008). The divining bones, which comprise most objects, consist of bones of animals such as lions, hyenas, goats, baboons, crocodiles and antelopes. The bones represent all the forces that affect humans, regardless of their culture (Cumes, 2014). Because of the enlightening powers of divination, it is generally the first step in traditional African treatment (Omonzejele, 2008).

The treatment can also take other forms depending on the information obtained and may be used for spiritual protection when the cause of the illness is perceived as an attack by evil spirits (Ezekwesili-Ofili & Okaka, 2019). The ill person would be protected by a talisman,

amulets, specially designed body signs, or a spiritual bath to drive away the evil spirits (Westerlund, 2006). Diviners may also offer sacrifices at the request of the ancestors and spirits (Olupona, 2004). These sacrifices would be in the form of slaughtering certain animals with the certainty that their spirits are effective to replace life (Olupona, 2004). Sacrifices can also appease spirits, ancestors, or the gods if a disease is perceived to be caused by an invocation of a curse or violation of taboos (Idowu, 1973).

### *The Faith-healer*

Communities in South Africa believe that faith healers are led by both the ancestors and by God-sent messages (Zuma et al., 2016). Those who are ill consult faith healers for treatment to reveal what is hidden in the messages of their illness and what treatment can be applied. Faith healers heal through prayer (Adjaye, 2001). Not only is prayer used as a tool to investigate the cause but also to intervene in the healing of the individual with the illness. Other main methods of treatment include the use of water and minerals such as ash and salt (Zuma et al., 2016). The most common treatment for the mentally ill is exorcism, where the healer expels evil spirits from people and places (Pfeifer, 1994). Exorcism can only be performed by a faith healer who is a religious leader and has the authority to do so. This practice may be accompanied by dancing to the beating of drums, singing, and at times flogging the individual or touching them with objects, such as animal tails, amongst others, to chase out the spirit (Adjaye, 2001).

In the South African context, it is essential to note that some patients, their families, and traditional healers consider biomedical interventions necessary to treat the symptoms of diseases attributed to bewitchment (Mokgobi, 2014). Some, therefore, recognise psychiatric assessments, hospitalisation, and medication as an effective way of treating psychotic symptoms believed to be caused by witchcraft. However, it is essential to recognise that although these sources are found to be helpful, they are not necessarily the first line of treatment. Instead, the help of a psychiatrist or psychologist may be the last option after talking to family and friends or seeing a doctor or GP (Rinne, 2001).

Traditional healers provide culturally appropriate health care that is linked to the explanatory models of indigenous South Africans (Campbell-Hall et al., 2010). Considering that Africans have their way of understanding their universe and illness, it is vital to examine how they conceptualise mental illness, precisely the level of their mental health literacy.

Therefore, this study aims to examine the conceptualisation of mental illness among a group of indigenous Africans in the Dihlabeng Municipality area of the Free State.

### **3. Theoretical Framework**

#### **3.1.Explanatory models of mental illness**

Many African indigenous societies conceptualise mental illness based on their own explanatory models of illness rather than according to Western psychiatric nosology (Herselman, 2004; Nwoye, 2006). Explanatory models were developed by Kleinman (1978) out of a critique of western diagnostic categories, which he called 'category fallacy'. Explanatory models of mental illness refer to how people think about mental illness and include the origin of the illness, the onset, severity and prognosis of the illness, the type of treatment and the treatment provider needed (Kleinman, 1978). These models arise when people ask themselves questions such as: What is the nature of the problem, why has it affected me, why now, what will happen next? The system thus functions as a product of how people, in tune with different social and cultural contexts, understand, label, explain and treat illness (Kleinman, 2013). This shows that explanatory models of illness generally help people to deal with, and make sense of, an illness as a social construct of reality (Fox et al., 2005).

Kleinman found that patients understand and explain their illnesses using conceptual models different from their doctors (Rich et al., 2002). Therefore, disease explanations that are not consistent with a preferred explanatory model may not be explored, may seem implausible and could be considered less satisfactory than those consistent with the preferred explanatory model (Lynch & Medin, 2006). Consequently, it is crucial to elicit specific explanatory models, especially when the patient and doctor have different cultural roots. In addition, this could encourage physicians to be more open to communication and place their expertise alongside the patient's explanations and perspectives (Kleinman & Benson, 2006).

Explanatory models serve as a means to bridge cultural differences between patients and doctors (psychiatrists) from different backgrounds, as well as to bridge conceptual gaps and generate empathy and a therapeutic connection (Weiss & Somma, 2007). Culture affects how clinicians and patients display and understand different types of distress (Bhugra & Gupta, 2010). This is particularly true in South Africa, where patients come from a variety of cultural backgrounds. In addition, individual, family and community perceptions of mental illness may differ from those of professionals trained in western biomedical concepts (Opare-Henaku & Utsey, 2017). Therefore, using a biomedical perspective alone for clinicians in Africa is

insufficient to understand people's experiences of mental illness from their worldview, which may influence the patients' behaviour, treatment and response to therapy (Kometsi et al., 2020).

Each patient must be thoroughly aware of their perspective, health beliefs, fears and treatment expectations (Nambi et al., 2002). This would mean describing the many causal attributions for mental illness that exist in different ethnic groups (Nambi et al., 2002). Kleinman (1980) suggested using a mini-ethnography to explore individual questions such as "Why me?", "Why now?", "What is going on?" and "Who can intervene or treat the illness?" are crucial for treatment. According to Rich et al. (2002), the core idea is that the illness can be treated more successfully if the clinician understands what illness means to the patient and the tacit beliefs and assumptions the patient brings to clinical treatment. This highlights the importance of explanatory models serving as a link between what patients believe about their illness and what is considered appropriate and suitable treatment (Laws, 2016). Failure to do so may result in patients rejecting help from mental health professionals or failing to comply with treatment (Jorm et al., 1997). The explanatory model of illness is also an essential aspect of mental health literacy for both professionals and the public (Malla et al., 2015).

Mental health literacy is a relative concept influenced by conceptions of illness, such as the explanatory models of patients and healers or professionals (Bhugra & Gupta, 2010). It can be assumed that many indigenous Africans lack understanding and awareness of mental health problems because their worldview influences their conception of illness (Kometsi et al., 2020). According to Atilola (2016), these views assume that a lack of mental health literacy, or worse, ignorance, is associated with a mismatch in the biomedical understanding of mental illness. Assumptions about a lack of mental health literacy ignore that clinical phenomena are socially produced and that different civilisations derive their knowledge from different worldviews (Kleinman, 1980). This affects the explanatory models of disease (Kometsi et al., 2020). A culturally sensitive approach to treatment that focuses on exploring explanatory models during assessment and treatment is an effective way to deal with the complexity of patient and family needs by placing culture and narratives at the centre of care. This could be used to enhance community mental health programmes, improve service delivery, educate the public and ultimately improve the quality of life for people with mental illness (Arthur & Whitley, 2015).

In summary, understanding the public's explanatory models of mental health literacy can help achieve better mental health outcomes. According to Kometsi et al. (2020), exploring each

patient's explanatory model would be helpful as it may lead to developing culturally appropriate treatment plans that address patients' concerns and priorities in the cultural context of their daily lives. Apart from these clinical benefits, increased awareness of explanatory models related to mental health literacy could positively impact mental health decision-makers, training health professionals and public education campaigns (Wei et al., 2015).

## **4. Research Methodology**

### **4.1. Research problem and objectives**

The study aims to investigate mental health literacy among the indigenous African residents of Dihlabeng Local Municipality in the Free State. The following objectives were derived from the aims of this study.

#### ***Research Objective 1***

- To investigate participants' conceptualisation of mental illness.

#### ***Research Objective 2***

- To investigate the participants' knowledge and beliefs about the aetiology and treatment of mental illness.

#### ***Research Objective 3***

- To investigate the relationship between participants' etiological and treatment beliefs.

### **4.2. Research design and methodology**

A quantitative approach was used to achieve the objectives of this study. A quantitative approach uses numerical data collected and analysed using statistical methods (Apuke, 2017). Quantitative studies emphasise the measurement and analysis of relationships between variables (Yilmaz, 2013). An advantage of the quantitative approach is its usefulness in studying many individuals, its relatively time-saving data analysis using statistical software, and its relatively rapid data collection (Eyisi, 2016). This quantitative-based study was conducted in the form of a survey. A survey is a structured series of questions or statements asked of a group of people to measure their attitudes, beliefs, values, or action tendencies (Goodwin, 2005). For this study, a survey design was considered because it is flexible and best suited to explore people's opinions, attitudes, beliefs, and values at a given point in time regarding a wide range of topics (Ponto, 2015). In addition, survey research is best suited when the researcher wants to gain a representative picture of the attitudes and characteristics of a large group (Nardi, 2018).

In addition to the current study being a quantitative survey approach and cross-sectional design, correlational design was also used. Correlational research describes the intensity and

direction of the relationship between two or more variables (Rindfleisch et al., 2008; Stangor, 2014). Yilmaz (2013) supports this idea by stating that the essence of quantitative research is the study of relationships between variables. Therefore, correlational design was used to determine if any relationship exists and the strength and direction of the relationship between variables (Yilmaz, 2013). In addition, this study also employed a cross-sectional design because data were collected at one point in time (Muijs, 2004), and no follow-up surveys were conducted (Bryman, 2012). Cross-sectional studies are also helpful for public health planning, understanding disease aetiology, and hypothesis generation (Mamady, 2016).

### **4.3. Participants and sampling procedure**

The study was conducted in the Free State province in South Africa, Thabo Mofutsanyana District Municipality, and the sample was drawn from two towns, Bethlehem and Fouriesburg. In order to recruit a sample size of 240 participants, a randomised public recruitment strategy was adopted using a sample size calculator. Data were collected in November 2021. Participants in this study were randomly recruited in public places with large numbers of people, such as taxi or bus stations, on township streets, and sometimes in their homes. Only indigenous African participants over 18 were included in this study. No participants were excluded based on their education level, gender, financial situation, or marital status. Participants were recruited using probability sampling, known as multistage cluster sampling, followed by simple random sampling using a computer programme called a randomiser (Saghaei, 2004). For example, the randomiser generated sets of random numbers to select participants. Some individuals were skipped to select the next participant based on the following random number. On each day of data collection, a randomiser was calculated to generate six new sets of ten unique integers each, with each integer having a value between one and five. According to Adwok (2015), in probability sampling, each member of the target population has a known chance of being included in the sample. This increases the likelihood that the sample is representative of the population and the possibility of drawing inferences about the population from the sample (Stangor, 2014).

Before completing the questionnaire, a fact sheet outlining the aim of the study and an informed consent form were discussed with potential participants. Each participant was randomly given a questionnaire representing only one of the three vignettes for depression, schizophrenia, or alcohol use disorder. The participants read and completed these questionnaires with support from the research assistants.

#### **4.4.Ethical considerations**

Permission to conduct this study was obtained from the Research Ethics Committee of the Faculty of the Humanities at Free State University and the Dihlabeng Local Municipality. The university granted ethics clearance: UFS -HSD2020/0391/21, and the Dihlabeng Municipality provided written permission. Participants signed informed consent forms. Information leaflets explaining the study, including risks and voluntariness, were distributed to all participants so they could give and sign their consent to participate. They also had the opportunity to ask questions or withdraw from the study at any time.

Under the Health Professions Act (1974), researchers must protect confidential information obtained during the research. Participants were informed that all identifiable information would be kept strictly confidential and that the only individuals/organisations in possession of the data would be the researcher, the research director, and the University of the Free State. In addition, only the final results of the study will be published. The results will be made available to the participants upon their request. In addition, the anonymity of the participants was maintained by ensuring that no personal information, such as their first and last names, was provided on the questionnaires. This ensured that participants were as honest and protected from bias. Questionnaires were provided to participants and completed in either English or Sesotho, depending on which language participants preferred.

