MENTAL HEALTH CARE PRACTITIONERS’ PERCEPTIONS OF MENTAL ILLNESS WITHIN THE ISIXHOSA CULTURAL CONTEXT

BY

NOCAWA PHILOMINA LOMBO

SUBMITTED IN PARTIAL FULFILLMENT OF THE DEGREE MAGISTER ARTIUM

IN SOCIAL WORK (SOCIAL DEVELOPMENT AND PLANNING) IN THE FACULTY

OF HEALTH SCIENCES, NELSON MANDELA METROPOLITAN UNIVERSITY.

SUPERVISOR: PROF. T.T. MASHOLOGU-KUSE

DATE: JANUARY, 2010
ACKNOWLEDGEMENTS

First I would like to thank God Almighty for making my dreams come true by doing this study.

In addition I would like to thank the following people for supporting me throughout this study:

A special thank you to my supervisor Prof Mashologu-Kuse for her sustaining SUPPORT, GUIDANCE AND PATIENCE. You sacrificed your family time for me. Without your support I could have never managed.

My husband ‘Zim’ for being available for me whenever I needed support and comfort and for holding the fort whilst I was busy with my studies. I really appreciate what you have done for me.

My three daughters – Kanyisa, Pumelela and Xabiso for their computer skills and encouragement.

My niece ‘Zololo’ for her computer skills and support.

Mariana, the Independent Coder for assisting with the themes and sub-themes.

My whole family for their support especially my sisters.

The staff of Komani Hospital for being the participants in this study.

My colleagues for their encouragement and support.
ABSTRACT

This study sought to explore the perceptions of mental health care practitioners’ perceptions on mental illness within the isiXhosa cultural context. A qualitative exploratory descriptive and contextual design was used for the study. A non-probability purposive sampling method was used to select eight participants from Komani Hospital in Queenstown. Data was collected through semi-structured interviews. The services of an Independent Interviewer were used to avoid any bias as interviews took place where the researcher is employed.

All interviews were transcribed verbatim and the data collected was analyzed according to Tesch’s eight steps of data analysis as described in Cresswell (1994:155). The researcher utilized services of an Independent Coder who verified the identified major themes. Four major themes emerged from the analysis of the interview: Mental health care practitioner’s perceptions of mental illness, perception of the causes of mental illness within the isiXhosa cultural context, mental health care practitioners’ views in the management and treatment of mental illness and suggestions put forward to improve the services to mental health care users.

The major findings of this study were the lack of knowledge of culture of mental health care users. It is recommended that it would be proper if there could be co-operation between mental health care practitioners and traditional healers by working together as a team.

Key Words:
Mental illness, mental health care users, mental health care practitioners.
# TABLE OF CONTENTS

Acknowledgements
Abstract

## CHAPTER 1: INTRODUCTION AND PROBLEM FORMULATION

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.2</td>
<td>Literature Review</td>
<td>3</td>
</tr>
<tr>
<td>1.2.1</td>
<td>Conceptual Frameworks</td>
<td>3</td>
</tr>
<tr>
<td>1.2.1.1</td>
<td>Modernization Theory</td>
<td>3</td>
</tr>
<tr>
<td>1.2.1.2</td>
<td>Empowerment Theory</td>
<td>4</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Studies Conducted</td>
<td>6</td>
</tr>
<tr>
<td>1.3</td>
<td>Problem Formulation</td>
<td>7</td>
</tr>
<tr>
<td>1.4</td>
<td>Research Question</td>
<td>8</td>
</tr>
<tr>
<td>1.5</td>
<td>Goals and Objectives of the Study</td>
<td>8</td>
</tr>
<tr>
<td>1.5.1</td>
<td>Goal</td>
<td>8</td>
</tr>
<tr>
<td>1.5.2</td>
<td>Objectives</td>
<td>8</td>
</tr>
<tr>
<td>1.6</td>
<td>Research Design and Methodology</td>
<td>8</td>
</tr>
<tr>
<td>1.6.1</td>
<td>Research Design</td>
<td>8</td>
</tr>
<tr>
<td>1.6.2</td>
<td>Research Population</td>
<td>9</td>
</tr>
<tr>
<td>1.6.3</td>
<td>Sampling</td>
<td>10</td>
</tr>
<tr>
<td>1.6.4</td>
<td>Methods of Data Collection</td>
<td>11</td>
</tr>
<tr>
<td>1.6.4.1</td>
<td>Structured Interview</td>
<td>11</td>
</tr>
<tr>
<td>1.6.4.2</td>
<td>Unstructured Interview</td>
<td>11</td>
</tr>
<tr>
<td>1.6.4.3</td>
<td>Semi-Structured Interview</td>
<td>11</td>
</tr>
<tr>
<td>1.6.4.4</td>
<td>Tape Recording</td>
<td>12</td>
</tr>
<tr>
<td>1.7</td>
<td>Pilot Study</td>
<td>13</td>
</tr>
<tr>
<td>1.8</td>
<td>Methods of Data Analysis</td>
<td>13</td>
</tr>
</tbody>
</table>
CHAPTER 2: RESEARCH DESIGN AND METHODOLOGY

2.1 Introduction.........................................................................................................18
2.2 Rationale for the Study.......................................................................................18
2.3 Goals and Objectives of the Study....................................................................19
2.3.1 Goal..................................................................................................................19
2.3.2 Objectives.......................................................................................................19
2.3 Research Designs.............................................................................................19
2.3.1 Qualitative Research....................................................................................20
2.3.2 Exploratory Research....................................................................................21
2.3.3 Descriptive Research....................................................................................21
2.3.4 Contextual Research.....................................................................................22
2.5 Research Methodology....................................................................................22
2.5.1 Research Population......................................................................................22
2.5.2 Sampling Methods........................................................................................23
2.5.3 Data Collection Methods..............................................................................24
2.5.3.1 Semi-Structured Interviews......................................................................24
2.5.3.1.2 Interview Schedule/Guide.................................................................25
2.5.4 Setting up Appointments.............................................................................26
2.5.4.1 The Interviews..........................................................................................27
2.5.4.2 Recording the Interview..........................................................................27
2.5.4.3 Role of the Independent Interviewer.......................................................28
2.6 Pilot Study........................................................................................................29
2.7 Data Analysis....................................................................................................29
2.8 Data Verification...............................................................................................31
CHAPTER 3: RESEARCH FINDINGS AND LITERATURE CONTROL

3.1 Introduction.............................................................................................................34
3.2 Profile of the Participants.......................................................................................35
3.3 Presentation of Findings.........................................................................................36
3.4 Discussion of Identified Themes...........................................................................38
3.3.1 Theme 1: Mental Health Care Practitioners’ perceptions of mental illness......38
3.3.1.1 Sub-theme: Mental disturbance that is characterized by strange behaviour....38
3.3.1.2 Sub-theme: Mental illness is a painful disease where one loses his/her dignity...42
3.3.1.2.1 The stigma of mental illness.................................................................45
3.3.1.2.2 The psychological consequences of mental illness..........................46
3.3.1.2.2.1 Loss of a sense of self.................................................................47
3.3.1.2.2.2 Loss of power.............................................................................48
3.3.1.2.2.3 Loss of meaning...........................................................................48
3.3.1.2.2.4 Loss of hope...............................................................................49
3.3.1.3 Sub-theme: Scientific causes for the development of mental illness..........49
3.3.1.3.1 Genetic Factors...............................................................................49
3.3.1.3.2 Social Factors..................................................................................50
3.3.1.3.3 Substance Abuse............................................................................50
3.3.1.3.4 Psychological Factors.................................................................50

3.3.2 Theme 2: Perception of the causes of mental illness within the isiXhosa cultural context........................................................................................................51
3.3.2.1 Sub-theme: Failure to observe customary practices..................................53
3.3.2.2 Witchcraft...............................................................................................56
3.3.2.3 Neglect of the calling and associated rituals to become a traditional healer (ukuthwasa)..........................................................................................59
CHAPTER 4: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1. Introduction.................................................................................................................77
4.1.1 Research Aims and Objectives....................................................................................77
4.2 Summary of the Research Design and Methodology..................................................78
4.2.1 Sampling selection of research participants.................................................................78
4.2.2 Data collection.............................................................................................................79
4.2.3 Data analysis.................................................................................................................79
4.3 Summary of the research findings...............................................................................79
4.3.1 Mental health care practitioners’ perceptions of mental illness.................................80
4.3.2 Perception of the causes of mental illness within the isiXhosa cultural context........80
4.3.3 Mental health care practitioners’ views on the management and treatment of mental illness.................................................................................................................81
4.3.4 Suggestions put forward..............................................................................................81
5. Major findings of the study............................................................................................82
6. Limitations of the study.................................................................................................84
7. Conclusions and Recommendations............................................................................85
7.1 Conclusions..............................................................................................................................85
7.2 Recommendations...................................................................................................................85
8. Concluding Remarks................................................................................................................87
9 References.................................................................................................................................89

Appendix 1: Interview Guide
Appendix 11: Letter of Request: Komani Hospital
Appendix 111: Consent Form by Participant
CHAPTER 1

1. INTRODUCTION AND PROBLEM FORMULATION

1.1 INTRODUCTION

Mental illness in South Africa is on the increase and Mental Health Care Act (No 17 of 2002) is faced with numerous challenges notably, a number of escalating patients that are admitted to psychiatric hospitals, although a community based psychiatric care policy was introduced in terms of the Mental Health Care Act of 2002. The Mental Health Care Act became effective in 2004 and its purpose is to ensure that no patient is confined to a psychiatric hospital unnecessarily; it encourages community care so that patients are rehabilitated in their communities. A Sunday Times investigation has found that the comprehensive service approach to delivery which the government devised to replace psychiatric hospital care does not exist in practice. A notable state psychiatrist Dr Bauman of Valkenberg hospital reported that “acute wards are now swamped with relapsed de-institutionalized patients … and that about 70% of psychiatric patients are re-admissions “(Sunday Times, 14/03/04).

In South Africa there are no statistics available for outpatients who are treated in their communities as many of them are defaulters but within the three biggest municipalities in the Eastern Cape it is estimated that during 2008 there were 12 255 outpatients who were treated in Buffalo City municipality clinics; 15 472 were treated in Chris Hani clinics and 13 420 were treated in Nelson Mandela Metropolitan clinics (Department of Health, Eastern Cape, 2009). For some reasons these figures may not correctly reflect the current situation as there are lot of other patients who are wandering aimlessly and homelessly. Some of these patients are picked up by police and being sent for admission within a 72 hour assessment to listed general hospitals and some after the assessment are transferred to psychiatric hospitals for re-admission.

The interest of the researcher in the present study was prompted by these frequent re-admissions of patients to the hospital (in spite of a community care policy) as well as reasons cited by their families regarding mental illness. Very few family members accepted mental illness as a brain
disease. The researcher believes that African people associate mental illness with cultural beliefs. For them culture plays a dominant role in defining and diagnosing mental illness. The researcher established that most family members have sent the mental health care users (mentally ill) for traditional treatment before admission to the hospital. In the isiXhosa tradition mental illness arises in the context of specific cultural beliefs like “ukufa kwesiXhosa” (illness of African people). When an individual is possessed by “ukufa kwesiXhosa” family members send him/her to traditional healers. The researcher believes that the decision by family members to send mental health care users for traditional treatment is due to their strong beliefs in cultural values.

In this study the researcher was interested in finding out from mental health care practitioners working in the hospital (psychologists, occupational therapists, physiotherapists, social workers, professional nurses and doctors) their perceptions of mental illness within the isiXhosa cultural context.

The present study therefore focused on the perceptions of mental illness within the isiXhosa cultural context. Such perceptions were investigated from a variety of professionals in the hospital where the researcher is employed. The researcher believes that the construction of culture and clinical background can be clearly understood by investigating the way in which mental illness is perceived by various professionals.

All these categories of professionals have contact with mental health care users at Komani hospital and all of them speak isiXhosa as their home language and are quite conversant with isiXhosa culture. In this manner mental illness was understood within the isiXhosa context in a broader sense. The results of the study will enable researchers and clinicians to understand isiXhosa culture and in future plan an effective mental health service that will empower all mental health care users and their families when the integration of traditional healing into the health system in South Africa is embraced.

Moreover, the current study moved beyond the purpose of the current investigation and sought to empower clinicians and communities about the isiXhosa culture because South Africa today is a multi-cultural democratic society. Furthermore, as far as mental health care practitioners are concerned, the majority are whites and English speaking and not quite conversant with isiXhosa culture and thus unable to give a proper diagnosis of African mental health care users. Clinicians
therefore cannot assume that all mental health care users can be treated in the same manner as they come from different cultural backgrounds.

1.2 LITERATURE REVIEW

1.2.1 CONCEPTUAL FRAMEWORKS

This study is informed by the following theoretical frameworks:

1.2.1.1. MODERNIZATION THEORY

With modernization theory, the emphasis is on viewing everything progressive and developmental with the lens of the West, North or the First World. The First World is seen as the ‘Father’ of development, and the Third World, in this instance, having to emulate what is advanced by the First World. Any strides and occurrence in the developing world, Second and Third Worlds, are viewed as traditional and backward (Coetzee & Graaff, 1996:25).

With this theory, the notion of development is viewed from an extraneous point of view, undermining the internal aspects of a particular country. People are viewed from a passive perspective, cannot initiate any development course. For example, here in South Africa we expatriate innovations that are applicable to the West, rather than examining them and consider their appropriateness within the context of our country. Our educational system, notably our social work curriculum, our parliamentary system, inter alia, has entirely undermined our indigenous concepts to the tune of modernization theory.

The theory according to Coetzee and Graaff (1996:27) refers to the transformation which takes place when a traditional or pre-modern society changes to such an extent that new forms of technological organizational or social characteristics of advanced society appear. They view modernization as a society striving towards bringing its own level of development in line with the advanced and modern accomplishment of other societies. In other words this theory refers to the development or progress that is taking place in a country through certain changes. A country will have to develop to become ‘modern’ in order to handle a wide variety of internal and external pressures. Modernization therefore means a process of bringing ‘up to date (Coetzee and Graaff, 1996:30) older things that are adapted to such an extent that they can stand the test of modern times. It is a movement towards development, moving from traditional perspective
change whereby external factors will have an impact on the individual, on the social structure and culture. This theory is relevant to the study because with the treatment of mental health care users many changes are taking place as mental health care users are no longer treated in isolation like before, and that traditional treatment will ultimately be incorporated into modern ways of treating and rehabilitating mental health care users.

The researcher must however, admit that we have benefited from modernization theory through the use of new techniques in agriculture, in supplementing subsistence farming we initially practiced, the invention of telecommunications and the like, but that does not mean that we have to abandon our indigenous ‘intellect’ and approach. Therefore, the weakness of this theory is that it fails to embrace the internal forces of a particular country hence this study wishes to address this lacuna and embrace all approaches, western and African, in advancing a comprehensive ‘package’ for mental health care users.