It took about 40 minutes to complete the questionnaires. The researcher and research assistants were available to answer and clarify participants' questions. The ethical principle of justice refers to participants' fair, objective and unbiased treatment (Allan, 2015). This was achieved by ensuring participants' anonymity throughout the process and ensuring that the information they provided could not be traced back to the participants. Another ethical principle followed in this study was nonmaleficence, which means avoiding harming the participants (HPCSA, 2016). The study was structured so that no physical, social, psychological or economic harm was caused. However, participants were informed that if they felt harmed, they could be referred to the nearest clinic or counselling centre offering psychological services.

#### 4.5. Characteristics of sample

The biographical variables in the study were gender, age group, level of education, marital status, religion, and language spoken at home. A nominal scale was utilised to measure all the biographical variables. Data on the distribution of the 240 participants concerning the six biographical variables were calculated using the SPSS version 28.0 computer software and are presented in Table 1 (below).

**Table 1**

*Sample distribution according to gender, age group, marital status, educational level, religion, and home language*

<b>Demographics</b>	<b>N</b>	<b>%</b>
<b>Gender</b>		
Male	118	49.2
Female	122	50.8
<b>Age group</b>		
18-34	158	65.8
35-49	54	22.5
50-64	23	9.6
65+	5	2.1
<b>Marital status</b>		
Single	139	57.9
Married	38	15.8
Separated/Divorced	14	5.8
Widowed	19	7.9
Living with a partner	30	12.5
<b>Educational level</b>		
Never went to school	8	3.3
Primary	23	9.6
Secondary	85	35.4
Tertiary	124	51.7
<b>Religion</b>		

Atheist	6	2.5
Christian	164	68.3
Jehovah's Witness	12	5.0
African religion	42	17.5
Hindu	1	0.4
Non-Religious	12	5.0
Other	1	0.4
Not indicated	2	0.8
<b>Language spoken at home</b>		
Afrikaans	1	0.4
isiZulu	30	12.5
Sepedi	4	1.7
Swati	1	0.4
English	2	0.8
Sesotho	200	83.3
isiXhosa	2	0.8
<b>Total</b>	<b>240</b>	<b>100</b>

Of the total group, 50.8% were females, while 49.2% were male. Concerning age, most participants were between 18-34, with 65.8%. Regarding marital status, the majority were single, at 57.9%. Furthermore, the majority of the population's educational level was tertiary, at 51.7%. In addition, concerning religion, most of the population reported being Christian, 68.3%. Finally, the language spoken in the area was Sesotho, 83.3%.

#### **4.6.Measuring instrument**

The instrument used to collect data was the shorter version of *The Attitudes and Beliefs about Mental Health Problems: Professional and Public Views' Questionnaire* (Jorm et al., 1999). The questionnaire comprises three sections. The first section of the questionnaire contains information explaining the survey and questions asking participants to consent to participate in the study. In addition, this section required simple demographic information such as age, gender, marital status, education level, religion and language spoken at home. The second section of the questionnaire contained vignettes of various individuals who meet the diagnostic criteria under the Diagnostic and Statistical Manual of Mental Disorders, Firth Edition DSM-5: American Psychiatric Association, (2013) for depression, schizophrenia, and

alcohol use disorder. Each of these vignettes contains information on the onset, duration, frequency, progression, and severity of the individual behaviours exhibited by each person per vignette (Zanele). In addition, the impact(s) of the mental illness on the vignette character is also supplied in the vignettes. The third part of the questionnaire contained questions to elicit understanding, attitudes, and perceptions of mental illness. The first questions are open-ended, allowing participants to freely express their opinions and use personal phrases, which allowed the researcher to gain a deeper understanding and comprehensive information from their answers. Most of the questions in the questionnaire consisted of Likert scales, and some required a "yes" or "no" response. In summary, these questions captured 'participants' perceptions of the cause of mental illness, their thoughts regarding various professionals and helpful treatments, the likelihood of their recovery, social distance and attitudes toward people with mental illness, likely sources of knowledge about mental illness, and knowledge of available treatment facilities. According to the study by Kometsi (2016), a Pearson's correlation coefficient was employed to test the questionnaire used in his study, and a result of .85, using a sample of South African adults, indicated that the questionnaire was reliable for use with the participants in this study.

The *'Attitudes and Beliefs about Mental Health Problems: Professional and Public Views'* questionnaire was initially designed for a population different from South Africa's. The questionnaire was translated into the Sesotho language, spoken in the Dihlabeng community. The three vignettes on depression, schizophrenia and alcohol abuse, as well as the questionnaire, were translated into Sesotho. The translation guidelines suggested by Babbie and Mouton (2001), Guillemin et al. (1993) and Rosnow and Rosenthal (1996) were followed. Two experienced Sesotho translators were engaged in translating the questionnaire. The first person translated the English questionnaire into Sesotho, and the other translated the Sesotho version back into English without seeing the English version. A challenge for the translators was the lack of consistent Sesotho words for medical and psychiatric terminology, which they acknowledged. Where equivalent Sesotho words could not be identified, other words which were similar in meaning were used to form a sentence but still convey the essence of the meaning.

The reliability coefficients of the respective measuring instruments were calculated using Cronbach's coefficients. This is displayed in Table 2.

**Table 2***Reliability of Measuring Instrument*

Cronbach's Alpha	N of Items
.651	16

The reliability coefficient obtained from Cronbach's alpha analysis was 0.65 (approx. 0.7), indicating a good internal consistency level of the items in the data collection tool used in the study. Reliability coefficients of **0.7** or higher are deemed acceptable in studies within the context of the social sciences (Lance et al., 2006).

**4.7.Pilot study**

A pilot study was conducted to address Stopher (2012) suggestion that the questionnaire, survey designs and procedures should be tested before conducting the primary survey. According to Clark-Carter (2010), this is particularly important when the researcher uses an existing questionnaire for a new population. In addition, according to Kim (2011), since the wording of a questionnaire is crucial in any survey, a pilot study is conducted to identify and correct ambiguities and to determine whether the instructions are clear and whether there are any procedural difficulties in administering the questionnaire in the current study (Kim, 2011).

According to In (2017), pilot studies are also helpful for training research assistants. A total of six research assistants were recruited and trained to collect data for this study. They all resided in Bethlehem and had completed Grade 12, meaning they completed their high school education. The researchers assumed that participants in the Free State region would speak Sesotho; therefore, two of the six research assistants were fluent in Sesotho, and the other four had a good command of the language. The pilot study was conducted for one day; after that, data collection for the main study commenced.

**4.7.1.1.Pilot location and sample**

The pilot sample of 24 people (10% of the main study), of whom 47.2% were male and 52.8% female, were recruited in Paul Roux, a small town of 6,152 people in the Free State

province. The black African population comprised 91.6%, with Sesotho being the predominant first language at 88.3% (Stats, 2011). Paul Roux is located in Thabo Mofutsanyana District, which is part of Dihlabeng Municipality. The town was chosen because the researcher believed that the population were similar to Bethlehem and Fouriesburg, which are part of the same district. The steps used to recruit the pilot sample were the same as those used to recruit the sample for the main study. However, the data collected during the pilot study were not included in the results of this study, as the aim of the pilot study was only to test the data collection methods (In, 2017).

#### **4.8. Statistical analysis**

Data were collected and analysed using the Statistical Package for Social Sciences for Windows (IBM SPSS Statistics) version 28.0. Data analysis uses statistics to organise, summarise and interpret the data (Mishra et al., 2018). Therefore, descriptive and inferential statistical analyses were conducted to achieve these goals.

##### **4.8.1. Descriptive statistics**

Descriptive statistics provide numerical and graphical methods to summarise the collected data clearly and understandably (Franzese & Iuliano, 2019). Descriptive statistics are used to reduce the data to a more straightforward summary and to identify patterns in the data. This includes calculating various descriptive measures such as averages and percentages (Isotalo, 2009). Inferential statistics make inferences about collected data or studied populations (Franzese & Iuliano, 2019). This form of statistical analysis includes methods such as interval estimates and hypothesis testing (Isotalo, 2009). The two inferential statistical methods used in this study were chi-square analysis and regression analysis.

##### **4.8.2. Chi-square analysis**

Chi-square analysis is a non-parametric statistical test comparing categorical information with expected information (Jackson, 2012). It does not measure the value of a set of items but compares the frequencies of different categories of items in a sample. According to Nihan (2020), the chi-square statistic can be used to test the hypothesis that there is no relationship between two or more groups, populations or criteria. However, according to Gavin (2008) and Jackson (2012), the following assumptions must be met before the chi-square test can be used: 1) the sample must be randomly selected, 2) the data must be in raw frequencies, not percentages, 3) the variables measured must be independent, 4) the values or categories of the

independent and dependent variables must be mutually exclusive and complete, and 5) the observed frequencies should be greater than five. Nevertheless, Chi-square analysis was conducted to test the relationship between some demographic data or variables and the questions examined in this study.

## 5. RESULTS

This section presents the findings of the study based on the data generated and analysed using SPSS version 28. Both descriptive and inferential statistics (Chi-Square test) were conducted to address the study objectives. The results obtained are presented below.

**Table 3**

*Sample distribution according to gender, age group, marital status, educational level, religion, and language spoken at home*

<b>Demographics</b>	<b>N</b>	<b>%</b>
<b>Gender</b>		
Male	118	49.2
Female	122	50.8
<b>Age group</b>		
18-34	158	65.8
35-49	54	22.5
50-64	23	9.6
65+	5	2.1
<b>Marital status</b>		
Single	139	57.9
Married	38	15.8
Separated/Divorced	14	5.8
Widowed	19	7.9
Living with a partner	30	12.5
<b>Educational level</b>		
Never went to school	8	3.3
Primary	23	9.6
Secondary	85	35.4
Tertiary	124	51.7
<b>Religion</b>		
Atheist	6	2.5
Christian	164	68.3
Jehovah's Witness	12	5.0

African religion	42	17.5
Hindu	1	0.4
Non-Religious	12	5.0
Other	1	0.4
Not indicated	2	0.8
<b>Language spoken at home</b>		
Afrikaans	1	0.4
isiZulu	30	12.5
Sepedi	4	1.7
Swati	1	0.4
English	2	0.8
Sesotho	200	83.3
isiXhosa	2	0.8
<b>Total</b>	<b>240</b>	<b>100</b>

Results of the descriptive statistics presented in Table 3 showed that a total of 240 participants aged 18 years and above participated in the study. There was a relatively even distribution of the participants across gender. The participants aged between 18 and 34 years were the majority in terms of age groups in the sample at 65.8%. The results also showed that many of the participants, 57.9% were single. Statistics relating to the distribution in terms of educational level revealed that the majority had tertiary education at 51.7%. People that practised Christianity constituted a majority in terms of religion, with 68.3%. Finally, most participants reported Sesotho as their language of communication at home, at 83.3%.

### 5.1.Objective one

To investigate participants' conceptualisation of mental illness.

**Table 4**

*Categories used to conceptualise mental illness and examples of responses*

Category of explanation	Examples of responses
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Medical	Weak mind, mental illness, overworked, going through personal things and now that is making her feel worthless, lacks sleep and her brain is lacking proper function
Psychological	Suffering from grief, lacks confidence, need to accept self, problems with her inner self, a mind disturbed situation, overwhelmed and has depression, crazy
Social	Lacks love, being alone, heaping up of a lot of circumstances, always stressing, never speaking with anyone, lack of support
Traditional	Has a calling, spiritual ancestral, visions, ancestors are bothering her
Religious	Spirit is troubled
Not indicated	Did not answer this question

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The conception of mental illness was assessed among the study participants with an item requesting them to describe what they think is wrong with a person presented in a Vignette. Table 4 presents the various responses the participants provided them, and to be meaningful, they were placed under different categories, including medical (e.g. brain malfunctioning), psychological (e.g. lack of confidence, grief), social (e.g. stress, loneliness), traditional (e.g. spiritual, ancestral calling), religious (e.g. spirit is troubled), and not indicated (to indicate that the question was not answered)

### **Table 5**

#### *Percentage of participants' conceptualisation of the disorder*

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Disorder, N (%)				
Category of explanation	Depression	Schizophrenia	Alcohol use disorder	Total

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Medical	10 (12.5)	1 (1.3)	1 (1.3)	12 (5.0)
Psychological	53 (66.3)	52 (65.0)	68 (85.0)	173 (72.1)
Social	15 (18.8)	16 (20.0)	11 (13.8)	42 (17.5)
Traditional	0 (0.0)	8 (10.0)	0 (0.0)	8 (3.3)
Religious	1 (1.3)	0 (0.0)	0 (0.0)	1 (0.4)
Not indicated	1 (1.3)	3 (3.8)	0 (0.0)	4 (1.7)
Total	80	80	80	240 (100)

$X^2 (10) = 38.79, p < .001$

Table 5 reveals the percentage of responses regarding the conceptualisation of mental illness. The majority (n = 173, 72.1%) of the participants conceptualised the conditions presented on the vignettes as psychological problems, followed by those that thought the problems were social (n = 42, 17.5%), medical (n = 12, 5.0%), traditional (n = 8, 3.3%). Only a handful of the participants (n = 1, 0.4%) conceptualised the cases as religious, and a few (n = 4, 1.7%) did not indicate a specific nature for the presented cases. Further observation of the results showed that for depression, more than half of the sample (n = 53, 66.3%) conceptualised the case as psychological, followed by those who explained the conditions in the vignette as a social problem (n = 15, 18.8%), then medical (n = 10, 12.5%). Only 1 (1.3%) person conceptualised the case as a religious problem and no specific problem. For schizophrenia, the majority (n = 52 (65%) of the participants described the condition in the vignette as a psychological problem, followed by those conceptualising schizophrenia as social (n = 16, 20%). The results, however, showed that it was only in the schizophrenia vignette that participants (n = 8, 10%) conceptualised the condition as a traditional problem. No participant attributed the conditions in the schizophrenia vignette to a religious problem, while 3 (3.8%) did not indicate the case as a specific problem. The majority of the participants (n = 68, 85.0%) explained the conditions of alcohol use disorder as a psychological problem, followed by 11 (13.8%) who explained the condition as a social problem, and only 1 (1.3%) indicated alcohol use disorder as a medical problem.

The chi-square analysis results showed significant differences in how the participants conceptualised the different mental illnesses  $X^2(10) = 38.79, p < .001$ . For instance, most of the sample in the alcohol use disorder category explained the condition as a psychological problem, while all the participants that conceptualised mental illness as a traditional problem were in the sample that responded to schizophrenia.

**Table 6**

*Examples used to conceptualise mental disorders*

Disorder			
Category of explanation	Depression	Schizophrenia	Alcohol use disorder
Medical	Maybe pregnant, going through personal things and now that is making her feel worthless, lacks sleep and her brain is lacking proper function	Weak mind, mental illness,	overworked,
Psychological	going through something (trauma), hurt in the past, lacking sleep which causes unusual behaviour, personal insecurity of seeking approval, childhood trauma, depressed	Suffering from grief, problems with her inner self, judging self, lack of motivation, crazy	has addiction on alcohol, stressed, creating a bad habit for herself, using alcohol as an escape and that's wrong, relied on being given a certain feeling by alcohol

Social	hurting from something it can be break up, might be dealing with rejection or she feels unwanted or maybe not enough,	lacks love, being alone, lack of support, feels lonely	lots of problems in her life, being pressured from her family, has a lot of things going on in her life, overwhelmed by either work or her life
Traditional		Has a calling, spiritual ancestral, visions	
Religious	Her spirit is troubled		
Not indicated	Unable to finish her work	No problem, poverty, and suffering	

The results presented in Table 6 showed the different examples of explanations or descriptions used to explain schizophrenia, depression, and alcohol use disorder across different categories of conceptualisation. For example, conceptualising depression as a medical problem, the individual in the vignette was thought to be pregnant. Also, “problem with inner self” was an example of a description used to capture schizophrenia as a psychological problem, and “pressure from the family” was an example of the expression used to conceptualise alcohol use disorder as a social problem.

**Table 7**

*Labels used for mental disorders*

Label used		
Depression	Schizophrenia	Alcohol use disorder
Abuse	Anxiety	Addiction

Alcoholic	Calling from ancestor	Alcohol abuse
Anxiety	Crazy	Alcohol addiction
Depression	Depression	Alcoholic
Ill	Emotional	Drinking unreasonably
Unlovable	Grief	Hangover
Depressed	Family issues	Heart problems
Evil spirit	Insecurity	Insecurity
Fatigue	Isolation	Drunkenness
Hangover	Lack of satisfaction	Lie
Isolation	Low self-esteem	Lack of satisfaction
Lack of interest and pleasure	Madness	Low self-confidence
Lacking sleep	Mental illness	Negative use of alcohol
Mental illness	Mental weakness	Peer pressure
Lonely	Overthinking	Selfish
Overthinking	Paranoia	Substance abuse
Phobia	Peer pressure	Stress
pregnancy	Spiritual	Unbalance
Stress	Stress	

A summary of different labels used by participants for each of the three disorders was presented in Table 5. It was observed that the participants provided numerous labels for the mental disorders presented in the vignettes, with only a few labels (anxiety, depression, stress) used for all three disorders. The results also showed that labels, such as addiction and drunkenness, were only used to describe alcohol use disorder. In addition, labels, such as callings and visions, were used only for labelling schizophrenia, and physical/medical-inclined labels, such as pregnancy and sleep, were specific to depression.

## 5.2.Objective two

To investigate the participants' knowledge and beliefs about aetiology and treatment of mental disorders.

### Table 8

*Knowledge and beliefs about aetiology of mental disorders*

Aetiology of mental disorders	Examples of responses
Medical	By her heart, morning sickness, being tired, chemical imbalance, hangover
Psychological	overthinking because of no time to mourn for her loss, imagining a lot, low self-esteem and anxiety, lost her self-confidence, needing the presence of a parent or a loved one, grief, being overwhelmed and doesn't know how to deal with it
Social	may have enemies because of her position at work, family situation, staying alone, always listening to people, not getting enough love and support, no support and lack friends, life issues, pressure from the family,
Traditional	her ancestors are calling her to do their duties on their behalf, not following traditional ways of doing things
Religious	The devil is attacking,

Table 8 presents results on the knowledge and belief about the aetiology of mental disorders assessed among the participants. Again, many responses were provided to describe what participants believed to be the cause of the conditions presented in the vignettes. For this study, the responses provided were classified into medical (e.g. chemical imbalance), psychological (e.g. overthinking, low self-esteem), social (e.g. lived events, lack of support), traditional (e.g. spiritual, ancestral calling), and religious (e.g. devil's attack).

### Table 9

*Percentages of participants on knowledge and belief of aetiology of mental disorder*

Disorder, N (%)				
Category of aetiology	Depression	Schizophrenia	Alcohol use disorder	Total

Medical	9 (11.3)	1 (1.3)	1 (1.3)	11 (4.6)
Psychological	53 (66.3)	41 (51.2)	52 (65.0)	146 (60.8)
Social	17 (21.3)	32 (40.0)	27 (33.8)	76 (31.7)
Traditional	0 (0.0)	6 (7.5)	0 (0.0)	6 (2.5)
Religious	1 (1.3)	0 (0.0)	0 (0.0)	1 (0.4)
Total	80	80	80	240 (100)

$\chi^2(8) = 32.06, p < .001$

The results in Table 9 present the percentage of responses regarding knowledge and beliefs of the aetiology of mental disorders across the three disorders assessed in this study. Many ( $n = 146, 60.8\%$ ) of the participants expressed that mental disorders are caused by psychological factors, followed by those that ascribed the causes of mental disorders to social ( $n = 76, 31.7\%$ ), medical ( $n = 11, 4.6\%$ ), traditional ( $n = 6, 2.5\%$ ), and religious ( $n = 1, 0.4\%$ ) factors. Most of the participants that believed medical factors caused mental disorders were in the sample for the depression vignette, while all the participants that believed that traditional conditions cause mental illness were in the sample for the schizophrenia vignette.

The results of the chi-square analysis showed significant differences in the participant's belief in the aetiology of mental disorders across the three disorders assessed  $\chi^2(8) = 32.06, p < .001$ . For instance, the majority of the sample in the alcohol use disorder category explained the condition as a psychological problem, and the category with the least attributions to all three disorders was that of religion.

### **Table 10**

*Examples used to describe the knowledge and belief of aetiology of mental disorders*

Disorder
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Category of aetiology	Depression	Schizophrenia	Alcohol use disorder
Medical	Being tired, morning sickness, chemical imbalance, lack of sleep, exhausted, consistent fatigue	By her heart,	Hangover
Psychological	Past trauma, overthinking and expecting approval, piling up her sadness, personal problems, being hurt, previous insecurities, overthinking, hopelessness	Not have time to mourn and overthinking, imagining a lot, thinking a lot, low self-esteem and anxiety, lost self-confidence	stressed or might be experiencing anxiety, being overwhelmed and doesn't know how to deal with it, too much stress, got hooked on drinking to create a specific effect
Social	Family issues, a break up (cheated on) or family always comparing her to someone, loneliness, overwhelmed by work,	Affected because of her working position, family situation, staying alone, not getting enough love and support, not speaking to anyone	Life issues, pressure from the family, too much workload and expectations from the family, too much pressure on self, negative peer pressure,
Traditional		ancestors are calling to do their duties on their behalf, not following traditional	

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	ways of doing things, lack of belief
Religious	The devil is attacking,

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The results in Table 10 showed the various examples used to describe the aetiology of mental disorders across different disorders. For example, participants that believed that medical factors cause depression used expressions such as "morning sickness", "exhausted", and "chemical imbalance" as causes of depression. Expressions such as "imagining a lot", "low self-esteem", "anxiety" were used by participants that believed that psychological factors cause schizophrenia. For alcohol use disorder, participants that believed social factors caused the disorder used expressions such as "life issues", and "too much pressure on self" to describe the causes of alcohol use disorder.

**Table 11**

*Knowledge and beliefs about treatment of mental disorders*

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Treatment of mental disorders	Examples of responses
Encourage professional help-seeking	Go see a psychologist, talk and seek social work, counselling, attend counselling sessions and get professional mental help, by going to a doctor or talk out her problems from outside, mental health professional, to the rehab centre, Lifeline, needs to talk to someone and get rehab, She can go for therapy
Listen to/talk to/support	By having someone that she can talk to openly about how she's feeling, meet people and talk to them, talking to friends and family, talking to others who can relate,
Refer to family	By going to people around at home, talk to family,
Traditional	seeing a traditional healer, go to sangoma, go initiation school so that she can be a traditional doctor,

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Religious	By being prayed and offered a counselling
Other	Lock her up, she must believe in herself, needs to look for something to relieve the effect she wants from alcohol, separate from the wrong group of friends,

The results in Table 11 show the different categories of beliefs about treating mental disorders as expressed by the participants. Similar responses were combined to form the following categories: (1) encourage professional help-seeking (e.g. see a psychologist, go for therapy/rehabilitation), (2) listen to/talk to/support (e.g. meet people and talk to them, having someone to talk to openly about feelings), (3) refer to family (e.g. talk to family, be around people at home), (4) traditional (e.g. seeing a traditional healer, go to *sangoma*), (5) religious (e.g. being prayed for), and (6) other (lock up, separate from wrong group of friends).