1.2.1.2 EMPOWERMENT THEORY

Proponents of Empowerment Approach believe that this is a the keystone of social work because it involves the process of assisting individuals, groups, families and communities to discover and expand the resources and tools within and around them. This could be more possible if social workers understand the client’s environments and their needs. They argue that empowering is made easier by removing disapproving labels to individuals instead of providing opportunities for connections to family, institutions and communal resources (Gray and van Rooyen, 2002; Gray, 1997; Saleeby, 1997; Lee, 1996). Social workers should create opportunities for those who are alienated and distressed and seize some control over their lives. Empowerment requires that social workers should trust people’s intuitions, perspectives, and energies and believe in people’s ‘dreams’. This theory is applicable to the study because the results of the study will empower clinicians and communities within the isiXhosa culture due to the fact that isiXhosa culture is not yet recognized by the western culture in terms of treating mental health care users as the western culture tends to undermine the traditional culture and does not understand ‘ukufa kwesiXhosa’.

Gray and van Rooyen (2002) have advanced the Strength Perspective as an approach to empowerment because it helps social workers to change focus and to concentrate on the positive
aspects that make clients cope and perceive them as survivors instead of victims, needs as gaps, problems as challenges, and clients as partners in the problem solving.

The researcher notes a few concepts that are fundamental to the conceptualization of the study:

**Replacing the pathology culture**

This is the basic concept of the Strength Perspective (Gray, 2002) in which clients are regarded as resilient and thus cannot be seen as recipients but as partners who have assets, resources and strengths that will enable them to cope with mental illness. With this perspective, clients, in this instance, mental health care users, are viewed as ‘experts’ of their illness since they have a history and a ‘story’ to tell and how they have coped with the situation, and therefore can also be seen as facilitators in the helping process. Labeling individuals is being discouraged since the language of empowerment takes the ‘centre stage’ and replaces the language of pathology.

**Move away from disempowering approaches**

The Strength Perspective requires that social workers acknowledge that clients have strengths and are not to be regarded as oppressed, disadvantaged and powerless. In a stressful situation social workers and other professionals will have to find out from clients what they know and how they survived the stressful situation and assist them to connect with family members. In the present study the approach is very much relevant as mentally health care users cannot be seen as powerless and with the support of family members they can survive.

**Prevailing myths needs to be shattered**

In empowering people there are always blockages that prevent people from taking part in their lives and these blockages are not good for the people and need to be identified and focus on them and if neglected they may cause harm to the progress of clients. It is the role of mental health care practitioners therefore to identify these blockages and address them in their approach to understanding and treating mental health care users.

**Ownership is important in a strength perspective**
In a Strength Perspective Gray (2002) argues that people take ownership in being part of a project if they were involved from the initial stages of planning. Social workers and other practitioners should not undermine people’s input in a community development project but should incorporate their ideas and suggestions so that they can feel empowered and thus their capacities, enhanced.

**History of Strengths**

In this approach Gray (2002) mentions the importance of taking into consideration cultural factors as some strengths are seen differently from culture to culture. This is very much applicable to this study as some mental health care practitioners may view mental illness within the African context negatively whereas in the African culture a person may be undergoing ‘ukuthwasa’ (customary practices that are observed in the calling of traditional healers) and not really mentally ill.

This perspective helps social workers to move away from disempowering approaches and be sensitive about people’s capacity for survival. It also helps professionals to acknowledge the experience, strengths, abilities and competencies of clients and to view people’s situations and focusing on the positive element. The theory is much applicable to the study because mental health care users and mental health care practitioners need to be empowered about mental illness in relation to isiXhosa cultural context so that mental health care practitioners can be able to understand illnesses from a cultural perspective in order for them to undergo treatment that embraces their culture without being prejudice.

**1.2.2 STUDIES CONDUCTED:**

Within the South African context very limited literature exists about the perceptions of mental illness within the isiXhosa cultural context by mental health care practitioners. Many studies focus on the experiences of mental illness by Xhosa families or by patients themselves or some focus on specific forms of mental illness like schizophrenia, others on perceptions of black communities towards mental illness. The following studies have some kind of a relationship secondary or otherwise, with the current study in terms of both similarities and differences. In their study Lund et al. (1998:2) were of the opinion that the construction of culture by psychiatric research and clinical practice can be understood by investigating the way in which mental health
care users understand and experience their condition. Lund et al. (1998:4) interviewed black psychiatric patients attending a Cape Town psychiatric community clinic, who perceived their condition as ‘amafufunyana’. Their results showed the differential use of treatments by patients, including faith healers, herbalists, diviners, private practitioners and psychiatric services. In the current study the researcher did not interview any mental health care users in the hospital because of the poor level of concentration due to their mental status.

In another study that was conducted by Phakathi (2005:36) she found out that families experienced uncertainty in understanding and coping with their family members’ mental illness and that their experience was influenced by the family’s cultural beliefs and tradition on how they understand and cope with the illness. The current study highlights the significance of understanding the cultural practices and the experiential modes of helping as well as the support of the family and the extended kin.

A similar study that was conducted by Botha (2006:619) in which the focus was on understanding how community perceived schizophrenia, was conducted on all races and the phenomenon under investigation was schizophrenia, unlike the current study that focuses on mental illness within the isiXhosa cultural context. In another study that was conducted by Mojalefa (1995:139) he found that mental illness in black communities is perceived in terms of witchcraft as was perceived by some participants in the current study. This perception is substantiated in Chapter 3.

1.3 PROBLEM FORMULATION

The mentally ill are no longer treated in isolation like before but are supported and well cared for in hospitals by mental health care practitioners. A number of mental health care users are readmitted to psychiatric hospitals on a daily basis due to failure of the implementation of the community care policy in practice. This has been caused by a number of factors, e.g., failure of the health care approach to mental illness leading to inappropriate health care delivery to the people on the ‘ground’ and also failure to understand how mental illness is perceived by African communities. This lack of perception results in mentally ill people being re-admitted to hospitals. It is on the basis of this lacuna that the current study addressed mental health care practitioners’
perceptions of mental illness so that they can better understand mental illness within the isiXhosa cultural context and be empowered for an effective mental health care delivery system.

1.4 RESEARCH QUESTION

The researcher would like to have the following question answered:

What are the perceptions of mental health care practitioners about mental illness within the isiXhosa cultural context?

1.5 GOALS AND OBJECTIVES OF THE STUDY

1.5.1 The goal of the study is as follows:

To determine the perceptions of mental illness by mental health care practitioners within the isiXhosa cultural context.

1.5.2 Objectives

- To explore and describe the perceptions of mental illness by mental health care practitioners;
- Based on the research findings, the study will draw conclusions and make recommendations on appropriate policies and services to be rendered in respect of mental health care users.

1.6 RESEARCH DESIGN AND METHODOLOGY

1.6.1 Research Design:

The broad methodological approach used in this study can be described as qualitative in nature. According to Merriam (2001:6) qualitative research is based on the understanding of the situation from the participants’ perspective and what it means for participants to be in that setting, what their lives are like, what is going on for them, what their meaning are, and what the
world looks like. Flick (2006:16) pointed out that qualitative researchers study participants’ knowledge and practices.

In this study the researcher sought to understand how mental illness is perceived by mental health care practitioners of Komani hospital in relation to their beliefs and cultural values i.e. what is their knowledge of mental illness in relation to their cultural practices. The study can also be described as explorative and contextual because the researcher explored and described mental health care practitioners’ perceptions of mental illness within the isiXhosa cultural context. The study is also descriptive because descriptive data in the participant’s own spoken words identifying their beliefs and values were produced. The researcher will describe how mental illness is being perceived by participants.

1.6.2 Research Population

The population of the study consisted of all mental health care practitioners of Komani hospital who are working with mental health care users. Seaber (1988) in De Vos (1998:190) defines a population as” the total set from which the individuals or units of study are chosen. It is the totality of persons, events, organization units, case records or other sampling units with which our research problem is concerned”.

The study was conducted in Komani psychiatric hospital, Queenstown, a 440 bed general psychiatric hospital with wards including geriatric, acute and adolescent wards. There are also separate admission wards for males and females, an admission bay where all mental health care users are screened and later transferred to relevant wards and there is a ward for mental health care users committed through the court of law. The hospital serves all towns of former Transkei as there is no psychiatric hospital in the former Transkei. Over 85% of admissions to the hospital are isiXhosa speaking. The hospital is not a training facility although some practical training of block placement from student nurses is conducted. Queenstown where the hospital is situated is a small town of about 140 000 people in the interior of Eastern Cape Province. The town has no industries and most people depend on social grants. Unemployment rate in the town is 60%. Of that 60%, 33% of the population depends on social grants and 27% is not in receipt of any state allowance. The hospital services all the rural towns of former Transkei as there is no psychiatric hospital in the former Transkei. Many outpatients as far as Lusikisiki, a distance of
approximately 400 kilometers, fetch their outpatient treatment from Komani hospital as community based psychiatric services do not exist in practice.

1.6.3 Sampling

De Vos (1998:191) defines a sample as a “subset of measurements drawn from a population in which we are interested. It is studied in an effort to understand the population from which it was drawn”. Non probability sampling and in particular a purposive sample was used for the study. The sample was based on the researcher’s own understanding of the ‘community’ of Komani Hospital where she is employed. Purposive sampling according to Maree (2007:79) means that participants are selected because of some defining characteristics that make them the holders of the data needed for the study. In this type of sampling decisions are made for the explicit purpose of obtaining the richest possible source of information to answer the research question. A minimum of eight participants were recruited for this study and sampling was concluded when it reached a point of data saturation.

The criteria that were used for selection of participants in the study were as follows:

- The research participants belonged to the isiXhosa ethnic group and were able to speak isiXhosa.
- The participants were mental health care practitioners from various professions employed by Komani hospital for at least a period of three years.
- They were working with mental health care users in their scope of practice.
- The sample consisted of both males and females.

The sampling technique used was non-probability purposive sample which according to Babbie (2001:167) is based on the researcher’s knowledge of the population, its elements and the purpose of the study. In this study the researcher knows the population as it is where she is employed. The researcher recruited a minimum of eight participants whom she knew were able to express themselves freely in order to meet the purpose of the investigation. The researcher chose the technique as its advantage is to save time and expenses since the population is
accessible for research. To avoid researcher’s bias since she is an employee at the hospital where the study was conducted, the services of an Independent Interviewer were sought.

1.6.4. Methods of Data Collection

As the study is qualitative in nature the researcher used interview as the data collection method as it is pre-dominant in qualitative research. According to Kvale in Devos (2005:287) “qualitative interview attempts to understand the world from the participants’ point of view, to unfold the meaning of people’s experiences and to uncover their lived world prior to scientific explanation”. There are three types of interviews as described by De Vos (2005:292). They are: structured interview, unstructured interview and the semi structured interview.

A discussion of each follows below:

1.6.4.1 Structured Interview

De Vos (2005:292) describes a structured interview as a guided interview and is used when the information is about a certain topic but the answers cannot be anticipated. It is ideal for obtaining comprehensive and comparable data. The participants are asked the same questions in the same sequence. The researcher’s role here is to guide the respondents according to the sequence of questions on the interview guide. There is very little flexibility in the way questions are asked in or answered in the structured interview (Denzin & Lincoln, 1994:363).

1.6.4.2 Unstructured Interview

De Vos (2005:292) is of the opinion that the unstructured interview is sometimes referred to as the in-depth interview and as a conversation with a purpose, but the purpose is to understand experiences of other people. In this type of interview there are no questions formulated but they develop spontaneously during interaction between the interviewer and the interviewee.

1.6.4.3 Semi-Structured Interview

De Vos (2005:296) states that “researchers use semi-structured interviews in order to gain a detailed picture of participants’ beliefs about or perceptions or accounts of a particular topic”. This type of interview gives the researcher and participants more flexibility. In this study the researcher gained detailed participants’ perceptions on mental illness. The researcher selected
this method because of its flexibility as she was able to probe beyond the answers given and ask for clarification and elaboration where necessary. De Vos further states that with semi-structured interviews the researcher will have a set of pre-determined questions on an interview schedule, but the interview will be guided by the schedule rather than be dictated by it. An interview schedule was used to guide the researcher when asking questions. Within the interview schedule, four questions were presented to the research participants and they are:

- How do you as a mental health care practitioner of Komani hospital perceive mental illness?
  
  Njengoko uixelenga apha esibhedlele nje nge Gosa lengqondo yezeMpilo ungathi yintoni ukugula ngengqondo?

- What is your view of conservative African perception of mental illness?

- Ngokwenkolo yesiXhosa, nenkcubeko yakho, namava akho ucinga ukuba yintoni ebangela ukuba umntu agule ngenqondo?

- What do you think can be done to assist the mentally ill cope, manage and treat the mental illness?

- Ucinga ukuba angancedakala njani umntu ogula ngengqondo ukuze amelane nesisifo ukuze anyangeke?

- What suggestions can you put forward in improving the services of the mentally ill?

- Ungacebisa ntoni malunga nokuphucula inkonzo zabagula ngengqondo?

1.6.4.4 Tape Recording

All interviews were tape recorded and were done with the permission of each participant. Smit et al. in De Vos (2005:298) mentions that a tape recorder allows a much fuller record than notes taken during interviews and allows the researcher to concentrate on the interview proceedings. By using a tape recorder time was saved as the researcher did not record lengthy responses from the interviewees as the questions were open ended.
1.7 PILOT STUDY

The researcher conducted a pilot study before doing the actual research. This helped the researcher to find out whether questions being asked produced what the researcher sought to find out i.e. the pilot study is done to test the validity of the interview schedule as well as to sharpen the research tools. De Vos (1998:179) defines a pilot study “as process whereby the research design for a survey is tested”. Its purpose is to improve the success of the investigation and the effectiveness of the research tools. It is valuable for refining wording, layout and filtering.

In this study a pilot study was conducted with one participant. The purpose was to test the research methods and the data collection tool. A pilot study according to De Vos et al. (2005:206) is a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. The participant met the criteria as she has been working with the mentally ill at Komani Hospital for the past eight years; she belonged to the isiXhosa ethnic group and was able to speak isiXhosa.

1.8 METHODS OF DATA ANALYSIS

Creswell (2003:190) argues that data analysis involves preparing the data for analysis, conducting different analyses, moving deeper and deeper into understanding the data, representing the data and making an interpretation of larger meaning of the data. Again Creswell (1994:153) is of the opinion that qualitative data analysis is based on reduction and interpretation whereby the researcher takes a voluminous amount of information and reduces it to certain themes, sub-themes and categories and interprets this information by using some schema.