**Table 12**

*Percentage of participants related to knowledge and belief of treatment of mental disorders*

Disorder, N (%)				
Category of Treatment	Depression	Schizophrenia	Alcohol use disorder	Total
Encourage professional help-seeking	53 (66.3)	50 (62.5)	51 (63.7)	154 (64.2)
Listen to/talk to/support	16 (20.0)	13 (16.3)	9 (11.1)	38 (15.8)
Refer to family	0 (0.0)	3 (3.8)	2 (2.5)	5 (2.1)
Traditional	0 (0.0)	12 (15.0)	0 (0.0)	12 (5.0)
Religious	0 (0.0)	0 (0.0)	1 (1.3)	1 (0.4)
Other	10 (12.5)	2 (2.5)	17 (21.3)	29 (12.1)

Note indicated	1 (1.3)	0 (0.0)	0 (0.0)	1 (0.4)
Total	80	80	80	240 (100)

$X^2(12) = 44.49, p < .001$

The results in Table 12 showed the differences in participants' responses regarding the belief in the treatment of mental disorders across the three disorders assessed. It was observed that the majority (n = 154, 64.2%) of the participants believed that people with mental disorders should seek professional help to treat the disorder. Of the participants that believed that treatment for mental disorders could be achieved by listening or talking to other people, many were in the sample for the depression (n = 16, 20%) and schizophrenia (n = 13, 16.3%) vignettes, while many of those who believed that mental disorders could be treated by different 'other' means were in the sample for depression (n = 10, 12.5%) and alcohol use disorder (n = 17, 21.3%) vignettes. Interestingly, participants that believed that traditional methods should treat mental disorders were in the sample for the schizophrenia (n = 12, 15%) vignette, and religious treatment was suggested for alcohol use disorder (n = 1, 1.3%) alone.

The results of the chi-square analysis showed significant differences in the participants' belief of treatment of mental disorders across the three disorders assessed  $X^2(12) = 44.49, p < .001$ . For instance, most of the sample was in favour of encouraging professional help-seeking for the three mental disorders. In contrast, only those in the vignette of schizophrenia encouraged traditional help-seeking.

### Table 13

*Examples used to describe the knowledge and belief of treatment of mental disorders*

Category of Treatment	Depression	Schizophrenia	Alcohol use disorder
Encourage professional help-seeking	By seeing a doctor go to the clinic, getting professional help, rehab, go for a	Go see a psychologist, attend counselling sessions, and get	To the rehab centre, rehab, rehab, and life coaching, visit a psychologist,

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	psychological evaluation, a psychologist to counsel her,	professional mental help, by going to a doctor or talk out her problems from outside	
Listen to/talk to/support	Opening up to someone she trusts because she is being bothered, talking to people,	by having someone that she can talk to openly about how she's feeling, talk to someone, talking to friends and family	She needs to talk about what is bothering her,
Refer to family		By going to people around at home, talk to family	Talk to her family,
Traditional		seeing a traditional healer, go to sangoma, cultural ritual,	
Religious			By being prayed and offered a counselling
Other	She should get some sleep, maybe she needs to take a vacation, needs a break,	Lock her up, she must believe in herself	She needs a new way of wanting to relieve her stress, take a break, cut down her going out

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Table 13 presents the different examples used by the study participants to describe their belief in the treatment of mental disorders across the three disorders assessed. Participants that believed that depression can be treated by receiving help from professionals used words such as "seeing a doctor or go to the clinic", go for psychological evaluation" to express their

knowledge and belief about how depression could be treated. For schizophrenia, those that believed that listening or talking to someone could be a treatment used expressions such as "talking to friends and family", while examples of expression used by participants that believed in religious methods for treating alcohol use disorder include "being prayed for and offered counselling".

### 5.3.Objective three

To investigate the relationship between aetiological and treatment beliefs

**Table 14**

*Relationship between aetiological and treatment beliefs for mental disorders*

	Medical	Psychological	Social	Traditional	Religious	Total
Encourage professional help-seeking	8 (72.7)	99 (67.8)	47 (61.8)	0 (0.0)	0 (0.0)	154 (64.2)
Listen to/talk to/support	0 (0.0)	23 (15.8)	14 (18.4)	0 (0.0)	1 (100)	38 (15.8)
Refer to family	0 (0.0)	2 (1.4)	3 (3.9)	0 (0.0)	0 (0.0)	5 (2.1)
Traditional	0 (0.0)	3 (2.1)	3 (3.9)	6 (100)	0 (0.0)	12 (5.0)
Religious	0 (0.0)	1 (0.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.4)
Other	3 (27.3)	17 (11.6)	9 (11.8)	0 (0.0)	0 (0.0)	29 (12.1)
Not indicated	0 (0.0)	1 (0.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.4)
Total	11	146	76	6	1	240 (100)

$X^2 (24) = 130.33, p < .001$

The results obtained in Table 14 presented the summary of the Chi-square analysis showing the relationship between aetiological and treatment beliefs for mental disorders among the participants ( $X^2(24) = 130.33, p < .001$ ). This suggests that the belief that the participants have about the cause of mental illness influences their belief on how best to treat the mental illness. For instance, more participants who believed in seeking professional help for mental illness also reported professional-oriented (medical and psychological) causes of mental illness. Similarly, all the participants that ascribed traditional causes to mental illness reported belief in traditional means of treatment.

## 6. Discussion

The overall aim of the study was to explore mental health literacy among the indigenous African residents of Dihlabeng Local Municipality in the Free State. Thus, the study sought to respond to three objectives. First, to explore participants' conceptualisation of mental illness. Second, to explore the participants' knowledge and beliefs about the aetiology and treatment of mental illness. Finally, to explore the relationship between participants' aetiological and treatment beliefs. The reliability (internal consistency) of the current measuring instrument was shown to be acceptable in studies within the context of the social sciences (see Table 2) (Lance et al., 2006).

### 6.1. Conceptualisation of mental illness

This study explored participants' conceptualisations of mental disorders. Vignettes about depression, schizophrenia and alcohol use disorder were presented to the participants using a structured questionnaire. The various responses provided were categorised into psychological, medical, traditional, social and religious to generate meaningful data. The findings in this research study manifested an adoption of both western and non-western explanations. In addition, this study revealed essential findings concerning perceptions of mental illness among participants. Firstly, the results demonstrate an endorsement of multiple explanatory models of mental disorders, thus signifying an embracement of western influences. Psychological, followed by social and medical, were the most dominant responses provided, while traditional and religious explanations were also provided to a lower degree.

Secondly, participants did not utilise standard psychological terminology to define mental illness but instead applied broad, all-encompassing terms such as stress to label depression, schizophrenia and alcohol use disorder. This confirms Kometsi's (2016) study, which revealed that many participants conceptualised mental illness as experiencing stress. The outcomes of this study endorse Jorm's (2012) statement that when the public does not use mental illness labels such as depression, they frequently use normalising labels such as stress or life problems.

Participants also used numerous other phrases, such as *addiction*, *drunkenness (alcohol use disorder)*, *callings*, *visions (schizophrenia)*, *pregnancy*, and *sleep (depression)*, to label the disorders. These are phrases that appear to be familiar as they have also been proven to be used frequently in studies by Kelly et al. (2016), van der Zeijst et al. (2021) and Lewis et al. (2021). This indicated that lay people's conceptions of mental illness do not suggest a lack of

knowledge due to their use of terminology; instead, the elicitation thereof may assist mental health workers to understanding better the patient and their context (Choudhry et al., 2016).

The collective results of the study showed that the majority (72.1%) of the participants conceptualised the illnesses portrayed in the vignettes as psychological problems. This implies that most participants understood all three conditions as psychological concepts. Therefore, most participants' findings for conceptualising these disorders as psychological conditions have clinical and therapeutic value because they may enhance a need to seek appropriate psychological services.

Furthermore, the results showed that only a few participants ( $n= 8$ , 3.33%) regarded all conditions (depression, schizophrenia, alcohol use disorder) as a traditional problem, and ( $n=1$ , 0.4%) as a religious problem. A noteworthy finding in this research study is that only schizophrenia ( $n=8$ , 10%), among the three conditions explored in this study, was conceptualised traditionally. This reflects the participants' African holistic worldview about conceptions of health and disease (Bojuwoye & Moletsane-Kekae, 2018). These observations imply that the Africentric paradigm, in contrast to the Eurocentric perspective, acknowledges the prospect that the basis of psychopathology is not only in the illness of the body, mind, or in social contexts, as emphasised in the west (Engel, 1977), but is sometimes rooted in the spiritual or ancestral upbringing of the individual exhibiting the illness (Engel, 1977). African communities in South Africa view harmony between the individual and ancestors as critical to maintaining good mental health.

## **6.2. Knowledge and beliefs about aetiology and treatment of mental illness**

Participants were asked a series of questions to assess their knowledge and beliefs about the aetiology and treatment of mental illness. The responses from participants were vast, as can be seen by a few examples: *chemical imbalance, tiredness, overthinking, low self-esteem, family situations, no support, ancestral calling, failure to perform traditional rituals, and devil attacks*. These responses were classified into meaningful psychological, medical, social, traditional and religious categories to draw meaningful inferences. The overall findings on aetiological knowledge and beliefs indicate that the majority of participants are in support of psychological and social factors as causes of mental illness. These results are consistent with the findings of most studies that attribute the causes of mental health to psychosocial factors such as dissatisfaction, low self-esteem, rejection, overthinking, worry, and conflict in

interpersonal relationships (van der Ham et al., 2011; Naeem et al., 2012; Fellmeth et al., 2015) the adoption of western values, the decline of traditional values (Kolstad & Gjesvik, 2014) and mental health problems due to a lack of social support (Fellmeth et al., 2015). This may reflect the reality of stressful lives experienced in varying degrees by people worldwide (Kometsi, 2016). This also confirms the view expressed by Angermeyer and Dietrich (2006) that lay peoples' beliefs about the causes of mental disorders differ from the findings of psychiatric research in that psychosocial factors often predominate over biological factors.

When examining differences in participants' understanding of individual disorders, the results of this study show that only depression, at 11%, was more likely to be attributed to medical causes. Research on perceptions of mental illness treatment shows that the general public consensus on the best way to treat depression is to see a general practitioner (Jorm et al., 2005; Altweck et al., 2015). This verdict may confirm that the public views biological factors as less important than psychological factors in terms of mental illness (Jorm et al., 2005). According to Kelly et al. (2007), there has been a striking observation that people are usually uncertain about the biological causes of mental illness.

However, for the vignette representing schizophrenia, participants consistently endorsed traditional aetiological factors (n= 12, 15%). Of the three disorders, only schizophrenia was viewed as having traditional aetiological factors, such as ancestors calling them to do their duties and failing to perform certain traditional rituals. Belief in supernatural causes of mental illness is a well-known phenomenon among indigenous peoples (Kometsi, 2016). This is consistent with a study conducted in Nigeria, which found that participants endorsed supernatural causes for mental illnesses (Kermode et al., 2009). South African studies confirm that indigenous Africans often attribute mental health problems to cultural causes such as witchcraft or their ancestors rather than genetic or biological causes (Mohamed-Kaloo & Laher, 2014; Sorsdahl et al., 2010; Kometsi, 2016). In South Africa, individual, familial, and community-level perceptions of mental disorders may vary from those of specialists trained in western biomedical concepts (Henaku & Utsey, 2017). This finding emphasises that only using a biomedical perspective for physicians in Africa is insufficient to comprehend people's experiences of mental illness from their worldview, which may influence their behaviour, treatment, and response to therapy (Kometsi et al., 2020).