The following are Techs’ eight steps found in Cresswell (1994:154-155) that were applied in this study:

- The researcher carefully read through all the interview transcriptions to get a sense of the whole and dotted down some ideas as they came to mind.
- The researcher picked up the most interesting interview and a short one; she went through it and interpreted its meaning.
• When the interpretation was done the researcher made a list of all topics and clustered similar topics together so that they will make one major topic.
• Lists of topics were compared with the data and abbreviation for each topic was made through the use of coding and the codes were written next to the segments of the texts.
• The researcher reduced topics to categories by grouping topics that related to each other. Lines were drawn between categories to show their interrelationships.
• The researcher decided on the topics, codes and categories.
• The data that belonged to each category was assembled in one place and a preliminary analysis was performed.
• The existing data was recoded when necessary, during the final stage.
The researcher made use of the services of an Independent Coder who verified the categories and themes.

1.9 METHODS OF DATA VERIFICATION

In qualitative research validity and reliability of a study can be evaluated according to Guba’s (1981) model. He proposes four aspects that are applicable for the assessment and trustworthiness of any study i.e. truth value, applicability, consistency and neutrality.

- **Truth Value** establishes how confident the researcher is with the truth of the findings, based on the research design, informants and context of the study. Lincoln and Guba (1981) in De Vos (1998:349) argue that truth value is subject oriented and is not defined a priori by the researcher and termed this ‘credibility’. For them qualitative study can be considered credible when it presents accurate descriptions or interpretations of human experience where people also share that experience and be able to recognize the description.

- **Applicability** - Lincoln and Guba (1981) in De Vos (1998:349) states that applicability refers to the degree to which findings can be applied to other contexts and settings or with other groups. It is when the researcher generalizes the findings to a larger population. They further argue that applicability is established through transferability and note that transferability is the responsibility of the person wanting to transfer.
- Consistency – refers to when the researcher establishes whether the findings would be consistent if they were replicated with the same subjects or in similar contexts. According to Krefting in De Vos (1998:331) consistency is defined in terms of dependability.

- Neutrality – is defined as the freedom from bias in the research procedures and results. It refers to the degree to which findings are a function solely of informants and conditions of the research and not of other biases, motivational and prospective (De Vos, 1998:350). According to him conformability is the strategy to ensure neutrality.

1.10 ETHICAL CONSIDERATIONS

Ethics is about doing the right thing. DeVos (1998:24) notes that participants are human beings, it is important that they must be treated with care, i.e. they must be informed about the whole research process beforehand and about the potential impact of the investigation so that they can withdraw if they so wish. Devos (2005:57) defines ethics as “a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioral expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other resources, assistants and students”.

In this study the researcher considered the following professional ethics:

Violation of privacy/anonymity/confidentiality

Participants were ensured of anonymity and confidentiality and that their privacy and sensitivity about mental illness would be protected. The researcher ensured that participants have a right to privacy and the information would be handled in a confidential manner. To secure anonymity and confidentiality the researcher will use ‘1 and 2’ to refer to participants’ names. The tape recorded information was kept in a private place and will be destroyed after use.

Avoid Deception of subjects

Deception of subjects according to Loewenberg and Dolgaff (1988) in DeVos (2005:60) refers to “deliberately misrepresenting facts in order to make another person believe what is not true, violating the respect to which every person is entitled”. The researcher explained the research process to participants and did not hold any information or offer incorrect information in order to ensure participation of subjects.
**Informed Consent**

Babbie (2007:68) is of the opinion that informed consent emphasizes the importance of accurately informing participants about the nature of the research and obtaining their verbal or written consent. Participants choose to participate in an investigation after being informed of facts that are likely to influence their decisions. Before interviews took place participants were allowed to sign a letter of consent so as to get their consent on participating in the research study. They were informed of all the research procedures in their own language.

**1.11 CONCEPT CLARIFICATION**

**Mental illness** – is the state in which an individual shows deficit in functioning, is unable to maintain personal relationships and cannot adapt to an environment (Frisch & Frisch, 1998:804)

**Mental health care user** – Within the context of this study refers to a person who is identified as suffering from mental illness and who has been admitted to Komani psychiatric hospital and is receiving treatment (Mental Health Care Act, No 17 of 2002).

**Mental health care practitioner** – means a registered medical practitioner or a nurse, occupational therapist, psychologist, or social worker who has been trained to provide prescribed mental health care treatment and rehabilitation services (Mental Health Care Act, No 17 of 2002).

**1.12 PROVISIONAL LAYOUT OF CHAPTERS**

The following is an outline of chapters that will be included in this study:

**Chapter 1 Introduction and the problem formulation**

In chapter 1 the background of the study, literature review, the research question, goal and objectives were presented. It outlines briefly the research design, methodology, and ethical considerations.
Chapter 2 Research design and methodology

In chapter 2 the researcher describes in detail the research methodology and the process that will be followed in data collection and data analysis.

Chapter 3 Research findings and the literature control

Chapter 3 highlights the research findings and the literature that supports the findings.

Chapter 4 Summary, conclusions and recommendations

Chapter 4 being the last chapter provides the summary of the research findings, notably major findings of the study along with recommendations from a service delivery and a policy perspective.

1.13 DISSEMINATION OF RESULTS

Research findings will be presented primarily in the form of treatise. The results will be made available to all participants and a copy will be distributed to the Chief Executive Officer of Komani Hospital so that clinicians can have access to the results. Should the opportunity arise the researcher will present results at a scientific conference, after which it will be refined and published in accredited journals.
CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

In chapter one a brief introduction and overview of the research study as well as literature review was presented including a description of the research problem. In this chapter the research methodology is described comprehensively and a detailed description of data collection methods is presented. The study adopted a qualitative research design and the rationale for the study is outlined. Included also in this chapter are the ethical considerations adhere to.

2.2. RATIONALE FOR THE STUDY

This study is aimed at determining the perceptions of mental illness by mental health care practitioners within the isiXhosa cultural context. The researcher made use of a qualitative, descriptive, explorative and contextual design strategy in order to meet the above aim. The intent of the researcher in conducting the study was prompted by the frequent re-admissions of patients to the hospital as well as reasons cited by family members regarding mental illness.

The community based care policy that was introduced by government to replace psychiatric hospital care does not exist in practice as many patients are re-admitted to psychiatric hospitals. This has been caused by a number of factors, e.g., failure of health care approach to mental illness leading to inappropriate health care delivery to the people on the ‘ground,’ and also failure to understand how mental illness is perceived by African communities.

This lack of perception results in mentally ill people being re-admitted to hospitals. This has troubled the researcher and prompted her to investigate the mental health care practitioner’s perceptions of mental illness within the isiXhosa cultural context. By conducting the study the
researcher will empower all mental health care practitioners, families and communities about the African cultural context of mental illness.

2.3 GOALS AND OBJECTIVES OF THE STUDY

The researcher’s aim of conducting the study was as follows:

2.3.1 Goal

The goal of this research study was to determine the perceptions of mental illness by mental health care practitioners within the isiXhosa cultural context.

2.3.2 Objectives

- To explore and describe the perceptions of mental illness by mental health care practitioners.
- To draw conclusions and make recommendations on appropriate policies and services to be rendered in respect of mental health care users.

2.4 RESEARCH DESIGN

Thyer (1993) in De Vos (1998:123) views a research design as “a detailed plan for how a research study is to be conducted” Yegidis and Weinbach (1996:89) are of the opinion that a research design is implemented to attempt to find answers to the researcher’s focused questions and is “a response to a series of decisions about how best to answer focused questions. The major issues it addresses are:

- “Where and when should the research be conducted?
- What information should be collected and from whom?
- How should it be collected?
- What variables will need to be measured and how should they be measured?
- How should information collected be organized and analyzed?
• How will research findings be disseminated”?

The answer to the above questions was arrived at by conducting a study that is qualitative, descriptive, explorative and contextual. The researcher will explain these concepts briefly.

2.4.1 Qualitative Research

Qualitative Research according to Patton (1985) in Merriam (2001:6) “is an effort to understand situations in their uniqueness as part of a particular context and the interactions there.” Merriam further explains that “qualitative researchers are interested in understanding the meaning people have constructed, that is, how they make sense of their world and the experiences they have in the world” (Merriam, 2001:6).

Based on the above explanation this study is based on a qualitative approach and it attempts to understand the viewpoints of participants i.e. how they perceive mental illness; the qualitative approach of this study attempts to explore and describe the perceptions of mental illness by mental health care practitioners. In this manner the qualitative research attempts to understand the participant’s views and thoughts along a developmental continuum.

Maree (2007:5) pointed out that Qualitative Research usually involves smaller sample size and sampling is flexible, continues until no new themes emerge from the data collection process. In this study the sample size consisted of eight participants.

Hessie-Biber and Leavy (2004:3) express that in Qualitative Research data is usually obtained through different research methods that range from unstructured to structured interviews, along a continuum, observations, documents and visual materials. In this study the researcher has utilized semi-structured interviews. De Vos (2002:79) defines qualitative research as “the research that elicits participants’ accounts of meaning, experiences or perceptions. It also produces descriptive data in the participants’ own written or spoken words”. Linking the definition to the study, the researcher explored and described perceptions of mental health care practitioners within the isiXhosa cultural context. Qualitative Research according to Flick
2.4.2 Exploratory Research

Exploratory research according to Yegidis and Weinbach (1996:92) “is appropriate when problems have been identified but our understanding of them is quite limited. It is conducted to lay the groundwork for other knowledge-building that will follow”. Exploratory research as the name implies is conducted to explore a topic i.e. to know more about the phenomenon under study. Mouton and Marais (1990) in De Vos (1998:124) state that the aim in exploratory studies is:

- “To gain new insights into phenomenon,
- To undertake a preliminary investigation prior to a more structured study of the phenomenon,
- To explicate the central concepts and constructs
- To determine priorities for future research
- To develop new hypothesis about an existing phenomenon”.

Yegidis and Weinbach (1996:92) are of the opinion that in exploratory studies the researcher begins his/her inquiry without much into which variables may be related to the problem but as the study progresses the researcher will narrow the list. They further explain that in exploratory studies there may be few cases studied or large number may be selected in order to learn as much as possible about the problem and there are no legitimate claims to their being representative of others not selected for study. In this study, the researcher explored the perceptions of mental illness by mental health care practitioners within the isiXhosa cultural context in order to gain the mental health care practitioners’ thoughts, beliefs and opinions about mental illness. (In this study few cases were studied i.e. eight participants to form a sample).

2.4.3 Descriptive Research

Descriptive research describes situations and events, according to Yegidis and Weinbach (1996:93), “it consists of the findings derived from exploratory research and its goal is the
measurement and description of relevant variables i.e. those identified using exploratory research”. The current study moves beyond exploration and into description of perceptions of mental illness by mental health care practitioners and what it means to be mentally ill within the isiXhosa cultural context. In a descriptive study the researcher generalizes from cases studied to those that are similar but were not part of the research study, thus the researcher used purposive sampling in order to gain rich information that represented the entire group.

2.4.4. Contextual Research

Struwig and Stead (2001:12) maintain that “contextualism examines social environments in their totality”. Contextual research therefore is about analyzing the environment of the research participants. Contextual research according to Ritchie and Lewis (2003:27)” is concerned with identifying what exists in the social world and the way it manifests itself”. They further explain that a major feature of qualitative methods is their facility to describe and display phenomenon as experienced by the study populations, in fine-tuned detail in the study participant’s own terms”. In this study the researcher wanted to understand mental illness as perceived by mental health care practitioners within the isiXhosa cultural context. The context under which the study was investigated is that of isiXhosa hence the participants belonged to the isiXhosa ethnic group.

2.5 RESEARCH METHODOLOGY

2.5.1 Research Population

In defining the population for the study three questions need to be addressed according to Ritchie and Lewis (2003:87)

- “Which group or subpopulation of central interest to the subject matter of the study. This involves deciding which population will by virtue of their proximity to the research question, be able to provide the richest and most relevant information.
- Are there subsets of the central population that should be excluded? This might be because of the specific circumstances or experiences.
- Are there additional groups or subpopulations that should be included because their views, experiences would bring contrasting or complementary insights to the enquiry”?
The population of this study consisted of all mental health care practitioners of Komani Hospital who are working with mental health care users. In describing a research population Yegidis and Weinbach (1996:114) state that it is “the entire population of people or elements that share some defined characteristics”. Their definition is similar to that of Bless, Higson-Smith and Kagee (2006:98) who define population as “the entire set of objects or people which is the focus of the research study and about which the researcher wants to determine some characteristics”. In this study the research population was made up of all mental health care practitioners of Komani Hospital who are working with mental health care users. The characteristics that participants had are those of being professionals.

2.5.2. Sampling Methods

Sampling refers to” the process used to select a portion of the population for study”. (Maree, 2007:5). According to Gray, Williams, Karp and Dalphin (2007:102) “sampling is the selection of a relatively small group of individuals from whom we obtain data in order to be able to generalize about a large group”. A sample therefore is a small number of people from whom data is collected. Seaberg (1988) in De Vos (1998:191) agrees with Gray et al. when he notes that a sample “is a small portion of the total set of objects or persons which together comprise the subject of our study”. A sample is studied in order to understand a population from which it was drawn or sometimes there may not be sufficient time to study a large population. De Vos (1998:191) is of the opinion that the use of samples may therefore results in more accurate information than might have been obtained if one had studied the entire population.

In this study non probability and purposive sampling methods were used in selecting participants. The researcher chose the typical characteristics of the participants to be included. Eight participants sufficed in meeting the objectives of the study. Purposive sampling according to Gray et al. (2007:105) “is a general term for judgmental sampling in which the researcher purposively selects certain groups of individuals for their relevance to the issue being studied”. In purposive sampling members of a sample are chosen with a ‘purpose’ to represent a location or type in relation to a key criterion. The principal aims are:

- “To ensure that all the key constituencies of relevance to the subject matter are covered;
To ensure that, within each of the key criteria, some diversity is included so that the impact of the characteristics concerned can be explored” (Ritchie and Lewis, 2003:79).

Its major advantage is that it is a way to ensure that the researcher gets at least some information from respondents who are hard to locate and crucial to the study. The criteria that were used in this study for selection of participants were as follows:

- The research participants belonged to the isiXhosa ethnic group and were able to speak isiXhosa.
- The participants were mental health care practitioners employed by Komani hospital for at least a period of three years.
- They had to be working with mental health care users in their scope of practice.
- The sample consisted of both males and females.

In this study the researcher utilized the services of an Independent Interviewer to avoid bias information as the interview site is the researcher’s workplace.