The tendency noted in this study for schizophrenia to be mainly associated with indigenous factors is probably due to the nature of the symptoms of this illness, such as hearing voices and interacting with other 'entities' beyond one's physical experience. To support this, Fabrega (1989) argues that schizophrenia disrupts the individual's sense of self and others and the self's ability to relate meaningfully to the cultural world. This is consistent with Kleinman (1978, 1980) assertion that illness is culturally constructed. In addition, Okello and Musisi (2006) remarked that mental illness is understood to be culturally related from an African perspective. Therefore, the community members might not refer to an illness as a mental illness as the westerners would.

Another exciting trend discovered regarding knowledge and beliefs about treatment was that the majority ( $n = 154, 64.2\%$ ) of the participants believed that people with mental disorders should seek professional help for treatment of the disorder. These previous confirmed findings (Samouilha & Seabi, 2010; Hugo et al., 2003) that the public typically believed that mental health professionals offered the most effective treatment for mental disorders. In Kelly et al. (2007), most youths and all adults rated professional help as helpful. Evidence shows that most of the literature investigating help-seeking beliefs reveals a growing trend to seek professional support instead of help from 'lay people' (Tata & Leong, 1994; Kuo et al., 2006). This is contrary to some results where participants discouraged professional psychological or psychiatric treatment and recommended that people should not pursue any treatment, and participants favored the use of traditional treatment of willpower approaches (Choudhry et al., 2016).

### **6.3. Relationship between participants' aetiological and treatment belief**

This section sought to determine whether there is a relationship between aetiological and treatment beliefs. The overarching findings for all the aetiological beliefs manifested a strong preference (64.2%) for professional help-seeking, followed by listening to/talk to/support. It is encouraging to note that professional help is widely recognised by most of the participants in this research. The second is the highly identified source of help, listen to/talk to/support as a preferred method of help-seeking. This finding was supported by a study in five low- and middle-income countries that disclosed that participants had higher support from informal help sources such as talking to friends, support from religious leaders and other non-health professionals than formal sources of help (D'Avanzo et al. 2012; Jordans et al., 2018).

Further assessment was undertaken to ascertain whether participants' beliefs about the cause of mental illness influenced their belief on how best to treat the mental illness. Interestingly, most participants who believed in seeking professional help for mental illness also reported professional-oriented (medical, social and psychological) causes of mental illness. It has been revealed that there is a meaningful relationship between the conceptualisation of mental disorders and aetiological beliefs. Similarly, all the participants that ascribed traditional causes to mental illness reported belief in traditional means of treatment. This could be because patients experience a discrepancy between the biomedical conceptualisation of illness and the patient's perception and experience of illness, which is exacerbated by cultural differences between the patient and the doctor (Putsch & Joyce, 1990). In the case of traditional healers, they may be able to bridge this gap as they often have the same background as their patients and therefore have a better understanding of how the patient views their symptoms and the cultural meanings attributed to them (Mufamadi, 2001). According to Ndeti (2007), 'the healer understands the significance of ancestral spirits, shares a belief in supernatural powers and identifies with the reality of witchcraft.' Robertson (2006) also argues that 'many feel that traditional healers provide more holistic care than medical practitioners, that they are more accessible and take an approach that is more appropriate and therefore more likely to be accepted by the community.' This highlights the need for mental health professionals to recognise that the acceptability of interventions proposed to patients can have important implications for treatment adherence. It also highlights the need for mental health professionals to understand their patients' worldviews, even if they are not of the same culture (Robertson, 2006).

#### **6.4.Limitations of the study**

It is recognised that the current study has several limitations. Therefore, the following limitations should be taken into consideration when interpreting the outcomes of this study:

##### *Vignette technique*

A vignette technique was used as a survey instrument, facilitating the discovery of participants' responses to assumed situations. However, validity could be mentioned as one of the significant methodological problems with using vignettes in quantitative research, as they cannot fully capture the elements of reality and people's lives as other research instruments.

### *Cross-section vs longitudinal study*

Cross-sectional studies are limited in that no causality can be claimed. Therefore, future research may benefit from conducting a longitudinal study design to account for causality. In addition, collecting data from various indigenous African communities could increase the sample size and enhance diversity across the study population. This broad inclusion would increase the potential for generalisation.

### *Quantitative vs mixed methods*

Quantitative research methods involve structured questionnaires with narrow questions. It leads to limited results, as described in the research study. Therefore, the results may not reflect what is happening in a generalised way. In addition, participants have a limited choice of answers because of the closed-ended questions posed by the researcher. The basic assumption is that integrating quantitative and qualitative approaches could allow for a more complete and synergistic use of data to understand better the research problem and complex phenomena than would be possible with either approach alone. Better understanding can be achieved by triangulating one set of results with another, thereby increasing the validity of conclusions.

### *Sample usage*

Another limitation that should be considered when interpreting the results of this study concerns representativeness and generalisability. Although the sample was randomly selected to be representative of the adult African residents of Dihlabeng Municipality, the data collected in this study does not represent the entire population of this municipality. Therefore, it is essential to consider that the mental health literacy of indigenous Africans across South Africa should be investigated.

### *Self-administrated questionnaire*

Although the questionnaire used in this study was designed to be self-completed, many participants completed it in the presence of the researcher or research assistants. Furthermore, those who could not read or write were assisted in completing the questionnaire. In addition, the results are based solely on self-report. Therefore, bias due to social desirability and reporting cannot be excluded.

*Covid-19*

Due to the Covid-19 restrictions, social distancing may have hindered confidentiality due to the data collection sites being in public places.

## **7. Recommendations**

### *Mental health literacy campaigns*

This study highlighted the need for awareness campaigns to enhance mental health literacy among indigenous Africans. It is suggested that the purpose of these interventions would be to educate the public about the nature of mental illness, stigma, prevention, causation, and treatment. Another aspect of these interventions would be to reduce stigma and foster public acceptance of the mentally ill. It is recommended that planning these interventions should take into deliberation peoples' worldviews and include cultural experts within the community in the planning of the interventions.

### *Collaboration between traditional and medical practitioners*

The participant's conceptualisation of mental illness, particularly schizophrenia, in this study and their endorsement of traditional causation and treatment of mental illness support this recommendation. Collaboration promotes a focus on holistic healing, which is central to the African worldview and is intended to promote physical, mental and spiritual well-being.

### *Increasing mental health services in communities*

Within this study, most of the population was aware of mental illnesses and recommended professional health seeking. Although this has been an encouraging finding highlighting more clinical involvement, both communities lack public mental health services and only have local clinics and hospitals. In addition, only one town receives monthly mental health outreach services. Therefore, it is recommended that policymakers and officials responsible for planning and delivering health services make mental health services more accessible to all communities.

## 8. Conclusion

In consolidating the findings of this study, the results demonstrated several explanatory models, including western and traditional explanations. Most participants did not use scientifically approved terms to conceptualise mental disorders but phrases relative to their respective contexts. The bulk of participants conceptualised disorders as psychological. The results also showed the orderly manner in which the community's conceptualisation of mental illness was categorised, namely psychological, social, medical, traditional and religious. The traditional conceptualisation was an exciting finding for schizophrenia. This finding promotes interest in the participants' conceptualisations of mental illness and their explanatory models. According to Malla et al. (2015), this underscores how important it is for clinicians to accept explanatory models of mental illness based on scientific evidence and those explained to them by the people they serve.

In addition, perceptions of mental illness were significantly related to participants' treatment beliefs. In terms of treatment, more participants were inclined to seek professional help. An encouraging finding to note was that the majority of the participants widely recognised professional help. A further interesting discovery was that the participants who believed in seeking professional help for mental illness also reported a professional-oriented (medical, social and psychological) cause of mental illness. The findings also revealed that for depression and alcohol use disorder, participants believed that mental illness is caused by life stressors, low self-esteem, and addiction. In the case of schizophrenia, participants mainly cited traditional factors such as ancestral calling and failure to perform certain cultural rituals. The endorsement of both psychosocial and traditional aetiological factors could indicate that participants were becoming more open to different ways of understanding and interpreting their reality because they believe both play a role in mental health. In clinical practice, this could indicate that some patients are more likely to seek professional help while others prefer traditional healers.

Lastly, the study also revealed a positive relationship between aetiological and treatment beliefs for mental disorders among the participants. Indicating a positive relationship between that which participants believe to be the causes of mental illness influences their belief on how best to treat the mental illness.

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## ADDENDUM A: QUESTIONNAIRE



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

### Mental Health Literacy: Knowledge and beliefs about mental illness amongst indigenous African residents of Dhlabeng Local Municipality in the Free State.

#### QUESTIONNAIRE (APPENDIX B)

PLEASE FILL IN THIS QUESTIONNAIRE **ACCURATELY** AS POSSIBLE.

#### Demographic Information:

Age .....

#### Gender:

1. Female   
2. Male

#### Marital Status

1. Single   
2. Married   
3. Separated/Divorced   
4. Widowed   
5. Living with a partner

#### Where do you stay?

#### Dhlabeng Local Municipality

1. Yes   
2. No

#### Race / Ethnicity

1. African   
2. Indian   
3. Coloured   
4. White   
5. Other  *specify*.....

#### What is your highest level of education?

1. Never went to school   
2. Primary   
3. Secondary



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

4. Tertiary

**Religious Affiliation**

- |                     |                          |                  |                          |
|---------------------|--------------------------|------------------|--------------------------|
| 1. Atheist          | <input type="checkbox"/> | 6. Buddhist      | <input type="checkbox"/> |
| 2. Christian        | <input type="checkbox"/> | 7. Hindu         | <input type="checkbox"/> |
| 3. Jehova's Witness | <input type="checkbox"/> | 8. Jewish        | <input type="checkbox"/> |
| 4. Muslim           | <input type="checkbox"/> | 9. Non-religious | <input type="checkbox"/> |
| 5. African religion | <input type="checkbox"/> |                  |                          |
| 10. Other           | <input type="checkbox"/> | specify.....     |                          |

**Home Language:**

- |              |                          |              |                          |
|--------------|--------------------------|--------------|--------------------------|
| 1. Afrikaans | <input type="checkbox"/> | 7. English   | <input type="checkbox"/> |
| 2. isiZulu   | <input type="checkbox"/> | 8. Ndebele   | <input type="checkbox"/> |
| 3. Sepedi    | <input type="checkbox"/> | 9. Sesotho   | <input type="checkbox"/> |
| 4. Swati     | <input type="checkbox"/> | 10. Tsonga   | <input type="checkbox"/> |
| 5. Tswana    | <input type="checkbox"/> | 11. isiXhosa | <input type="checkbox"/> |
| 6. Venda     | <input type="checkbox"/> | 12. Other    | <input type="checkbox"/> |
|              |                          | specify..... |                          |

Below is a scenario describing health problems of an individual and her life issues. She is not a real person, but there are people like her. If you happen to know someone who resembles her in any way, that is a total coincidence. After reading/listening to this scenario please answer the questions that would follow. Remember, there are no right or wrong answers.

**Vignette**

Zanele is 30 years-old. She has been feeling unusually sad and miserable for the last few weeks. Even though she is tired all the time, she has trouble sleeping nearly every night. Zanele doesn't feel like eating and has lost weight. She can't keep her mind on her work and keeps delaying making any decisions. Even day-to-day tasks seem too much for her. This has come to the attention of Zanele's boss, who is concerned about the poor quality of her work. Zanele feels she will never be happy again and believes her family would be better without her. Zanele has been so desperate, she is thinking of ways to end her.

Q1. What, if anything, would you say is wrong with Zanele?

.....  
.....

Q2. What do you think is the cause of Zanele's problem/s?

.....  
.....

Q3. What would you call Zanele's problem?

.....  
.....



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

Q4. How do you think Zanele could best be helped?

.....  
.....

Q5. If you had a problem right now like Zanele, would you go for help?

- a. Yes
- b. No

If you responded "Yes" to Question 5 above: Answer Questions 6 & 7. Or else, proceed to Question 8

Q6. Whom would you ask for help?

.....