2.5.3 Data collection methods

Tutty, Roothy and Grinell (1996:52) state that “without doubt the most utilized data collection method in qualitative studies is the interview”. For the purpose of this research study, the researcher will use the interview as a method of data collection specifically semi-structured interviews. In addition a tape recorder was also used. The researcher had a set of predetermined questions on an interview schedule. Before the start of the interview, the researcher introduced the study to the participants as well as the Independent Interviewer. The researcher explained to participants why the interview will be conducted by the Independent Interviewer.

2.5.3.1 Semi-Structured Interviews

May (2001:123) states that in a semi-structured interview “questions are normally specified but the interviewer is freer to probe beyond the answers…and can seek clarification and elaboration about the topic”. De Vos et al. (2005:296) express this point clearly when they state that “semi-
structured interviews are used when a researcher is interested in gaining a detailed picture of the participants’ beliefs about or perceptions of a particular topic”.

In this study the researcher gained a detailed picture of participants’ beliefs about mental illness within the isiXhosa cultural context, therefore semi-structured interviews served the purpose of the interview. The researcher chose this tool as it is flexible to both the interviewer and the interviewee (Ritchie and Lewis, 2003:111). It allows interviewer to alter the sequence of questions in the way in which they are phrased. In semi-structured interviews, interview schedules are used as a guide, guiding the interviewer in the manner in which questions should be asked and they allow the interviewer to stay focused throughout the interview.

2.5.3.1.2 Interview Schedule/Guide

The interview schedule consists of detailed sequence of carefully worded questions which are prepared before the interview. The questions prepared address the issues in which the researcher was interested. In this study the participants were asked the following predetermined questions:

- How do you as a mental health care practitioner of Komani hospital perceive mental illness?
- Njengoko uxelele apha esibhedlele ungathi yintoni ukugula ngengqondo?
- What are the factors that should be considered in assisting a mentally ill person cope with mental illness?
- Ucinga ukuba angancedwa njani umntu ogula ngengqondo?
- What is your view of conservative African perception of mental illness?
- Luthini uluvo lwakho malunga nokugula kwesiXhosa?
- What suggestions can you put forward for understanding and treating a mentally ill person?
- Ungacebisa ntoni malunga nokunyanga umntu ogula ngengqondo?

Kvale (1996:133) concludes by describing questions that can be used through the interview process to help clarify data as follows:
- Introduction question: These are referred to as opening questions by the interviewer to the participants. They may yield spontaneous, rich descriptions where the participants provide what they experienced on the investigated phenomenon.
- Follow up questions: These indicate that the interviewer’s ability to listen and give clarification where necessary.
- Probing questions: The interviewer here pursues the answers and probing the contents.
- Specifying questions: The interviewer uses such questions to get more precise descriptions.
- Structuring questions: The interviewer may directly and politely break off long answers that are irrelevant to the topic of investigation.
- Silence questions: The interviewer can take a lead from therapist in employing silence to further the interview by allowing participants to pause and after pause they may bring new information.
- Interpreting questions: The interviewer may rephrase what the participants have said to ensure clarification.

Within the context of this study, the researcher made use of all questions mentioned above except the silence questions.

2.5.4 SETTING UP APPOINTMENTS

The researcher did not experience any problems with setting up of the appointments with the participants but minor problems took place in getting them to honour the appointments but rescheduling of time was done with success. All participants preferred to be interviewed at the hospital. The researcher had to accompany the Independent Interviewer to the hospital, as the researcher knows the geography of the hospital, since she is working there and to support the Independent Interviewer, but during interviews the researcher was not there. Interviews were conducted during lunch time of participants and some in the evening for those participants who were working night duty.
2.5.5 The Interviews

All participants were keen to talk about their perceptions of mental illness. Although there was a written correspondence sent to the participants regarding the research, the researcher met them individually before the actual interviews to discuss ethical considerations and the reasons why the interviews will be conducted by the Independent Interviewer. Once the researcher had explained to them the procedure of the interviews, including the use of the tape recorder, they seemed to be satisfied. Interviews were held with eight participants that met the suggested criteria of the research population. Interviews were tape recorded with the permission of the participants. They were transcribed and analyzed to ensure that the research question relates to the purpose of the investigation.

The researcher received positive feedback from the participants about their perception of mental illness. The participants saw interviews as an opportunity to express their views about mental illness and to make changes that were necessary should the research results be published. All interviews were conducted in isiXhosa and participants were free to include English vocabulary should it be difficult for them to express some psychiatric terms in isiXhosa. The interviews were recorded and transcripts were made and translated into English by the researcher. The researcher then met with her supervisor and the Independent Coder to reach a consensus regarding the identification of themes and sub-themes.

2.5.5.1 Recording the Interview

A tape recorder was used to capture the interviews which subsequently were transcribed verbatim. Using a tape recorder during interviews allowed the researcher to devote her full attention to listen to the participants and to probe in depth. Using a tape recorder was done with the permission of the participants as it was included in the consent forms. During the recording the researcher was able to get accurate, verbatim record of interview including hesitations in tone by participant.
2.5.6 Role of the Independent Interviewer

It was necessary for the interviewer to be clear about her own role in the interview process so that she can help participants understand their role at an early stage of an interview. The interviewer played an active role during the interview process as she was a leader and a facilitator that enabled participants to talk about their thoughts, feelings, views, perceptions and experiences. It was the role of the interviewer to assist participants to talk and give fulsome answers and provide more depth when probing. Questions were asked to reflect and to raise relevant issues that were not directly asked. Interviewing is an art that requires certain skills in order for it to be effective. The following are the skills that are required for an effective interviewer.

- **Active listening**

  Maree (2007:88) expresses that “good interviewers are good listeners who do not dominate the interview but understand that they are there to listen”. It is important therefore for the interviewer to listen to participants. This could be done by also showing non-verbal communication like facial expression, body gestures and maintaining eye contact.

- **Probing**

  Probes according to Ritchie and Lewis (2003:148) are responsive, follow up questions designed to elicit more information, description, and find out more on what has been asked. They ensure that the interviewer understands the answers given by the participants.

- **Reflecting**

  This refers to verbalizing and paraphrasing the same statements as the participants’ remarks. Reflection communication is useful because it encourages the participants to correct any misunderstanding by the interviewer.

- **Clarifying**
The interviewer uses clarification to get clarity on statements that are not clearly stated by the participants.

- **Summarizing**

To summarize is to make conclusions by discussing main ideas that were of concern during interview and reviewing what the main themes of conversation were. Summarizing allows the interviewer and the interviewee to conclude the interview formally. In this study the researcher made use of all the above mentioned skills of interview.

### 2.6 PILOT STUDY

A pilot study according to Devos (2005:205) is done to improve the success and effectiveness of the investigation. He defines it as “a prerequisite for the successful execution and completion of a research project”. Bless and Higson-Smith (2000) in Devos (2005:206) defines a pilot study as “a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate”.

In this study the researcher conducted a pilot study with the first participant. This was done to obtain information and assess the methodology that was used. The data collected in the pilot interviews contributed to the research findings. A pilot study is also helpful in deciding whether the interview guide is working and assist in estimating costs and length of main investigation but its main purpose is to sharpen research tools.

### 2.7 DATA ANALYSIS

Data Analysis means to bring data together in a meaningful way in order for researchers to interpret or make sense of it. According to Cresswell (2003:190) data analysis “involves preparing the data for analysis, conducting different analyses, moving deeper and deeper into understanding the data, representing the data, and making an interpretation of the larger meaning of the data”.

Kvale (1996:214) mentions three different contexts of interpretation in qualitative analysis:
- “Self understanding – where the researcher attempts to formulate in a condensed form what the participants themselves understand to be the meaning of their statements.
- Critical commonsense understanding – where the researcher interprets what participants experience about a topic in his/her own understanding.
- Theoretical understanding – where the researcher’s interpretation goes beyond the participants’ self understanding like a theoretical perspective”.

In this study the researcher considered Kvale’s context of interpretation when interviewing the participants. The data analysis methods that were used were that of Tesch (1990) in Cresswell (1994:154-155), who proposed the following steps as outlined below:

- The researcher will read through the transcripts to get a sense of the whole.
- The researcher will get one script at a time randomly to read through it and will dot down ideas that will come in the margin.
- Similar topics will be grouped together, major topics will be separated from unique topics
- The researcher will compare list of topics with the data and code each topic next to the segments of the texts.
- The researcher will reduce topics to categories by grouping topics that relate to each other.
- The researcher will decide on the topics, codes and categories and will be formed and arranged alphabetically.
- The data belonging to each category will be assembled in one place and a preliminary analysis will be performed.
- Existing data will be recoded where necessary.

An Independent coder was utilized to assist the researcher to verify the categories and themes. On completion both the researcher and the Independent coder independently coded interviews and identified categories. When coding was done the researcher and the coder met to discuss the identified themes.
2.8 DATA AVERIFICATION

Data verification involves checking for the most common biases that can steal into the process of drawing conclusions (De Vos, 1998:351). There are various models that can be used in validity and reliability in a study but for the sake of this study the researcher used Guba’s model (1985). Validity and reliability refers to a research that is credible and trustworthy.


**Truth-value** – This refers to the confidence in the truth of data i.e. the researcher will have to ensure that findings are believable i.e. they are perceptions, beliefs, knowledge and thoughts of the participants. In Qualitative Research, truth value is obtained for the discovery of human experiences as they are lived and perceived by informants. This study is about the beliefs and perceptions of mental health care practitioners and not their experiences.

**Applicability** – This refers to the degree to which data can be transferred to another context or setting. In this study the researcher will have to present sufficient descriptive data about mental illness in order to allow someone interested to apply the findings to another context. Lincoln and Guba (1985) in De Vos (1998:350) argue that as long as the researcher presents sufficient descriptive data to allow comparison, he has addressed the problem of applicability.

**Consistency** – Consistency of the data refers to whether the findings would be consistent if the research study was to be conducted with the same subjects or in a similar context. During interviews the researcher will have to learn from the interviewees and not to control them.

**Neutrality** – Neutrality refers to the objectivity of data. It is defined as the freedom from bias in the research procedures and results”. It refers to the degree to which findings are a function solely of informants and conditions of the research and not of other biases, motivation and perspectives (De Vos, 1998:350).
2.9 ETHICAL CONSIDERATIONS

In conducting the study the researcher will have to comply with the professional ethics so as to ensure the success of the study. De Vos (2005:57) defines ethics as “a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioral expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students”. In this study every research decision which the researcher made was made with regard to the following professional ethics:

2.9.1 Informed Consent

Ruane (2006:19) expresses that “the principle of informed consent is about the right of individuals to determine for them whether or not they want to be part of a research project”. Research participants have rights to be informed about the research project and should not be forced into participating. In this study in order to ensure that participants volunteered before the interviews are conducted, they were given consent forms to sign as a proof that they were not coerced but participated freely. Informed consent forms also remind them that they have a right to withdraw at any point during the study. In the forms it was stipulated clearly the purpose of the study, the research methodology and their rights as participants. They knew before hand that a tape recorder would be used.

2.9.2 Violation of Privacy/Anonymity/Confidentiality

It is the researcher’s responsibility to manage private information shared by participants. The researcher ensured that participants have a right to confidentiality and that their privacy and sensitivity about mental illness will be protected. No other unauthorized person except the Independent Interviewer gained access to any information divulged by the participants. Ruane (2005:22) mentions that participants’ right to privacy requires the researcher to pay attention to:
sensitivity of the information; location or setting of the research and the disclosure of the study’s findings. In this study the researcher was aware of the sensitivity of the topic about mental illness, interviews were held in the office where there was privacy and telephone lines and cell phones were switched off to avoid any disturbances. To meet anonymity the researcher collected information in such a way that it cannot be linked to any participant.

2.9.3 Avoid Deception of participants

Deception according to Cohen, Manion and Morrison (2007:66) “may lie in not telling people that they are being researched, not telling the truth, telling lies or compromising the truth”. In this study the researcher explained the research process to participants and did not hold any information or offer incorrect information in order to ensure participation of subjects.

2.9.4 No harm to participants

Participants can be harmed physically or emotionally. Emotional harm to participants may be difficult to predict before hand. The participants should be informed before hand about the potential impact of the investigation. Researchers will have to remove those participants who can be vulnerable during investigation so that they can withdraw before hand. In this study the researcher did not anticipate any harm as professionals were interviewed and not mentally ill patients.

2.10 CONCLUSION

In this chapter a detailed description of the research design and methodology was discussed. The data collection methods were discussed as well as detailed description of data analysis. The researcher described qualitative approach, descriptive, exploratory and contextual designs. Data verification methods were also mentioned and lastly ethical considerations to be considered during investigation were discussed. In the next chapter, presentation of the research findings will be done with a view to assess the achievement of the research objectives.
CHAPTER 3

RESEARCH FINDINGS AND LITERATURE CONTROL

3.1 INTRODUCTION

The previous chapter described the research design and methodology citing the manner in which data was analyzed. The aim of this study was to explore and describe the perceptions of mental illness by mental health care practitioners. This chapter will discuss the results of the data collected. Non purposive sampling technique was used to select eight mental health care practitioners. Explorative, descriptive and contextual research designs were used in the research study. Data was collected at Komani hospital in Queenstown by means of semi-structured interviews. The sample was drawn from the population of mental health care practitioners from Komani hospital. A letter requesting permission to conduct research in the hospital was written to the Chief Executive Officer. Follow ups were made through personal enquiries as the researcher is working in the hospital. Permission was granted with no conditions attached. Prospective participants were given consent forms to read and give consent to participate in the research study. As the researcher is employed in the hospital and to avoid researcher’s bias, the researcher utilized services of an Independent Interviewer.

The researcher used an interview schedule to guide the way in which questions should be asked. Before the interview was conducted the researcher discussed interview questions with the Independent Interviewer so as to get clarity on what was expected. At the beginning of the interviews the researcher introduced the Independent Interviewer to the participants and thereafter left the Independent Interviewer to conduct the interviews.

In the Interview Guide there were four main questions other than biographical questions that were asked to the research participants and they are:
• How do you as a mental health care practitioner of Komani hospital perceive mental illness?

• *Njengoko uxelela apha esibhedele njenge Gosa leze Mpilo yengqondo ungathi yintoni ukugula ngengqondo?*

• What is your view of conservative African perception of mental illness?

• *Ngokwenkolo yesiXhosa, nenkcubeko yakho, namava akho ucinga ukuba yintoni ebangela ukuba umntu agule ngengqondo?*

• What do you think can be done to assist the mentally ill cope, manage and treat the mental illness?

• *Ucinga ukuba angancedakala njani umntu ogula ngengqondo ukuze amelane nesisifo ukuze anyangeke?*

• As a mental health care practitioner what would you recommend in terms of policy development and service delivery?