Q7. What might stop you from seeking help from this person/place?

.....  
.....

Q8. In your opinion, how likely it is that Zanele's situation might have been caused by:

	Very likely	Don't know	Less likely
a. Own bad character			
b. Chemical imbalance in the brain			
c. The way she was raised			
d. Stressful circumstances in her life			
e. Genetic or inherited problems			
f. God's will			
g. Failure to perform certain cultural rituals			
h. Ancestral anger			
i. Evil spirits/sorcery			
j. Punishment for sins she committed			

Q9. There are a number of different people, some professional, some not, who could possibly help Zanele. Are each of the following people likely to be helpful, harmful, or neither for Zanele?



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

	Helpful	Harmful
a. Family GP / Doctor		
b. Pharmacist /Chemist		
c. A Counsellor		
d. Social Worker		
e. Telephone Counselling, like <a href="#">Life Line</a>		
f. A Psychiatrist		
g. A Psychologist		
h. Help from close family member		
i. Help from close friends		
j. Sangoma (Diviner)		
k. Nyanga (Herbalist)		
l. uMthandazi (Faith healer)		
m. A Church Minister/Priest/ Pastor		
n. To deal with her problem on her own		

Q10. Do you think the following different MEDICINES are likely to be helpful, harmful, or neither to Zanele?

	Helpful	Harmful
a. Vitamins, <u>minerals</u> and tonics		
b. Traditional medicine		
c. Pain relievers such as <u>asprin</u> , <u>panado</u> , <u>grandpa</u> , <u>compral</u>		
d. Antidepressant		
e. Antibiotics		
f. Sleeping pills		



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g. Anti-psychotics		
h. Tranquilizers such as <del>valium</del>		

Q11. The next few questions ask what you think are Zanele's chances of recovery. What would be the likely result if Zanele had the sort of professional help you think is most appropriate?

Would you say.... (*please choose one*)

- a. Full recovery with no further problems
- b. Partial recovery, but problems would probably re-occur
- c. No improvement

Q12. What would be the likely result if Zanele did NOT have any professional help? Would you say.... (*please choose one*)

- a. Full recovery with no further problems
- b. Partial recovery, but problems would probably re-occur
- c. No improvement

Q13. Suppose Zanele received the sort of help that you think is most appropriate for her problems, for each of the following, how do you think Zanele would be IN THE LONG TERM, compared to other people in the community?

	More likely	Less likely	Don't know
a. Be violent			
b. Drink too much alcohol			
c. Take illegal drugs			
d. Have poor friendships			
e. Attempt suicide			
f. <u>Be understanding</u> of other people's feelings			
g. Have a good marriage			
h. Be a caring parent			
i. Be a productive worker			
j. Be creative or artistic			



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

**Q14. Now, for the next few questions, we would like you to tell us what DO YOU THINK OR BELIEVE about these statements?**

	Agree	Disagree	I don't know
a. A problem like Zanele's is a sign of personal weakness			
b. Zanele's problem is not a real medical illness			
c. People with a problem like Zanele's are dangerous			
d. It is best to avoid people with a problem like Zanele's so that you don't develop this problem			
e. I would not employ someone I knew she had a problem like Zanele's			

**Q15. Do you think that Zanele would be discriminated against by others in the community, if they knew about her problems?**

- a. Yes
- b. No

**Q16. The next few questions ask about how willing you would be to have contact with someone like Zanele**

	Willing	Unwilling	Don't know
a. How willing would you be to move next door to Zanele?			
b. How willing would you be to spend an evening socializing with Zanele?			
c. How willing would you be to make friends with Zanele?			
d. How willing would you be to have a relationship with Zanele?			
e. How willing would you be to have Zanele start working closely with you on a job?			
f. How willing would you be to have Zanele looking after your children?			
g. How willing would you be to live in the same room with Zanele?			



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

h. How willing would you be to have people like Zanele living in your neighbourhood?			
--	--	--	--

Q17. People with a problem like Zanele's are:

	Strongly agree	Strongly disagree	I don't know
a. Dangerous			
b. Unpredictable			
c. Lacking self-control			
d. Aggressive			
e. Frightening			

Q18. Has anyone in your family or close circle of friends ever had problems similar to Zanele's?

- a. Yes   
b. No

Q19. If you were to come into contact with people having a problem like Zanele's, would your contact with them be friendly and cooperative?

- a. Yes   
b. No

Q20. The following questions are about mental health, media and mental health organizations. Have you seen, read, or heard any news or stories about mental health in the last 6 months?

- a. Yes   
b. No

Q21. If you answered 'Yes' to Q20, did you read about, see or hear these news or stories in/from....

- a. The newspaper   
b. Magazine   
c. Radio   
d. Television   
e. Internet   
f. Community Health Worker   
g. Other (specify)

.....

Q22. What is the nearest place in your area that provides treatment for people with mental health problems?

.....  
.....





Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

**Q23. Is there anything else you would like to say or mention about Zanele's problem?**

.....  
.....  
.....  
.....

**THANK YOU!**



**Mental Health Literacy: Knowledge and beliefs about mental illness amongst indigenous African residents of Dihlabeng Local Municipality in the Free State.**

**QUESTIONNAIRE (APPENDIX B)**

PLEASE FILL IN THIS QUESTIONNAIRE **ACCURATELY** AS POSSIBLE.

**Demographic Information:**

Age.....

Gender:

1. Female   
2. Male

Marital Status

1. Single   
2. Married   
3. Separated/Divorced   
4. Widowed   
5. Living with a partner

Where do you stay?

Dihlabeng Local Municipality

1. Yes   
2. No

Race / Ethnicity

1. African  3. Coloured   
2. Indian  4. White   
5. Other  *specify*.....

What is your highest level of education?

1. Never went to school   
2. Primary   
3. Secondary



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

4. Tertiary

Religious Affiliation

- |                     |                          |                      |                          |
|---------------------|--------------------------|----------------------|--------------------------|
| 1. Atheist          | <input type="checkbox"/> | 6. Buddhist          | <input type="checkbox"/> |
| 2. Christian        | <input type="checkbox"/> | 7. Hindu             | <input type="checkbox"/> |
| 3. Jehova's Witness | <input type="checkbox"/> | 8. Jewish            | <input type="checkbox"/> |
| 4. Muslim           | <input type="checkbox"/> | 9. Non-religious     | <input type="checkbox"/> |
| 5. African religion | <input type="checkbox"/> |                      |                          |
| 10. Other           | <input type="checkbox"/> | <i>specify</i> ..... |                          |

Home Language:

- |                      |                          |              |                          |
|----------------------|--------------------------|--------------|--------------------------|
| 1. Afrikaans         | <input type="checkbox"/> | 7. English   | <input type="checkbox"/> |
| 2. isiZulu           | <input type="checkbox"/> | 8. Ndebele   | <input type="checkbox"/> |
| 3. Sepedi            | <input type="checkbox"/> | 9. Sesotho   | <input type="checkbox"/> |
| 4. Swati             | <input type="checkbox"/> | 10. Tsonga   | <input type="checkbox"/> |
| 5. Tswana            | <input type="checkbox"/> | 11. isiXhosa | <input type="checkbox"/> |
| 6. Venda             | <input type="checkbox"/> | 12. Other    | <input type="checkbox"/> |
| <i>specify</i> ..... |                          |              |                          |

Below is a scenario describing health problems of an individual and her life issues. She is not a real person, but there are people like her. If you happen to know someone who resembles her in any way, that is a total coincidence. After reading/listening to this scenario please answer the questions that would follow. Remember, there are no right or wrong answers.

**Vignette**

Zanele is 30 years old. During the last month she has started to drink more than her usual amount of alcohol. In fact, Zanele has noticed that she needs to drink twice as much as she used to, to get the same effect. Several times, she has tried to cut down, or stop drinking, but she can't. Each time she has tried to cut down, she becomes very agitated, sweaty and she couldn't sleep, so she took another drink. Zanele's family has complained that she is often hungover, and has become unreliable- making plans one day, and cancelling them the next day.

Q1. What, if anything, would you say is wrong with Zanele?

.....  
.....

Q2. What do you think is the cause of Zanele's problem/s?

.....  
.....

Q3. What would you call Zanele's problem?

.....  
.....



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

Q4. How do you think Zanele could best be helped?

.....

.....

Q5. If you had a problem right now like Zanele, would you go for help?

- a. Yes
- b. No

If you responded "Yes" to Question 5 above: Answer Questions 6 & 7. Or else, proceed to Question 8

Q6. Whom would you ask for help?

.....

Q7. What might stop you from seeking help from this person/place?

.....

.....

Q8. In your opinion, how likely it is that Zanele's situation might have been caused by:

	Very likely	Don't know	Less likely
a. Own bad character			
b. Chemical imbalance in the brain			
c. The way she was raised			
d. Stressful circumstances in her life			
e. Genetic or inherited problems			
f. God's will			
g. Failure to perform certain cultural rituals			
h. Ancestral anger			
i. Evil spirits/sorcery			
j. Punishment for sins she committed			

Q9. There are a number of different people, some professional, some not, who could possibly help Zanele. Are each of the following people likely to be helpful, harmful, or neither for Zanele?



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

	Helpful	Harmful
a. Family GP / Doctor		
b. Pharmacist /Chemist		
c. A Counsellor		
d. Social Worker		
e. Telephone Counselling, like <a href="#">Life Line</a>		
f. A Psychiatrist		
g. A Psychologist		
h. Help from close family member		
i. Help from close friends		
j. Sangoma (Diviner)		
k. Nyanga (Herbalist)		
l. uMthandazi (Faith healer)		
m. A Church Minister/Priest/ Pastor		
n. To deal with her problem on her own		

Q10. Do you think the following different MEDICINES are likely to be helpful, harmful, or neither to Zanele?

	Helpful	Harmful
a. Vitamins, <u>minerals</u> and tonics		
b. Traditional medicine		
c. Pain relievers such as <u>asprin</u> , <u>panado</u> , <u>grandpa</u> , <u>compral</u>		
d. Antidepressant		
e. Antibiotics		
f. Sleeping pills		



g. Anti-psychotics		
h. Tranquilizers such as <del>valium</del>		

Q11. The next few questions ask what you think are Zanele's chances of recovery. What would be the likely result if Zanele had the sort of professional help you think is most appropriate?

Would you say.... (*please choose one*)

- a. Full recovery with no further problems
- b. Partial recovery, but problems would probably re-occur
- c. No improvement

Q12. What would be the likely result if Zanele did NOT have any professional help? Would you say.... (*please choose one*)

- a. Full recovery with no further problems
- b. Partial recovery, but problems would probably re-occur
- c. No improvement

Q13. Suppose Zanele received the sort of help that you think is most appropriate for her problems, for each of the following, how do you think Zanele would be IN THE LONG TERM, compared to other people in the community?

	More likely	Less likely	Don't know
a. Be violent			
b. Drink too much alcohol			
c. Take illegal drugs			
d. Have poor friendships			
e. Attempt suicide			
f. <u>Be understanding</u> of other people's feelings			
g. Have a good marriage			
h. Be a caring parent			
i. Be a productive worker			
j. Be creative or artistic			



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

**Q14. Now, for the next few questions, we would like you to tell us what DO YOU THINK OR BELIEVE about these statements?**

	Agree	Disagree	I don't know
a. A problem like Zanele's is a sign of personal weakness			
b. Zanele's problem is not a real medical illness			
c. People with a problem like Zanele's are dangerous			
d. It is best to avoid people with a problem like Zanele's so that you don't develop this problem			
e. I would not employ someone I knew she had a problem like Zanele's			

**Q15. Do you think that Zanele would be discriminated against by others in the community, if they knew about her problems?**

- a. Yes
- b. No

**Q16. The next few questions ask about how willing you would be to have contact with someone like Zanele**

	Willing	Unwilling	Don't know
a. How willing would you be to move next door to Zanele?			
b. How willing would you be to spend an evening socializing with Zanele?			
c. How willing would you be to make friends with Zanele?			
d. How willing would you be to have a relationship with Zanele?			
e. How willing would you be to have Zanele start working closely with you on a job?			
f. How willing would you be to have Zanele looking after your children?			
g. How willing would you be to live in the same room with Zanele?			



h. How willing would you be to have people like Zanele living in your neighbourhood?			
--	--	--	--

Q17. People with a problem like Zanele's are:

	Strongly agree	Strongly disagree	I don't know
a. Dangerous			
b. Unpredictable			
c. Lacking self-control			
d. Aggressive			
e. Frightening			

Q18. Has anyone in your family or close circle of friends ever had problems similar to Zanele's?

- a. Yes
- b. No

Q19. If you were to come into contact with people having a problem like Zanele's, would your contact with them be friendly and cooperative?

- a. Yes
- b. No

Q20. The following questions are about mental health, media and mental health organizations. Have you seen, read, or heard any news or stories about mental health in the last 6 months?

- a. Yes
- b. No

Q21. If you answered 'Yes' to Q20, did you read about, see or hear these news or stories in/from....

- a. The newspaper
- b. Magazine
- c. Radio
- d. Television
- e. Internet
- f. Community Health Worker
- g. Other (specify)

.....

Q22. What is the nearest place in your area that provides treatment for people with mental health problems?

.....  
.....





Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

**Q23. Is there anything else you would like to say or mention about Zanele's problem?**

.....  
.....  
.....  
.....

**THANK YOU!**



**Mental Health Literacy: Knowledge and beliefs about mental illness amongst indigenous African residents of Dihlabeng Local Municipality in the Free State.**

**QUESTIONNAIRE (APPENDIX B)**

PLEASE FILL IN THIS QUESTIONNAIRE **ACCURATELY** AS POSSIBLE.

**Demographic Information:**

Age .....

Gender:

1. Female   
2. Male

Marital Status

1. Single   
2. Married   
3. Separated/Divorced   
4. Widowed   
5. Living with a partner

Where do you stay?

Dihlabeng Local Municipality

1. Yes   
2. No

Race / Ethnicity

1. African  3. Coloured   
2. Indian  4. White   
5. Other  *specify*.....

What is your highest level of education?

1. Never went to school   
2. Primary   
3. Secondary



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

4. Tertiary

**Religious Affiliation**

- |                     |                          |                  |                          |
|---------------------|--------------------------|------------------|--------------------------|
| 1. Atheist          | <input type="checkbox"/> | 6. Buddhist      | <input type="checkbox"/> |
| 2. Christian        | <input type="checkbox"/> | 7. Hindu         | <input type="checkbox"/> |
| 3. Jehova's Witness | <input type="checkbox"/> | 8. Jewish        | <input type="checkbox"/> |
| 4. Muslim           | <input type="checkbox"/> | 9. Non-religious | <input type="checkbox"/> |
| 5. African religion | <input type="checkbox"/> |                  |                          |
| 10. Other           | <input type="checkbox"/> | specify.....=    |                          |

**Home Language:**

- |              |                          |              |                          |
|--------------|--------------------------|--------------|--------------------------|
| 1. Afrikaans | <input type="checkbox"/> | 7. English   | <input type="checkbox"/> |
| 2. isiZulu   | <input type="checkbox"/> | 8. Ndebele   | <input type="checkbox"/> |
| 3. Sepedi    | <input type="checkbox"/> | 9. Sesotho   | <input type="checkbox"/> |
| 4. Swati     | <input type="checkbox"/> | 10. Tsonga   | <input type="checkbox"/> |
| 5. Tswana    | <input type="checkbox"/> | 11. isiXhosa | <input type="checkbox"/> |
| 6. Venda     | <input type="checkbox"/> | 12. Other    | <input type="checkbox"/> |
|              |                          | specify..... |                          |

Below is a scenario describing health problems of an individual and her life issues. She is not a real person, but there are people like her. If you happen to know someone who resembles her in any way, that is a total coincidence. After reading/listening to this scenario please answer the questions that would follow. Remember, there are no right or wrong answers.

**Vignette**

Zanele is 30 years old. Until a year ago, life was pretty okay for her. But then things started to change. She thought that people around her were making disapproving comments and talking behind her back. She was convinced that people were spying on her and they could hear what she was thinking. Zanele lost her drive to participate in work and family activities and retreated to her bedroom, eventually spending most of the day there. Zanele was hearing voices of her grandmother who passed away 10 years ago. These voices were telling her what to do and what to think. Zanele also reported seeing visions of her late grandmother. She has been living this way for the past six months.

Q1. What, if anything, would you say is wrong with Zanele?

.....  
.....

Q2. What do you think is the cause of Zanele's problem/s?

.....  
.....

Q3. What would you call Zanele's problem?

.....  
.....



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

Q4. How do you think Zanele could best be helped?

.....  
.....

Q5. If you had a problem right now like Zanele, would you go for help?

- a. Yes
- b. No

If you responded "Yes" to Question 5 above: Answer Questions 6 & 7. Or else, proceed to Question 8

Q6. Whom would you ask for help?

.....

Q7. What might stop you from seeking help from this person/place?

.....  
.....

Q8. In your opinion, how likely it is that Zanele's situation might have been caused by:

	Very likely	Don't know	Less likely
a. Own bad character			
b. Chemical imbalance in the brain			
c. The way she was raised			
d. Stressful circumstances in her life			
e. Genetic or inherited problems			
f. God's will			
g. Failure to perform certain cultural rituals			
h. Ancestral anger			
i. Evil spirits/sorcery			
j. Punishment for sins she committed			

Q9. There are a number of different people, some professional, some not, who could possibly help Zanele. Are each of the following people likely to be helpful, harmful, or neither for Zanele?



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

	Helpful	Harmful
a. Family GP / Doctor		
b. Pharmacist /Chemist		
c. A Counsellor		
d. Social Worker		
e. Telephone Counselling, like <a href="#">Life Line</a>		
f. A Psychiatrist		
g. A Psychologist		
h. Help from close family member		
i. Help from close friends		
j. Sangoma (Diviner)		
k. Nyanga (Herbalist)		
l. uMthandazi (Faith healer)		
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b. Traditional medicine		
c. Pain relievers such as <u>asprin, panado, grandpa, combral</u>		
d. Antidepressant		
e. Antibiotics		
f. Sleeping pills		



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

g. Anti-psychotics		
h. Tranquilizers such as <del>valium</del>		

Q11. The next few questions ask what you think are Zanele's chances of recovery. What would be the likely result if Zanele had the sort of professional help you think is most appropriate?

Would you say.... (*please choose one*)

- a. Full recovery with no further problems
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Q12. What would be the likely result if Zanele did NOT have any professional help? Would you say.... (*please choose one*)

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Q13. Suppose Zanele received the sort of help that you think is most appropriate for her problems, for each of the following, how do you think Zanele would be IN THE LONG TERM, compared to other people in the community?

	More likely	Less likely	Don't know
a. Be violent			
b. Drink too much alcohol			
c. Take illegal drugs			
d. Have poor friendships			
e. Attempt suicide			
f. <u>Be understanding</u> of other people's feelings			
g. Have a good marriage			
h. Be a caring parent			
i. Be a productive worker			
j. Be creative or artistic			



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

**Q14. Now, for the next few questions, we would like you to tell us what DO YOU THINK OR BELIEVE about these statements?**

	Agree	Disagree	I don't know
a. A problem like Zanele's is a sign of personal weakness			
b. Zanele's problem is not a real medical illness			
c. People with a problem like Zanele's are dangerous			
d. It is best to avoid people with a problem like Zanele's so that you don't develop this problem			
e. I would not employ someone I knew she had a problem like Zanele's			

**Q15. Do you think that Zanele would be discriminated against by others in the community, if they knew about her problems?**

- a. Yes
- b. No

**Q16. The next few questions ask about how willing you would be to have contact with someone like Zanele**

	Willing	Unwilling	Don't know
a. How willing would you be to move next door to Zanele?			
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c. How willing would you be to make friends with Zanele?			
d. How willing would you be to have a relationship with Zanele?			
e. How willing would you be to have Zanele start working closely with you on a job?			
f. How willing would you be to have Zanele looking after your children?			
g. How willing would you be to live in the same room with Zanele?			



Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

h. How willing would you be to have people like Zanele living in your neighbourhood?			
--	--	--	--

Q17. People with a problem like Zanele's are:

	Strongly agree	Strongly disagree	I don't know
a. Dangerous			
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c. Lacking self-control			
d. Aggressive			
e. Frightening			

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- b. No

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- a. Yes
- b. No

Q21. If you answered 'Yes' to Q20, did you read about, see or hear these news or stories in/from....

- a. The newspaper
- b. Magazine
- c. Radio
- d. Television
- e. Internet
- f. Community Health Worker
- g. Other (specify)

.....

Q22. What is the nearest place in your area that provides treatment for people with mental health problems?

.....  
.....





Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

Q23. Is there anything else you would like to say or mention about Zanele's problem?

.....  
.....  
.....  
.....

**THANK YOU!**





### **WHY ARE YOU INVITED TO TAKE PART IN THIS RESEARCH PROJECT?**

*You are invited to participate in this research project because you are an indigenous South African residing in Bethlehem or Fouriesburg and above 18 years.*

### **WHAT IS THE NATURE OF PARTICIPATION IN THIS STUDY?**

*You will be required to read the information leaflet, sign the consent form (Appendix A), and complete a questionnaire, namely The Attitudes and Beliefs about Mental Health Problems: Professional and Public Views' Questionnaire. This questionnaire consists of (1) demographical information, (2) case studies of vignettes, (3) questions based on the research aims and objectives. Questions included are open-ended and Likert-type scales. The expected duration of participation is approximately 30 minutes.*

### **CAN THE PARTICIPANT WITHDRAW FROM THE STUDY?**

*Participation in the study is voluntary. There is no penalty or loss of benefit for non-participation. You are under no obligation to consent to participation. If you decide to participate, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time during the data collection period without providing a reason. However, please note that it will not be possible to withdraw once the questionnaires have been submitted.*

### **WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?**

*The study will raise a need for public awareness campaigns on mental health promotion in indigenous African communities, thus, leading to improved mental well-being within the communities. The research aims to close the gap in the mental health literacy of indigenous Africans. It may be hypothesised that the awareness of the gap in indigenous African communities/population will lead to the need for mental health promotion through public awareness campaigns, resulting in the improved mental well-being of indigenous Africans. This study's findings will also guide healthcare planning policies on preferred patient referral pathways and subsequently improve the provision of mental healthcare service. The study will be responsive to the health needs of South African communities in line with the national health research priorities as outlined in Section 70 of the National Health Act.*

### **WHAT IS THE ANTICIPATED INCONVENIENCE OF TAKING PART IN THIS STUDY?**

*The research will be conducted within the community in public spaces, and participants may thus be subject to possible inconvenience. This might be regarding their time as they will be recruited randomly while going on with their daily activities. If any participant suffers personal or cultural embarrassment or reputation harm or emotional distress related to participating in the research. In that case, they will be referred to the nearest clinic where outreach services will be available for psychological attention*

*from mental health practitioners at the clinic or referred to psychology outreach services at the nearest clinics in the district. These include Dihlabeng Regional Hospital: Bohlokong clinic: Ms. L. Makoba (clinical psychologist) – 0583035337 and Ms M Makhate (intern clinical psychologist for outreach services) - 0583038350. Due to the public nature of the health clinics, participants will not be paying a fee. The number of services will be problem- and patient-specific and will be determined based on the clinical judgement of the treating professional.*