• *Njenge Gosa lezeMpilo yengqondo ungacebisa ntoni malunga nokuphuhlisa imigaqo nenkonzo zabagula ngengqondo?*

### 3.2 PROFILE OF THE PARTICIPANTS

In this study both males and females were interviewed and the study was not particular about gender. The participants who were interviewed possessed the following characteristics:

• The participants were mental health care practitioners employed by Komani Hospital for at least a period of three years.

• Their experience ranged from three to twelve years

• All participants were working with mental health care users in their scope of practice.

• The participants were both males and females (four males and four females)

• All participants belonged to the isiXhosa ethnic group and were able to speak isiXhosa.

A pilot study was conducted with one participant. The purpose was to test the research methods and the data collection tools in order to identify any problems that may be encountered during
the actual study. A pilot study according to DeVos et.al (2005:206) is a small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. The participant met the criteria as she has been working with the mentally ill at Komani Hospital for the past eight years; she belonged to the isiXhosa ethnic group and was able to speak isiXhosa.

3.3 PRESENTATION OF FINDINGS

Generally all participants in this study perceived mental illness as characterized by strange behavior as well as a painful disease where one loses his dignity. The family was regarded as the main support system that could assist the mental health care users with continued care. Almost all participants felt that the family should be included in the treatment process. Although there were scientific causes of mental illness more than half of the participants cited cultural causes as reasons for being mentally ill. They felt that mental illness within the isiXhosa cultural context is caused by: failure to observe cultural practices, witchcraft and failure to accept the calling of being a traditional healer (ukuthwasa). They expressed that knowledge of these cultural causes makes it easier for mental health care practitioners to manage and treat mental illness.

Almost all participants expressed that mental health care users are treated by traditional healers before admitted to the hospital. The hospital is a secondary form treatment for them. In the hospital they are treated by various professionals. These professionals consider environmental interaction as well as the family as the support system when they treat the mental health care users.

There are four themes and accompanying sub-themes that were identified from the participants’ responses. An overview of the themes and sub-themes is presented below.

3.3.1 Theme 1: Mental Health Care Practitioners’ perceptions of mental illness.

3.3.1.1 Sub-theme: Mental disturbance that is characterized by strange behavior.

3.3.1.2 Sub-theme: Mental illness is a painful disease where one loses his/her dignity.
3.3.1.3 Sub-theme: Scientific causes for development of mental illness

3.3.2 Theme 2: Perception of the causes of mental illness within the isiXhosa cultural context

3.3.2.1 Sub-theme: Failure to observe cultural practices

3.3.2.2 Sub-theme: Witchcraft

3.3.2.3 Sub-theme: Failure to observe the calling and associated rituals to become a traditional healer (Ukuthwasa)

3.3.3 Theme 3: Mental Health Care Practitioners’ views on the management and treatment of mental illness.

3.3.3.1 Sub-theme: Knowledge and respect for cultural beliefs

3.3.3.2 Sub-theme: Role of mental health care practitioners in the management and treatment of mental illness.

3.3.3.3 Sub-theme: Family as a support system in the management and treatment of mental illness

3.3.4 Theme 4: Suggestions put forward to improve services to mental health care users.

3.3.4.1 Sub-theme: Team Work

3.3.4.2 Sub-theme: Public Education about mental illness

3.3.4.3 Sub-theme: Department of Health to take adequate responsibility for mental health care
3.4 DISCUSSION OF IDENTIFIED THEMES

The researcher will discuss the participant’s perceptions of mental illness within the isiXhosa cultural context. The participants’ perceptions of mental illness was divided into four major themes namely: mental health care practitioners’ perceptions of mental illness, perception of the causes of mental illness within the isiXhosa cultural context, mental health care practitioners’ views on the management and treatment of mental illness and suggestions put forward to improve mental health services to mental health care users.

3.3.1 Theme 1: Mental Health Care Practitioners’ perceptions of mental illness.

The participants who were interviewed perceived mental illness in many ways and out of their responses there were also sub-themes that explain how they perceived mental illness. Their responses were categorized into three sub-themes namely: mental disturbance is characterized by strange behavior; mental illness is a painful disease where one loses his/her dignity, and scientific causes for the development of mental illness.

3.3.1.1 Sub-theme: Mental disturbance that is characterized by strange behavior.

The participants of the study perceived mental illness as a mental disturbance characterized by strange behavior and accompanied by signs and symptoms.

They expressed their views as follows:

“A person who is mentally ill behaves very strange because he neglects himself physically, does not want to wash for a number of days, dresses clumsily, and becomes naked in public places”.

“People who are mentally ill do strange things that are unusual like talking to himself non-stop, seeing things that are not there”.

38
“Mental illness is a disease whereby a person will do strange things and does not see anything wrong with such a behavior, things like wearing dirty clothes, talking irrelevantly and using an abusive language to people around him or shouting at people”.

“When disturbed mentally one can see about his behavior, he behaves strangely among other people like engaging in filthy habits like spitting in front of people, or smearing human feces and does not feel ashamed of that”.

“Mental illness is when a person is disturbed mentally in terms of thinking, by talking and even doing strange things that are unusual and you can see a mentally ill person by talking to himself, talking irrelevantly and seeing things that are not there”.

The manifestation of mental illness is somewhat difficult to understand because the interpretation of a strange behavior varies from person to person and from culture to culture. Mental illness is presenting in a variety of ways from person to person.

What the researcher has established was supported by one of the participants when she stated:

“There is no specific definition of mental illness as it is defined differently from person to person depending on the behavior of the person”.

The strange behaviors that participants expressed in defining mental illness are accompanied by signs and symptoms and most of the time these signs and symptoms are displayed well in advance before the actual illness takes place. According to Hicks (2005:4) a symptom is a medical complaint that is described by the patient like a chest pain or feeling sad, a sign is an abnormal finding by the physician which a patient may or may not be aware of, such as high blood pressure or rapid speech, a syndrome is a collection of signs and symptoms that typically
occur but which may be seen in several different illnesses. In a psychiatric setting these signs and symptoms are very important because diagnosis and treatment are made on the basis of symptoms. Mental health care practitioners seek to understand mental illness through presentation of symptoms by mental health care users. In treating mental illness the goal of mental health care practitioners is toward symptom relief.

In support of the above statement some of the participants expressed the following words:

“We do listen to the family or the patient so that we can be able to understand the symptoms he is presenting”.

“History taking is very important so that a person can be treated according to his symptoms and be given a correct treatment”.

“You will find that some of the symptoms that the patient present are similar to that of a scientific illness”.

“The psychiatrist as a specialized person would go deeper in his brains making comparisons to the symptoms he is presenting so that he can diagnose the patient properly”.

In this study the participants mentioned a variety of signs and symptoms of mental illness and according to Repper and Perkins (2003:3) diagnosis is defined in terms of clusters of symptoms. In other words mental health care practitioners arrive at a diagnosis when all categories of mental illness are present and do not single out one category. These authors further state that evidence of a person’s symptoms is sought in the description that is provided looking at a combination of thoughts, feelings and behavior of a person. Hicks (2005:7) points out that those psychologists make an assessment for signs and symptoms of mental illness in order to make a diagnosis. Bauman (1998:33) points out that it is psychiatrists who must interpret thoughts, feelings and
behaviors and apply universal concepts. In other words when psychiatrists have made their own interpretation they arrive at a specific diagnosis. In a psychiatric setting emphasis is on providing the mental health care user with an understandable explanation of the symptoms and giving practical advice. In this study the participants mentioned the following signs and symptoms:

“A person who is mentally disturbed shows a loss of interest in his/her appearance, neglects himself/herself physically, talks to himself/herself ... I think these are the signs he shows”.

“You can see a mentally ill person by talking to himself, talking irrelevantly, seeing things that are not there, can be dangerous to himself and can hurt himself, becomes violent by breaking furniture in the house”.

“A person who is mentally ill has certain signs and symptoms: Firstly his appearance says a lot about him i.e. grooming he becomes untidy, clumsy, dirty and does not want to wash, becomes withdrawn. His speech is also noticeable because some do not talk they become withdrawn, others talk without stopping”.

“There is a change in his sleeping patterns, he does not sleep well at night, wandering aimlessly, talks irrelevantly, engages in filthy habits like spitting in front of people and does not feel ashamed of that or smearing human feaces or undressing in public or becoming naked”.

The signs and symptoms that the participants have mentioned have been grouped into syndromes and classified into several specific disorders in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) and according to Hicks (2005:5) none of these disorders can be diagnosed exclusively on the basis of laboratory tests or other physical findings; so psychiatrists have
reached a consensus, based on clinical experience and research, on the signs and symptoms that are required to make a specific diagnosis.

There is a lot that is considered before a diagnosis can be made hence mental illness is defined differently from person to person and from culture to culture but what is of importance is that the presenting individual should be able to express the symptoms clearly. Swartz (1998:55) argues that the most obvious use of diagnosis is to provide the clinician with a picture of what is happening with the patient and to develop a treatment plan. In order to understand its meaning, one must know the mental health care user’s life history including psychological, socio cultural and biological needs as well as other forces that were of importance to the person’s development. In the psychiatric setting such information is usually supplied by the mental health care user’s family members.

3.3.1.2 Sub-theme: Mental illness is a painful disease where one loses his dignity.

The participants expressed that a person who is mentally ill loses his/her dignity because his/her views are disregarded by family members; he/she does not become part of decision-making in household matters, he/she is being isolated and is being labeled with bad names due to ‘stigma’ attached to mental illness. They stated that isolation starts with the family and goes beyond the communities and society in general. The following quotations from the participants endorse such an assertion:

“You can’t even re-act to anything that you do not like; people would say you are mentally disturbed”.

“Mental illness is a very painful disease because once it affects you, you lose your dignity, and you are not regarded as important anymore”.

“Mental illness is a painful disease that people do not understand...and we do not like a person to be labeled as ‘i Geza’ (Mad person) because that label defames a person”.
“Mental illness is a painful disease because a person is no longer respected by his family when he is mentally ill; he loses his dignity and becomes useless among family members”.

Repper and Perkins (2003:29) are of the opinion that rejection and exclusion among those diagnosed with mental illness is a reality of life and they are considered unpredictable, incapable of living an ordinary life and are the most excluded and devalued in society. When people are labeled or linked to undesirable characteristics they are being devalued and excluded. According to these authors the mentally ill experience discrimination and social exclusion in all areas of life – daily living, work, training and access to services. They state that social exclusion has its consequences among the mentally ill like unemployment which is associated with poverty, social isolation and loss of status, significantly increases disability and impedes recovery.

They argue that discrimination and exclusion are disabling to the mental health care users and they are the causes and consequences of mental illness. In other words mental health care users when isolated by their families or communities cause more stress to them and mental illness results in isolation. People with mental illness are seen as incompetent, invalid, unable to participate fully in society and in need of others to look after them and make decisions for them. This is evident in this study as one participant responded by saying:

“After discharge we visit them to find out how are they adjusting, we make a follow up to see that they have settled and ... if the patient stays alone it is then we contact social workers to place him with relatives”.

The following factors are consequences of social exclusion as presented by Repper and Perkins (2003:32):

- Media stereotyping
- Discrimination at work
• Lack of access to educational and training programmes
• Unemployment
• Poor income
• Homelessness and poor housing
• Lack of informal job contacts
• Contact with criminal justice system
• Ostracisation by the wider community
• Disrupted family and social networks
• Adverse effects of prescribed drug treatments
• Drug misuse
• Physical health problems
• Stigmatizing health and social services.

The above-mentioned factors are what is taking place in the lives of a mentally ill. Within the context of this study various comments by participants pointed to the following consequences: unemployment, drug misuse, homelessness, contact with criminal justice system, ostracisation by the wider community and stigmatizing health and social services. More than half of the participants felt that mental health care users are isolated and discriminated; isolation starts with the family and later become a community issue. They are not employed after rehabilitation thus they become involved in crimes, they become homeless as they are being rejected by their own families and are being stigmatized by being labeled with bad names. The participants based these perceptions on a lack of knowledge and understanding about mental illness.

To express consequences of social exclusion some participants said:

“I saw a mentally retarded person in a house being chained cruelly and to me this was not a good scene, if the community could accept them first, community does not understand them”.

“I think the responsibility lies with the community to accept the mentally ill and stop labeling them with bad names”.
“In some other cases the patient was admitted due to crime he committed among family members like killing his father or destroying dishes”.

“The availability of drugs and alcohol in the community becomes a problem because the patient does not have any job and has nothing to do he becomes bored”.

3.3.1.2.1 The stigma of mental illness

Uys & Middleton (2004:75) associate the social exclusion and discrimination with stigma that is attached to mental illness and putting the blame on the media which stereotypes the mentally ill as violent. These authors argue that stigma stains or scars the person’s reputation and it brands a person in a negative way in the eyes of society. They argue that the society has misconceptions about the mental health care users and this is part of the reason why many mental health care users and their families are socially shunned, cannot find work, housing or friends. Repper and Perkins (2003:204) argue that as long as stigma is rife, exclusion and discrimination of mental health care users cannot decrease. These authors further argue that stigma focuses attention on people who are recipients of rejection and exclusion rather than those who perpetrate the unjust treatment; hence many authors focus on the effect of stigma on the mental health care users. In this study the issue of the effects of perceived stigma to the mental health care users was mentioned by participants as a consequence of losing a dignity and the following quotations attest to this:

“There is also stigma attached to mental illness because even if you have nt done anything wrong you will be labeled with bad names”.

“A person will look down upon himself due to a stigma attached to mental illness, it would be better if mental illness could be accepted like any other illness”.
“Mental illness has lot of stigma attached to it; people do not understand mental illness”.

Uys & Middleton (2004:75) agree with some of the above mentioned quotations by the participants of this study when they state that the reason why the mental health care users are socially shunned becomes a vicious cycle as it keeps on repeating itself like; the person has symptoms of the mental illness, and feels strange and weird. People react to him/her in an exaggerated way because of the symptoms, but also because of the stigma. This reinforces the patient’s perception that he/she is not acceptable, deepening the suffering from withdrawal.

Due to stigma that is attached mental illness the mental health care users feel unwanted all the time. They are treated as a separate entity by families and communities all the time and in this manner they are losing their dignity. Uys & Middleton (2004:75) believe that the stigma against the mental health care users is common in South Africa, as Sapepa (1991) in Durban found that 80% of the respondents would not like to live in the same block of flats with the mentally ill or have a mentally ill person as a neighbour. However, the stigma and isolation attached to mental illness is aggravated by medical aid companies that are not willing to pay for hospitalization resulting from suicide attempts. This has been found in a survey that was done in South Africa by the Depression and Anxiety Support Group (2001) in Uys and Middleton (2004:75).

3.3.1.2.2 The psychological consequences of mental illness

Uys & Middleton (2004:74) pointed out that it is the society that makes mental health care users uncomfortable, sees them as weak, act strange and labels them as lazy. These authors believe that these perceptions are based on a lack of knowledge and understanding of what mental illness is and how it is treated. Rejection and social exclusion affect the mentally ill in many ways: thus Repper and Perkins (2003:49) believe that it causes mental illness and it has consequences of mental illness. Mental illness has the following psychological consequences for the mentally ill.
3.3.1.2.2.1 Loss of a sense of self

These above authors believe that a mentally ill person lives to survive as a normal person and would like to behave as a normal person but the sense of self is profoundly challenged by the experience of mental health problems, and being eclipsed by the identity of ‘mental patient’ which tends to mask all other identities. In other words a mentally ill person when being isolated and rejected by people around him loses his sense of self, devalues himself/herself, and becomes a passive dysfunctional self and a person’s sense of self affects the whole range of their vocational, intellectual, social emotional and spiritual functioning.

The following quotations attest to this:

“Mental illness is a very painful disease .....Once you say something people do not listen to you...and families do not involve you in decision-making”.

“Mental illness is a painful disease that people do not understand...a person with mental illness will look down upon himself”.

To justify what the participants said Repper and Perkins (2003:25) argue that once a person is diagnosed as being mentally ill enormous social consequences ensue. People who are labeled as mentally ill are usually presumed to be incapable of exercising decision-making power in their own best interests and they become part of a system that deprives them of control over their life as part of their treatment.

3.3.1.2.2.2 Loss of power

A mentally ill person loses power as soon as he/she is being diagnosed and having access to mental health services. The symptoms that he/she shows erode his/her sense of control and his/hers confidence. This is made worse by the prevailing view that the mentally ill are weak, lazy
and not able to determine what is best for them. This view by the society makes them to lose power and confidence.

3.3.1.2.2.3 Loss of meaning

Repper and Perkins (2003:50) argue that the meaning in life is connected to the various roles that we adopt. Mental illness results in loss of valued roles as worker, mother, father etc. The mentally ill sometimes see their normal functioning peers doing things they had planned to do like going to college, getting married or pursuing their careers and once it does not happen to them they feel left behind, meaningless, and isolated from former friends and family.

To endorse the loss of meaning the participant said:

“Mental illness is a very painful disease because once it affects you, you lose your dignity, and you are not regarded as important anymore.....to the people your views are worthless”.

“When he is mentally ill he loses his dignity and becomes useless among family members”.

“People would call you ‘iGeza’ and in that way you lose your dignity”.

“A person needs to be accepted by his family first so that he can gain his dignity as a mother or father”.

“It is a painful disease because a person is no longer respected by his family when he is mentally ill; he loses his dignity, and become useless among family members”.

48
It becomes very painful for mental health care users to be excluded by their own family members from household matters particularly if the mental health care user was the breadwinner at home and this leads to a loss of dignity.

3.3.1.2.2.4 Loss of hope

When diagnosed with mental illness many patients lose hope of a positive future and give up if they did not undergo professional help. They are faced with high levels of hopelessness as they have no courage to change or trust others; they give up thus others commit suicide through this level of hopelessness.

In this study the psychological consequences of mental illness that are perceived by mental health care practitioners result to rejection, labeling and exclusion by family members as well as the community.

3.3.1.3 Sub-theme: Scientific causes for development of mental illness

Participants in the study stated other reasons for the development of mental illness apart from the cultural reasons. They expressed that mental illness is often the result of drug abuse, genetic factors, social factors and psychological factors. These causes are discussed by various authors as follows:

3.3.1.3.1 Genetic Factors

According to Hicks (2005:2) vulnerability plays a role in many mental illnesses since the risk of becoming ill is greater if you have a closer relative who suffers from the same illness but no specific gene has been isolated that causes any illnesses. Saddock & Saddock (2003:23) states that genetic factors are linked with chromosomes, neural tube defects and various inborn errors.
3.3.1.3.2 Social Factors

The environment plays a major role in determining mental illness. Unsatisfactory environmental conditions may result in mental illness if left untreated. In this study it is the role of mental health care practitioners to prepare a satisfactory environment for the mental health care users during the rehabilitation process.

One participant said:

“I am a link between the family, the patient and the environment, motivating the family to maintain a contact by visiting the patient”.

3.3.1.3.3 Substance Abuse

Participants in this study blame alcohol and other substances as the cause and consequence of mental illness. People who are using alcohol and drugs may be mentally ill in the long run. Continued use may lead to the development of addiction or dependence if left untreated. According to Bauman (1998:216) abuse of harmful substances can be understood at the level of brain physiology. One participant said:

“Another thing I think the government can do is to decrease the number of sheebens in the communities as when patients receive their disability grant they spend it on alcohol”.

3.3.1.3.4 Psychological Factors

According to Saddock & Saddock (2003:24) some psychological and psychiatric disturbances occur after childbirth like mood disorders (post natal blues) which affect mostly women. Other factors begin from childhood like disorders of memory and motor disorders may lead to mental illness if not treated in the early stages.

Participants were not specific when they were mentioning these as they state:

“Other causes of mental illness are due to depression when a person is experiencing a disappointment in a relationship like becoming suicidal”.
The importance of the causes of mental illness in psychiatry can be seen during the treatment process. Treatment cannot take place without the causes. Psychiatrists when they treat mental health care users rely on the history that has been collected by mental health care practitioners. In this history the causal factors of mental illness are usually stipulated. In this section symptoms and diagnosis were already mentioned but causes, symptoms and diagnosis are worth mentioning so as to arrive to the effective treatment of the mental health care users.

3.3.2 Theme 2: Perception of the causes of mental illness within the isiXhosa cultural context.

Each culture has a unique system for identifying and labeling any abnormal behavior among its people. In the isiXhosa culture it is known that attitudes towards the mentally ill are influenced by cultural views and mental illness arises in the context of specific cultural beliefs like ‘ukufa kwesiXhosa’. When a person is possessed by ‘ukufa kwesiXhosa’ family members send him/her to traditional healers. Apart from sending a person to traditional healers in the isiXhosa culture traditional rituals are performed at every stage of an individual’s life-cycle like from birth, through puberty, when entering manhood / womanhood and this can be regarded as a Xhosa normal life. When all rituals have been done and still an individual shows abnormal behavior it is then the isiXhosa culture that searches for the ‘why’ the misfortune occurred.

In a study that was conducted by Botha in (2006:622) it was found that in many South African cultures there is still a strong association between mental illness and traditional religions, with culture bound syndromes having been described in various ethnic groups. In a study conducted by Phakathi (2005:37) it was found that in most situations when families are faced with a problem, they search for cultural reasons in trying to understand and solve the problem. One of the participants in Phakathi ‘s study described how she strongly believed that her son was bewitched, and that she took him to a lot of traditional healers in search for the cause and cure of her son’s mental illness.
What has been found by Phakathi in her study has been confirmed by Yen and Wilbraham (2003:564) when they stated that Africans are unable or unwilling to acknowledge responsibility for misfortune; they are more concerned with why rather than how misfortunes occur. This has relevance because Africans, in this context amaXhosa, are always seeking ‘why’ a certain misfortune occurs and the traditional healers are often portrayed as providing the causal answers. It becomes important therefore for professionals to understand and recognize their cultural beliefs because such beliefs have a meaning in their socio-cultural context and are significant for the treatment of mental illness.

In this study, the participants expressed their views about some of the cultural causes of mental illness. They believed that most family members send the mental health care users for traditional treatment before admission to the hospital. They associate that with strong cultural beliefs. In a study that was conducted by Botha et al. (2006:622) they reported that Mkize et al. conducted a survey to investigate pathways to care in Kwa Zulu Natal, and found that traditional and faith healers were often the first point of contact.

In this study some of the participants’ cultural beliefs were confirmed when they were quoted as saying:

“When a person is sent to the hospital according to our culture families establish whether the person does not need to do any cultural customs first”.

“Some patients have come to the hospital just to be calmed as they will claim that they have been to the traditional healer before”.

“Theyre relatives would also come to explain to me and some would ask for them to go and see their traditional healer; they would come to the hospital just to be calmed as they were restless”.
“Sometimes you will visit the area and you will find that a person has been mentally ill for quite a long time but family members would tell you that they have been treating him traditionally and would send him to the hospital later”.

These participants cited the following related cultural reasons as the causes of mental illness.

3.3.2.1. Sub-theme: Failure to observe customary practices

The participants expressed the neglect of cultural customs or omitting certain customs as one of the reasons for being mentally ill within the isiXhosa culture. They believed that understanding these cultural beliefs would enable them to intervene positively in the treatment of mental illness. The quotations below show what the participants said about the significance of cultural beliefs:

“I have seen many patients who do not want to associate mental illness with a brain disease but they associate it with cultural beliefs”.

“Clients in such areas would tell you that we would like him to come back from the hospital so that we can treat him traditionally”.

“We are running short of money but we will come to the hospital and ask for him/her so that we can follow a ritual”.

What has been said by these participants regarding the importance of understanding cultural beliefs in order to intervene in the treatment of mental illness has been confirmed by Vacc, De Vaney and Wittmer (1995) in Uys and Middleton (2004:137) when they stated that the counselor (mental health care practitioner) ought to be aware of his/her own culture in order to deliver
appropriate mental health care in diverse population groups. They caution that lack of knowledge of own culture, as well as that of others, can lead to prejudice and a tendency to impose own or inappropriate values on the client. Cultural-unawareness of the counselor can lead to a limited management plan.

The participants expressed that neglect of cultural customs has something to do with the ancestral belief system. They pointed out the there should be a good relationship between a person and his/her ancestors so that the person can have good health. If the relationship between the person and his/her ancestors is good the person will be protected from diseases and misfortunes. This relationship is being maintained by practicing cultural customs, if they are not done the ancestors become angry and the person becomes sick and in that way the person is being punished by ancestors. According to Uys and Middleton (2004:132) ancestors are believed to be very influential in the African traditional world-view. They are responsible for the explanation of the meaning of existence.

The ancestral belief rests on the view that death is not the end of the person’s life but a transition into a spiritual world. Tshotsho (1994:23) agrees with these authors when she states that ancestral worship is one of the amaXhosa rituals and amaXhosa believe that on dying the deceased adult becomes an ancestor who still shares in the activities of their daily lives. When the ancestors are forgotten or ignored and the customs are not kept, the ancestors feel disrespected and neglected. This makes them angry and they display their anger by withdrawing their protection and expose the individual and family to evil powers who can cause illness and misfortunes.

When people are practicing their cultural customs they interact with the spiritual world of their ancestors. According to this belief system neglecting to practice their cultural customs people are not interacting with the spiritual world and this will result in misfortunes. The ancestors are capable of punishing those who do not practice cultural customs by illness eg. mental illness, unhappiness and even death.

However, a good relationship between the person and his ancestors will lead to protection against the powers of sorcerers or other evil forces. Uys and Middleton (2004:132) argue that cultural practices for ancestors are protective, and neglect of them triggers anxiety and leads to
psychosomatic and psychological illnesses. The ancestors are believed to withdraw their protection and gifts of good fortune from those who do not practice their cultural customs and show their anger and displeasure by including illness and misfortune. In the isiXhosa culture it would be said that the ancestors have turned their backs away.

Some participants agree with the above mentioned author and expressed their views as follows:

“In our culture mental illness is caused by anger from the ancestors when a person has neglected to practice cultural customs that are necessary for his health”.

“The isiXhosa culture associates mental illness with lack of practicing cultural customs “.

“Mental illness in my culture is associated with neglecting cultural customs whereby the ancestors become angry when a person does not perform a certain ritual that is important”.

“We as amaXhosa have a belief that in order to have good health and good life it must come from the protection of our ancestors “.

The ancestral belief system according to Ngubane (1977) in Uys and Middleton (2004:133) argues that when good things in life are realized people say the ancestors are ‘with us’ and when misfortunes happen they say the ancestors are facing away from us. The participants expressed that everyone requires good health and it can only be achieved through obeying the ancestors. According to Uys and Middleton (2004:130) health including mental health is defined as a well-being that is culturally defined according to the individual’s belief system. Health implies respect for the belief in customs and the specific rituals and ceremonies which sustain and create a holistic equilibrium within the person.
Mental illness can be seen as another type of illness that manifests itself when an individual is not observing customary practices. Failure to obey the cultural duty of sacrificing regularly to the ancestors by for example slaughtering a goat and brewing beer leaves the person vulnerable to the ancestral wrath and loss of protection from noxious influences. Good health and good fortune are a rich reward for good behavior and constant sacrifice to the ancestors. Ill health is a punishment for neglect of the customs. According to Ngubane (1977) in Uys and Middleton (2004:133) good health or ill health is regarded as a net result of a delicate and intricate balance between a person’s family and his/her relationship with the ancestors. Without ancestors’ protection the descendants become vulnerable to all sorts of misfortune.

The following statement by one of the participants supports this view:

“If we do not practice our cultural customs our ancestors become angry and punish us and this result in becoming vulnerable to all sorts of diseases and misfortunes and sometimes a person becomes mentally ill because there is no protection from ancestors”.

Neglecting of cultural customs as a cause of mental illness in the isiXhosa Culture has not been found in this study only, but also in Tshotsho’s study (1994:82) which confirms the findings when she states that some of the causes of mental illness in Xhosa culture are failure to fulfill simple customs or requests of ancestors such as performing a slaughter ritual and brewing beer and omitting a particular custom.

3.3.2.2 Subtheme: Witchcraft

Tshotsho (1994:82) in her study found that another cause of mental illness in Xhosa culture is witchcraft. She states that witchcraft is related to Xhosa supernatural theories about illness. Relatives and neighbours who are jealous and envious of one’s achievements and successes resort to witchcraft to make the envied person mentally ill. To confirm this some participants stated the following:
“Some believe that their mental illness is caused by witchcraft they are being bewitched by relatives, friends or neighbours because of jealous”.

“We as amaXhosa do not accept mental illness as a brain disease, we always want reasons and we believe that somebody is jealous of us, somebody has bewitched us, we believe in witchcraft”.

“A person may be bewitched because of jealousy as may be he has a better earning job”.

“I think witchcraft plays a role, you will find that a person was working well, progressing and being responsible at home and all of a sudden becomes mentally ill then people would say he is being bewitched because of jealous neighbours or extended family members”.

According to Ngubane (1977) in Uys and Middleton (2004:131) “witchcraft involves manipulation of psychic powers, usually through the medium of mythical monsters called familiars”. Ngubane believes that witchcraft and sorcery are seen to be the evil work of human beings driven by envy and malice to harm their fellow human beings. In a study that was conducted by Mkize et al. (2004) in Botha et al. (2006:622) they found that traditional healers and faith healers were often the first point of contact and that many African clients perceived their illness to be a form of bewitchment.