#### **WILL WHAT I SAY BE KEPT CONFIDENTIAL?**

*All personal information is confidential and will not be disclosed to anyone. However, Due to the data collection occurring in public spaces, there is a slight probability that participants can be overheard.*

#### **HOW WILL THE INFORMATION BE STORED AND ULTIMATELY DESTROYED?**

*The researcher will store hard copies of your answers for a period of five years in a locked cupboard/filing cabinet at the Department of Psychology, University of the Free State. For future research or academic purposes, electronic information will be stored on a password-protected computer with encrypted files. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable. Hard-copy information will be destroyed with the use of a shredding machine. No foreseeable risks are detected.*

#### **WILL I RECEIVE PAYMENT OR ANY INCENTIVES FOR PARTICIPATING IN THIS STUDY?**

*Participants will receive no payment or reward for participating in the study.*

#### **HOW WILL THE PARTICIPANT BE INFORMED OF THE FINDINGS / RESULTS OF THE STUDY?**

*Participants who would like to be informed of the final research findings should contact Nonhlanhla Matsoele at nm76827@gmail.com. The findings will be accessible from 01/03/2022-01/03/2023. For any further information or to contact the researcher about any aspect of this study, please email her at nm76827@gmail.com. Should participants have concerns about how the research has been conducted, they may contact Dr Molelekoa J. Kometsi (Research supervisor) on 051 430 2881 or email kometsimj@ufs.ac.za. Due to work schedules, potential inconveniences may include not attending immediately to inquiries; however, the persons will reply to any contact made timeously. Furthermore, a minimal possibility of harm may occur as researchers will only be attending to research-related matters and selectively ignore others (outlining likely incidence and severity). Information shared in writing will be deleted after the matter has been attended to. If any of the participants report signs of personal or cultural embarrassment or reputation harm related to participating in the research, they will be referred to the nearest clinic where outreach services will be available for psychological attention.*

**Thank you for taking the time to read this information sheet and for participating in this study.**

### CONSENT TO PARTICIPATE IN THIS STUDY

I, \_\_\_\_\_ (participant name), confirm that the person requesting my consent to participate in this research has informed me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

I have read (or had explained to me) and understood the study as explained in the information sheet. I have had sufficient opportunity to ask questions and am prepared to participate in the study. I understand that my participation is voluntary and that I am free to withdraw at any time without penalty (if applicable). I am aware that the findings of this study will be anonymously processed into a research report, journal publications and/or conference proceedings.

I agree to participate in this research by completing this questionnaire.

I have received a signed copy of the informed consent agreement.

Full Name of Participant: \_\_\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_\_\_

Full Name(s) of Researcher(s): \_\_\_\_\_

Signature of Researcher: \_\_\_\_\_ Date: \_\_\_\_\_

Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

## Mental Health Literacy: Knowledge and beliefs about mental illness amongst indigenous African residents of Dhlabeng Local Municipality in the Free State

### INFORMED CONSENT (APPENDIX A)

Good day

Ms Nonhlanhla Matsoele, a master's research psychology student at the University of the Free State, is conducting a study in the Free State on people's attitudes regarding certain public health issues South Africans are facing today. The study aims to better understand what people know and understand about mental illness. Therefore, we would appreciate your input and we want to include your views. The questions will cover areas such as awareness of a specific mental illness, where people seek help, and how the mental illness could be treated. You do not have to answer any questions if you do not want to or do not feel comfortable answering a specific question.

It will take approximately 30 minutes to complete the questionnaire. If you agree to complete the questionnaire, you are free to withdraw from the study at any given time, without any consequences. No harm is foreseeable to participate in this study. This study will first be ethically reviewed by the General Human Research Ethics Committee (GHREC) of the University of the Free State. If you experience any problems or have concerns/questions regarding this study, please contact the researcher, Ms Nonhlanhla Matsoele or her supervisor Dr Molelekoa J. Kometsi (051 430 2881), or the faculty administration officer for ethics - Ms Charné Vercueil (VercueilCC@ufs.ac.za or 051 401 7083).

**Approval number:** UFS-HSD2020/0391/21

Please note the following before consenting to participate in this study:

1. Your anonymity and confidentiality will be ensured. All personal information is confidential and will not be disclosed to anyone.
2. You are free to decide if you want to answer all or only some of the questions. If you do not want to answer a question or do not feel comfortable answering a question, you may do so.
3. The results of this study will be used as part of a Master's dissertation and could be published in accredited journals.
4. Your participation in this study is voluntary. You are not forced to participate in this study, and you may withdraw, without any consequences.
5. You need to be 18 years or older to participate in this study. No person under the age of 18 is allowed to take part in this study. If you are under the age of 18, please inform the researcher and do not continue completing the questionnaire.

Do you have any questions about this research?



---

Mental Health Literacy and Stigma (Main Survey 18+) Questionnaire Shortened Version (August 2017)©

**Consent to Participate:**

I hereby confirm that I have read and understood the details of the proposed study. By completing this questionnaire, I consent to participate in this research project.

I understand that I am at liberty (free) to withdraw from participating in this research at any time, should I wish to do so.

Signature of participant

.....



## ADDENDUM C: ETHICS CLEARANCE CERTIFICATE



### GENERAL/HUMAN RESEARCH ETHICS COMMITTEE (GHREC)

06-Oct-2021

Dear Miss Nonhlanhla Matsoele

#### **Application Approved**

Research Project Title:

**Mental Health Literacy: Knowledge and beliefs about mental illness amongst indigenous African residents of Dihlabeng Local Municipality in the Free State.**

Ethical Clearance number:

**UFS-HSD2020/0391/21**

We are pleased to inform you that your application for ethical clearance has been approved. Your ethical clearance is valid for twelve (12) months from the date of issue. We request that any changes that may take place during the course of your study/research project be submitted to the ethics office to ensure ethical transparency. Furthermore, you are requested to submit the final report of your study/research project to the ethics office. Should you require more time to complete this research, please apply for an extension. Thank you for submitting your proposal for ethical clearance; we wish you the best of luck and success with your research.

Study approved, but please remove the clean up the information and consent form (paragraph highlighted in yellow).

Yours sincerely

**Dr Adri Du Plessis**

**Chairperson: General/Human Research Ethics Committee**

**Dr Adri  
du  
Plessis** Digitally signed  
by Dr Adri du  
Plessis  
Date:  
2021.10.08  
12:28:57 +02'00'

205 Nelson Mandela  
Drive  
Park West  
Bloemfontein 9301  
South Africa

P.O. Box 339  
Bloemfontein 9300  
Tel: +27 (0)51 401  
9337  
[duplessisA@ufs.ac.za](mailto:duplessisA@ufs.ac.za)  
[www.ufs.ac.za](http://www.ufs.ac.za)



**ADDENDUM D: GATEKEEPERS' APPROVAL LETTER**

E-mail: records2@dihlabeng.co.za	Please address reply to: MUNICIPAL MANAGER
DEPARTMENT	Our Reference .....
Enquiries	Your Reference .....

**OFFICE OF THE EXECUTIVE MAYOR**

26 November 2020


Dear Nonhlanhla Matsoele

We are in receipt of your communication dated 20 October 2020 regarding the conducting of a full research study as a prerequisite to the completion of your Master's Degree in Clinical Psychology, in the towns of Bethlehem and Fouriesburg.

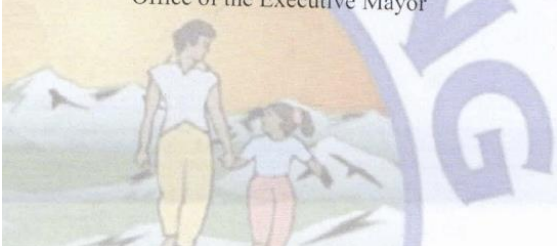
The Municipality whole-heartedly grants you the permission to conduct such research as we think that this will benefit the towns mentioned and the entire Dihlabeng Municipality. We further advise you and those who are recruited to strictly adhere to the covid-19 regulations as stipulated by the National Corona Virus Command Council.


We wish you success in all your studies as the Municipality.

Yours in Community Development.



Mr T.J Mokoena  
Strategic Manager  
Office of the Executive Mayor





Everyone, Every Household, Every Entity  
A Testimonial of our Excellent Service!

**HEAD OFFICE**  
9 Muller Street East  
PO Box 551  
Bethlehem  
9700

**Tel: 058 303 5732**  
**Fax: 058 303 4703**

**Website:**  
[www.dihlabeng.gov.za](http://www.dihlabeng.gov.za)  
**E-mail:**  
[records2@dihlabeng.co.za](mailto:records2@dihlabeng.co.za)

**CLARENS UNIT**  
**Tel: 058 256 1411**

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October, 20 2020

Dear Executive Mayor, Counselor Lindiwe Makhalema

I am Nonhlanhla Matsoele, a Masters Degree in Clinical Psychology student at the University of the Free State, conducting a full research study as a prerequisite to the completion of the Degree. My research aims to investigate what do the African residents of Dihlabeng Local Municipality in the Free State know and understand about some mental health issues facing Africans today. It is envisaged that the findings of this study will not only add value to academia, but also to the provision of mental health services amongst indigenous South Africans in general. This research is supervised by Dr. Molelekoa Kometsi, a clinical psychologist and lecturer at the University of the Free State.

I wish to request permission from you as a gatekeeper to allow me access into the communities of Bethlehem and Fouriesburg. These are the research sites where participants of this research will be recruited from. Participants will only be required to complete a questionnaire and no harm is anticipated to participants by taking part in this research. This research study will adhere to the following research ethical considerations as stipulated by the Health Professions Council of South Africa; respect to participants, informed consent, confidentiality and privacy, non-maleficence, beneficence and justice. In addition, the researcher will adhere to strict COVID-19 regulations which will entail, but not limited to, the wearing of masks and/or face shields by the researcher and participants, social distancing, sanitizing participants before and after the handling of the questionnaires as well as disinfecting objects such as pens before and after each use.


Furthermore, this study will first receive permission from the General Human Research Ethics Committee (GHREC) of the UFS prior to the data collection. It is, however, a prerequisite at the university to have gatekeepers' permission when submitting the research proposal for ethical clearance. I therefore, wish to humbly request the approval and permission from you as a gatekeeper to grant me a permission to access participants for my research. I sincerely hope my request will receive your favourable consideration.

Please do not hesitate to contact me or my supervisor should there be a need to do so.

Approved  



Kind Regards,

Mrs. NF Matsoele (079 500 5210)



Student Clinical Psychologist

Dr. MJ Kometsi (064 526 3526)



Supervisor & Clinical Psychologist



## ADDENDUM E: PROOF OF LANGUAGE EDITING



Date: 9 October 2022

### DECLARATION OF EDITING

I, Professor Margaret Williams, hereby declare that I did the language editing on the dissertation detailed below. The manuscript for submission purposes in fulfilment of the requirements for the degree Masters in Psychology in the Department of Psychology, Faculty of the Humanities at the University of the Free State. The manuscript has been edited for English language, inclusive of grammar, punctuation, and spelling, plus edited for APA/reference check, followed by technical editing/formatting.

#### TITLE

**Mental Health Literacy: Knowledge and beliefs about mental illness amongst indigenous African residents of Diklabeng Local Municipality in the Free State.**

#### AUTHOR

**Nonhlanhla Faith-Crescentia Matsoele**

Disclaimer: The author is free to accept or reject my changes to the document after editing. However, I do not bear responsibility for revisions made to the document after my edit on 09/10/2022.

Signed:

A handwritten signature in cursive script, appearing to read 'M Williams'.

Prof M Williams

Email: [maggie.williams@mandela.ac.za](mailto:maggie.williams@mandela.ac.za)  
Cell: 0825270600

## ADDENDUM F: TURNITIN REPORT

Mental Health Literacy: Knowledge and beliefs about mental illness amongst indigenous African residents of Dihlabeng Local Municipality in the Free State.

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