In the isiXhosa culture a person can be bewitched by many ways including ‘idliso’ (poison put in your food) as well as ‘amafufunyana’ as has been mentioned in this study by some of the participants. Uys and Middleton (2004:131) are of the opinion that some Africans believe that one of the many ways in which illnesses can be caused is by slipping poisonous substances into food and this poison can kill a person or cause mental illness or misfortune. Eating poisons or medicinal preparations in food is called ‘idliso’. These authors further state that some poisonous substances used to cause illnesses are not put into a person’s food but are spread across the doorway of a house at night. When a person steps out of the house in the morning, the medicine strikes through the feet and causes sickness or paralysis known as ‘ibekelo’ which is also
mentioned in the study by one of the participants as a way of showing how jealous are African people towards those who are fortunate than others.

Many authors (e.g. Edwards, 1984; Weiss, 1986; Lewis, 1971; O’Connel, 1982) have defined ‘amafufunyana’ differently as a form of evil spirit possession in which a ‘demon’ is cast inside the person by ‘jealous’ others, must be seen as a method of dealing with social imbalance, possession is concerned primarily with the enhancement of status and possession appear to be an adaptive response to acute stress and is associated among women with poor role performance in the domestic sphere (Hirst, 1996:272).

Swartz’s explanation of ‘amafufunyana’ (1998:163) is similar to the above when he states that amafufunyana occurs mainly in women in relatively powerless positions. He argues that different reports describe ‘amafufunyana’ with a variety of symptoms and this makes it impossible to think of it as a single diagnostic entity or specific set of ritualized actions with a specific set of consequences but with the mentally ill amafufunyana provides a theory of aetiology and a way of understanding what is happening, as well as a way of placing the blame for the affliction outside the patient.

Within the context of this study various comments by participants pointed amafufunyana as a form of bewitchment.

Some responses of the participants attest to this:

“In my culture people associate mental illness with amafufunyana whereby they believe that they are being possessed with evil spirits and that amafufunyana are caused by witchcraft”.

“Some will claim that they suffer from amafufunyana or are being poisoned as the amafufunyana are talking in their stomach”.

58
According to Bauman (1998:40) amafufunyana is the most well known of the traditional illnesses encountered in mental health settings and has been described among the amaXhosa and amaZulu groups. A person possessed with evil spirits shows symptoms like social withdrawal and loss of appetite. These spirits speak in one or more foreign languages and often in the ‘voice’ of the opposite sex, identifying the reason they were sent and by whom, the acute attack is considered to be a fairly ritualized and stereotyped episode of grunting then falling down (Bauman, 1998:41). In this study one of the participants confirmed what has been said by Bauman when she described one of her clients who was possessed by evil spirits of ‘amafufunyana’ when she states:

“You will find that those who have amafufunyana present as if they are schizophrenia like seeing strange things, hearing voices, voices changes and languages changes, Xhosa speaking would speak isiZulu or speak a strange language some have hysteria like falling down”.

It is important therefore for mental health care practitioners to acknowledge these symptoms so that they can be able to intervene positively in the treatment of their mental health care users.

3.3.2.3 Sub-theme: Neglect of the calling and associated rituals to become a traditional healer (Ukuthwasa).

In this study ukuthwasa has been associated with one of the cultural causes of mental illness. Ukuthwasa is described by Swartz (1998:165) as the state of emotional turmoil a person goes through on the path to becoming a traditional healer. Buhrmann (1982) in Swartz is of the opinion that ukuthwasa arises from a positive relationship with the ancestors and is a calling to become a healer. In endorsing the statement by Swartz the participants of this study expressed themselves as follows:

“In my culture people associate mental illness with ukuthwasa whereby a person would claim that he has a calling; he is being called by his ancestors to be a traditional healer”.

59
“I think another reason for being mentally ill in our culture is when a person is undergoing a process of ukuthwasa...I am not mentally ill but I need to follow a ritual so that I can become a traditional healer”.

“In our culture mental illness is associated with ukuthwasa where a person is being called to be a traditional healer but will have to undergo certain processes like slaughtering a goat and accepting the calling, and if the calling is not accepted the person becomes mentally ill”.

According to Bauman (1998:41) ‘ukuthwasa’ is commonly believed to be a calling by the ancestors to become a healer. He further states that the descriptions vary widely but typical features include feelings and fears of madness, vivid dreams, tearfulness, social withdrawal, and antisocial behavior and anxiety symptoms. ‘Intwaso’ was thought to affect mainly women but recent research indicates that it is also common among children (Bauman, 1998:41). Hirst (1993:101) is of the opinion that’ intwaso’ begins as an attack of umbilini i.e. ‘anxiety’ or nervousness, a condition of rather sudden onset that has much in common with fear. Tshotsho (1994:84) in her study described ‘ukuthwasa’ as another culture-bound syndrome which is common among amaXhosa. It is described as being due to the ancestors calling one to their service as a traditional healer. The afflicted becomes withdrawn and irritable when spoken to. Sometimes one becomes restless, violent, abusive and aggressive. There is a marked tendency to aimlessly wander, and may sometimes disappear for days. One neglects one’s personal hygiene and personal appearance, eats poorly, often looks and becomes really physically ill. One often hears voices talking to him/her and the most constant feature is excessive dreaming, dreams of an obscure and upsetting nature and a person is greatly disturbed by strangeness and effects of these dreams; the dreams are particularly disturbing because they are complex and unclear, unlike usual dreams, and they interfere with sleep.

According to Hirst (1993:101) persons afflicted with’ intwaso’ dream of water and rivers, of being submerged in a river pool, or in rare instances nowadays, actually immerse themselves in a
river or pool. He further mentions that traditionally the spontaneous immersion of a person in a river or pool (ukuthwetyulwa) was considered to be the diacritical sign and distinguishing mark of the future diviner. If the condition is resisted or ignored, it becomes worse and may lead to madness. In this study the participants mentioned the importance of responding to the calling as soon as possible as failure to respond may lead to mental illness.

3.3.3 Theme 3: Mental Health Care Practitioners’ views on the management and treatment of mental illness.

In treating mental illness the participants expressed that the mental health care users are treated in hospitals and in clinics. In this study it was established that even though the mental health care users start from traditional healers they are later admitted to the hospitals. Mental health care practitioners expressed the importance of knowing cultural beliefs as a factor in managing mental illness. At the hospital they are treated by various professionals and each professional uses his/her expertise in order to play his/her role. Mental health care practitioners mentioned the importance of including families as a support system towards mental illness. As it was established in this study mental health care users are treated according to their symptoms and symptoms are grouped into syndromes and classified into a specific disorder, so that an adequate diagnosis can be established. When treatment is established mental health care practitioners interprete a combination of thoughts, feelings and behaviors so that they can arrive at an effective treatment. In the psychiatric setting a Biopsychosocial Approach is used due to complex causation of mental illness.

This approach was mentioned by one of the participants when he states:

“At the hospital our approach is Biopsychosocial we use treatment like largatil and dissipal, we teach the patient about mental illness so that he can be able to listen to his body and knows when relapse is going to take place. If we have discovered that the source of stress is within the family we ask the social worker to intervene”.
3.3.3.1 Sub-theme: Knowledge of and respect for cultural belief systems.

According to Kneisl & Trigoboff (2009:167) the mental health care system comprises of individuals from different national, regional, ethnic, generational, socioeconomic, religious, and health status backgrounds. South Africa in particular consists of a group of nations with a diverse range of cultures and languages. This has been evident during the post-apartheid era where health care was being restructured in an attempt to make care more accessible and appropriate. This requires mental health care professionals who will have insight in the health care beliefs, rituals and traditions of a diverse group.

In this study the participants expressed the importance of knowing your own culture as well as that of others as a factor that can lead to effective treatment. The participants said that they are aware and respect the Xhosa culture and this made them to be able to communicate and listen to the mental health care users and their families.

The following quotations by the participants attest to this:

“We as Africans cannot deny the existence of our cultural customs therefore we do not deny the family their opportunities if they would like to send the patient to the traditional healer, we respect that”.

“We respect the family’s belief system and sometimes families and relatives come to ask for patients for purposes of performing a certain ritual or would like to consult a traditional healer, we do not deny them that opportunity”.

“We do not discourage the family in their cultural beliefs and cultural traditions; we know that they believe in traditional healers”.

“As African mental health care practitioners we cannot ignore our culture and tradition”.
What has been said by the participants has been confirmed by Vacc, De Vaney and Wittmer (1995) in Uys and Middleton (2004:137) when they state that the mental health care practitioner ought to be aware of his/her own culture in order to deliver appropriate mental health care in diverse population groups. They further stated that lack of knowledge of one’s culture as well as that of others can lead to prejudice and a tendency to impose own or inappropriate values on the client.

Within the psychiatric setting mental health care practitioners are trained to implement the western approach and ought to know and respect cultural beliefs of a diverse group. In this study the mental health care practitioners within the isiXhosa cultural context know and respect their cultural beliefs and that of the mental health care users and are also trained in the western approach. They operate within the dual allegiance because they implement programmes that are aiming at educating the mental health care users about mental illness and compliance of treatment and yet they respect their culture. One of the participants stated the following:

“Problems like these whereby the patient would like to focus on traditional treatment are discussed here, my role is to design programmes that will assist the patient in understanding his treatment better”.

“After we have taken history of the patient our role is to educate the patient and the family about mental illness so that families may not focus on cultural causes and traditional treatment only”.

In a study conducted by Kahn and Kelly (2001:37) on the views of Xhosa speaking psychiatric nurses on traditional healing and its role in mental health care in South Africa, they found that nurses in this situation are caught between two domains as they hold beliefs about health and illness and that of culture and they termed it a dual belief system.
In South Africa the African belief system was ignored and undermined during the apartheid era, it was seen as irrational, unregulated and ineffective whereas the western approach was regarded as rational, best, scientific and not widely available for Africans. Attitudes toward African belief system changed during the post apartheid era and deep understanding of this system is being slowly acknowledged in urban areas although in rural areas African treatment is still common. One of the participants said:

“Our catchment area consists of rural towns of former Transkei and this is where African view of treatment is rife. Clients in such areas would tell you that: we would like him to come back from the hospital so that we can treat him traditionally”.

In the hospital in which this study was conducted it was established that mental health care users are treated by traditional healers before admitted to the hospital. This dual belief system is embraced because mental health care practitioners state that they do not ignore cultural beliefs of the mental health care users but on the other hand teach them about the importance of taking treatment. This is evident in this study as some responses of the participants attest to this:

“If family members feel that they need to do a ritual in order for the patient to improve we respect that and we release the patient but we ask the family not to forget our treatment as well”.

“We emphasize the importance of our treatment, if they feel that the patient can be released in order to follow the ritual we release the patient”.

“We know that they believe in traditional healers but we emphasize the importance of taking our treatment as well”.

64
However, by allowing both forms of treatment the mental health care practitioners are aiming towards the rehabilitation of the mental health care user and to ensure the best possible care so that he/she can function normally among the members of the society and not really to prove the better form of treatment. Since some mental health care users are helped by African traditional treatment and others by western medicine the mental health care user should be allowed to use either or both. Bauman (1998:21) agrees with what the researcher is saying when he states that some African patients also accept western theories of illness, such as physiological causes, infections and stress. It is possible that the same illness could be caused by both bewitchment and a natural cause. The natural cause explains what caused the illness but bewitchment explains why the person became ill so they do not contradict each other.

3.3.3.2 Sub-theme: Role of mental health care practitioners in the treatment of mental health care users within the isiXhosa cultural context.

In this study it was established that a Biopsychosocial Approach is used at Komani Hospital where the study was conducted. According to Baumann (1998:11) a Biopsychosocial Approach is used due to causation of mental illness which is complex and shaped by social, cultural and historical factors. In other words when a mental health care user is being treated, not only the symptoms are treated but other factors in the life of a person are considered like physical, social, cultural and psychological.

Bauman (1998:440) further states that this approach stresses integrated systems approach to human behavior and illness, whereby systems approach highlights the analysis of different systems and their interactions with the environment. In this study the environmental interaction can be referred to the various aspects of life that are considered when a mental health care user is being treated, like physical, social, cultural and psychological. When these aspects of life are being considered for treatment they cannot be considered by one profession only, but various professionals ought to interact, thus playing various roles towards the management and treatment of mental illness.

Hicks (2005:8) points out that there are several types of medication for mental illness, often referred to as psychotropics. A person does not need psychiatric medication in order to feel better
but depends on the type of problems one is having, the severity of symptoms and willingness to undergo psychotherapy. He further points out that there are many types of psychotherapy that can help a person feel better either a sole treatment or in combination with medication. In this study it is evident that mental health care users are treated by various professionals so that they can be able to interact with their aspects of life as mentioned by Bauman.

The following quotations attest to this:

“A patient is assisted to accept his mental illness and is referred to the psychologist, the social worker and to the doctor to be part of his treatment in the hospital depending on his problem”.

“We treat mental illness collectively; we are a multi-disciplinary team that consists of a psychiatrist, a ward doctor, a psychologist, a social worker, an occupational therapist and a professional nurse”.

“When the problem of the patient is beyond our scope we refer the patient to other mental health care practitioners because we work as a team here like a ward doctor, a social worker, a psychologist and an occupational therapist”.

In the hospital where the study was conducted a Biopsychosocial Approach is used and this approach requires a variety of professionals because the focus is not on the illness but on the person who is having illness. The advantage of this approach is that it is rehabilitative, comprehensive and preventive. The main aim of this approach is to treat the mental health care user holistically. Treating the mental health care user holistically cannot be done by one profession, thus various professionals are involved in the treatment process of the mental health care user to focus on his/her social, psychological, spiritual, cultural and physical aspects.

Professionals who are involved in the management and treatment of mental illness are: the psychiatrist, the clinical psychologist, the psychiatric social worker, the occupational therapist and the psychiatric professional nurse. Kneisl and Trigoboff (2009:22) believe that these
professionals require formal academic instruction often at a graduate level coupled with extensive clinical experience.

In a psychiatric setting the combined skills of these various professionals is a necessity in order to meet the needs of each mental health care user. These professionals work together on a problem with a common goal of rehabilitating the person within a comprehensive approach. According to Kneisl and Trigoboff (2009:23) the aim of mental health care practitioners working together is that of co-operation and according to these authors, co-operators are interested in helping both themselves and their colleagues to aid the client in the rehabilitation process. In this study what has been said by these authors is evident when more than half of the participants’ responses attest to this:

“We treat mental illness collectively we are a multi-disciplinary team ...each team member plays a different role in terms of treating the mentally ill...we meet in order to resolve some challenges”.

“I do not work alone we are a team and each one of us plays a different role. We meet as a team and discuss patients’ problems”.

“As a team we are a multi-disciplinary team, we share the problem of the patient in order to solve it from all aspects”.

“We work as a team here and we are called a multi-disciplinary team. Each professional makes a contribution towards the patient’s problem for purposes of coming up with solutions”.

The management and treatment of mental illness consists of various methods of treatment like medication which consists of psychotropic drugs, counseling, and psychotherapy or talk therapy.
according to (Hicks, 2005:7) and many other forms of therapy including electroconvulsive therapy. The use of these methods of treatment depends on the severity of the symptoms as some mental health care users make use of a sole treatment and others, a combination. As mentioned previously in psychiatry mental health care users are made active participants in treatment and are not merely instructed to take medication. Bauman (1998:452) and Kneisl & Trigoboff (2009:776) state that a therapeutic alliance between the mental health care users and the mental health care practitioners should be formed whereby mental health care users should be given time to express their fears about taking medication and be able to report any adverse effects that they may experience.

Mental health care practitioners should educate the mental health care users about mental illness and family members should be involved in this alliance because they have an influence in the mental health care users. Sometimes if they disapprove, one of their members who is mentally ill can sabotage treatment process by discouraging the taking of medication. In this study the formation of this therapeutic alliance is taking place as some of the participants’ responses attest to it:

“*At the hospital a patient is taught on when to take medication and how much medication to take, he is given much support so that he can understand mental illness and accept himself, he is taught that mental illness is not totally curable but a person will always receive medication for quite a long time, his family is not left out but becomes part of his treatment as they are taught to accept his mental illness.*”

“*At the hospital we speak to the patient we educate him about mental illness, we make him understand that he is mentally ill so that he can accept mental illness first, we involve the family as well to be part of the treatment so that they can understand the patient and when he complains about anything they cannot say he is mentally ill*”.
“In the hospital we stabilize the patient first, and once the patient has been stabilized education become important, families and relatives become part of the treatment. We advise them on medication”.

Besides psychotropic drugs some mental health care users respond well to psychotherapy which is referred to as ‘talk therapy (Hicks, 2005:7). Psychotherapy according to Hicks refers to helping clients gain insight into their problems and being reassured to feel more confident. It involves forming a confidential relationship with a professional whereby the client will be able to say things that he/she might not be able to share with anyone else. The professional will give guidance and suggestions to the client on how to understand and resolve the problems.

According to Frisch & Frisch (1998:249) such an approach is usually long term and requires much motivation on the part of the client to invest considerable time. Hicks (2005:7) states that there are many types of psychotherapy depending on the aim of each therapy. In this study participants mentioned individual therapy in the form of counseling, family therapy and group therapy as a form of treatment toward the mental health care users. All these forms of treatment including the psychotropic drugs are used by mental health care practitioners as a means of managing and treating mental illness.

3.3.3 Sub-theme: Family as a support system in the management and treatment of mental illness.

According to Andrews & Boyle (2003:14) a family is the basic social unit which provides the context in which health promotion and maintenance are defined and carried out by family members within cultural diverse communities. The participants expressed that family involvement is necessary in the management and treatment of mental illness. They expressed that families have an influence over the medication of the mental health care user and decide which type of medication is suitable for the mental health care user; therefore they cannot exclude families in the treatment process. The following quotations endorse such a perception:
“Families play a leading role in the treatment of the mentally ill. They must accept the mentally ill first even if the patient has done something at home like breaking a table….if he was a head of family he must be able to play that role and be supportive toward him”.

“The family plays a supportive role to the patient….they must be part of the treatment and be able to supervise the treatment and report any changes or side effects. We empower the family to play such a role, we teach them certain skills so that they can be able to manage the patient”.

“Families play a supportive role towards the family by visiting him regularly and supervise his treatment when discharged. We assist families by educating them about mental illness so that they can cope with the patient when at home”.

“The family plays a supportive role to the patient …it is the family who supervise his treatment at home and brings him back when he has relapsed”.

Frisch & Frisch (1998:661) are of the opinion that a family is like a system that is connected to each other. If a significant event like mental illness affects one family member it will have an impact on others as well. These authors further point out that a family works to achieve a state of equilibrium, if one is affected by mental illness the equilibrium is upset and the relationships, supports, and tasks of everyday living need to be readjusted. In this study the systems approach is used because the state of equilibrium is being maintained by mental health care practitioners whose role is to empower the families in the management and treatment of mental health care users. The goal of treatment is to achieve equilibrium. In this study more than half of the participants expressed that mental health care users who are admitted to the hospital are being supported by their family members; they are viewed holistically and cannot be treated in isolation.
Frisch & Frisch’s view of family as a system is supported by Uys & Middleton (2004:77) when they state that the families of people with mental illness usually shoulder the greatest part of the burden of caring for them and the family is the main resource of the person suffering from mental illness. Families act as caregivers; they support other families with similar problems.

Kneisl & Trigoboff (2009:821) state that involving family members in a client’s treatment plan serves two main goals: enlisting the family as an ally in promoting and bringing about therapeutic progress and supporting family caregivers. These authors believe that whilst families are supporting the patients, as caregivers they need to be supported as well. In this study families are supported by the mental health care practitioners.

The support of the family becomes very important when the mental health care user is admitted to or discharged from the hospital because the family is viewed as the context in which continued treatment and management of the condition takes place.

In comparing the traditional African and the western families, there is a difference as the western families are underpinned by individualism. According to Mtuze (2004:103) in western families each person is an island, each person is minding his or her business. In contrast, the traditional African families are warm and caring for the well being of others. He describes the African families as in this kind of existence, one person’s personhood and identity is fulfilled and complimented by the other person’s personhood. Each person is because the other person is. In this view he is supported by Yen & Welbraham (2003:567) when they state that African culture is said to be ‘collectivist or ‘communalist’ in that it is kinship based and the interests of the social group are more highly valued than those of the individual, the western culture is based on selfish individualistic interests and achievement, competition and pressure to succeed. Moreover, African families believe in extended kin where collectivity takes place. According to Madu, Baguma and Pritz (1999:197) state that in traditional families no man is an island, a man or a boy, old or young, depend on the family circle and anything happening to any of them may result in chain-reaction. In such families there is ‘ubuntu’ which according to Mtuze (2004:103) involves sharing yourself, your humanity with the other person i.e. a fundamental humanity and caring for the well being of others. Mbigi (1992:23) refers to this as interdependence of family members where he shows that African families require collective corporation of all the members. Mbigi also mentions other principles of ubuntu, namely; morality, totality, and spirit of man.
3.3.4. Theme 4: Suggestions to improve services to mental health care users.

The question that was posed to the participants was whether they thought there were things that could be of assistance in improving the mental health care service delivery. Participants presented suggestions that the Department of Health should consider as they would help in improving the services rendered in respect of the mental health care users. Participants felt that there is a need to emphasize team work, participants emphasized a need for public education to take place in all spheres, and participants felt strongly about the Department of Health to take responsibility for mental health care. Other suggestions presented by participants are policy related.

3.3.4.1 Sub-theme: Team Work

Participants felt strongly about working together of mental health care practitioners with traditional healers. They felt that South Africa as a multi-cultural society in the post apartheid era needs to consider working with traditional healers. Participants endorsed this idea as follows:

“I also think that we can be able to manage those with culture bound syndromes if we can work hand in hand with traditional healers because as African mental health care practitioners we cannot ignore our culture and tradition. Also I think those who suffer from ‘intwaso’ can be advised to undergo the process as diagnosed by their traditional healers”.

“I think the time has come for us to work hand in hand with traditional healers because our patients do visit the traditional healers before admission. Some of the patients we treat do not respond to treatment perhaps if we can sit together with traditional healers they might be of assistance, perhaps they can be able to test their traditional treatment….Working together with traditional healers can improve the service delivery and improve the social functioning of our patients”.

72
There is a great improvement in the attitudes of health professionals regarding working with traditional healers. The change might be the result of seeing that some mental health care users are not responding to treatment. The working together of these professionals requires a lot of co-operation as sometimes those who are not trained can be part of the team work just for money without any proper training or initiation.

3.3.4.2 Sub-theme: Public Education

Participants felt that mental illness is despised by communities. People do not know mental illness and those who are affected by it are ill treated, labeled with bad names and are not treated with the dignity they deserve. They felt that mental illness is not treated like any other disease; there is a stigma attached to it and this stigma leads to exclusion and discrimination of mental health care users. Participants felt that it is lack of knowledge that results into ill-treatment of mental health care users by communities. They felt that public education is needed in all spheres like communities, schools and churches. Public Education will be in the form of ‘mental Illness awareness campaigns’, ‘open days’ and ‘talking to the media’.

Participants voiced the following to support the above assertions:

“There is a need for Open Days whereby the communities can be invited to visit the mental health care users and interact with them whether one has a mental health care user in his/her home or not, also Public Education is of importance, people should be taught by our multi disciplinary team through mental awareness campaigns”.

“Mental illness has lot of stigma attached to it. People do not understand mental illness, it would be better if the department of Health could hold Mental Awareness Campaigns in the communities to educate the public because when we look at TB for example it was stigmatized but presently people are beginning to accept it and it is due to education that it is accepted”.
“As professionals we have a responsibility to educate the public about mental illness as there is still a lot of stigma attached to mental illness...we need to visit schools, churches and clinics to teach communities about mental illness...if we can talk to the media about mental illness like in a radio or TV that will be of help in improving the negative attitude toward mental illness”.

3.3.4.3 Sub-theme: Department of Health to take full responsibility for mental health care

Participants felt strongly about the neglect of mental health care services within the Department of Health. They blamed the National Department of Health by neglecting and discriminating against the entire psychiatric services through its underfunding as compared to other health components. They stated that the underfunding has resulted into a shortage of specialist staff like psychiatrists. They expressed the need for the Department of Health to increase the budget for psychiatric services.

One of the participants voiced the following to support the above assertions:

“Mental Health Care is a neglected field, there is a need for an increase in budget of psychiatric services, and there is a lack of special equipment like ECT and resuscitation machines”.

Participants felt that Mental Health Care as a neglected field resulted into the neglect of mental health care users by the Department of Health because there are no provisions made for those mental health care users who are homeless or being rejected by their families due to crime committed and other reasons; thus they end up staying at the hospital. Participants felt that there is a need for Half Way houses to be built for such mental health care users and they can utilize their disability grants and stay independently in these Half Way houses.

Their suggestions are captured in the quotes below:

“ It would be better if the Government can establish Half Way houses whereby when mental health care users are discharged from hospitals they can be accommodated especially those
mental health care users who are not accepted back by their families as we have nowhere to send them but to keep them in the hospital”.

“The Department of Health regards psychiatric hospitals as specialized services but they are neglected and the department does not prioritize our needs, for example we are short staffed here...The government is treating General hospitals differently than us as they are being prioritized but I feel we are neglected”.

Baumann (1998:32) agrees with what has been said by the participants regarding the mental health care that is neglected when he states that separation of psychiatry from general medicine has had damaging consequences in the sense that psychiatry has become marginalized and psychological aspects of care in general medicine have been neglected. According to him mental health is compromised by its relatively low status within the general health care system. This is reflected in the underfunding of psychiatric services and that medical personnel are few.

Participants further expressed the need for changing certain legislation regarding mental health care users. They felt that the government should make laws that allow mental health care users to be employed just like the physically disabled, also laws that can protect the mental health care users’ disability grant from being misused by family members and other stakeholders like cash loans. Participants felt that laws regulating traditional healers to practice should be in place so that they can register just like other mental health care practitioners as they will be of help in the management and treatment of mental illness.

Participants suggested the following:

“Employment can be established and the employers can be taught skills on handling mental health care users so that they can mix with the work force and not isolate them”.

“Disability grant policies need to change because families and relatives misuse the disability grant of mental health care users....the government must have a strict policy that will prevent the mental health care users from being exploited by families”.
“There is a need to create laws that can allow mental health care users to be employed with the workforce in a labor market after they have been rehabilitated like having a certain percentage of the mental health care users in a private organization or government institution”.

The purpose of this chapter was to present the research findings of this study supported by relevant and appropriate literature. The profile of the research participants was provided in order to give a background and context of the study. The researcher discussed themes and subthemes that came from the process of data analysis. They were substantiated with relevant literature and excerpts by participants. The first theme dealt with mental health care practitioners’ perceptions of mental illness, the second theme discussed the perception of the causes of mental illness within the isiXhosa cultural context, the third theme dealt with the mental health care practitioners’ views on the management and treatment of mental illness and the last theme was based on the suggestions to improve services to mental health care users. Both males and females participated in the study as there was no preference to gender. The last chapter that follows presents the summary, conclusions and recommendations of this study.
CHAPTER 4

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

4.1. INTRODUCTION

Chapter one provided the reader with an overview of the introduction and problem formulation. The theoretical framework embraced literature review, the proposed research plan and the procedures to be followed were also part of discussion in Chapter 1. In Chapter 2 the objectives and aims of the study as well as the research design and methodology were presented. Qualitative, descriptive, explorative and contextual research approaches were used in this study. These approaches assisted the researcher to explore and describe the perceptions of mental illness by mental health care practitioners. In Chapter 3 the findings of the study were substantiated and discussed agreeing to the themes and sub-themes that emerged during the process of data analysis. Verbatim quotations of participants’ responses substantiated with relevant literature were used to compare and contrast the findings. The themes and subthemes that emerged were done through the consensus discussion between the supervisor, the researcher and the Independent coder.

In this chapter a brief summary of the findings will be presented together with conclusions and recommendations based on the findings of the research study.

4.1.1 Research Aims and Objectives

The main aim of the study was to determine the perceptions of mental illness by mental health care practitioners within the isiXhosa cultural context.

The objectives were:
To explore and describe the perceptions of mental illness by mental health care practitioners.
Based on the research findings, the concluding objective of the study was to draw conclusions and make recommendations on appropriate policies and services to be rendered in respect of mental health care users.

4.2 SUMMARY OF THE RESEARCH DESIGN AND METHODOLOGY

The qualitative methodological approach that was used in this study was appropriate and allowed the researcher to explore and gain understanding of the situation from the participants’ perspective, how they perceive mental illness within the isiXhosa cultural context. The study was descriptive, explorative and contextual because the participants described and explored their perception of mental illness within the isiXhosa cultural context in their own spoken words identifying their beliefs and values.

The qualitative research approach and semi-structured interviews as a method of data collection were used in this study and this enabled the researcher to gather more information on the mental health care practitioners’ perceptions of mental illness within the isiXhosa cultural context. Gathering such information was important because within the South African society very limited information exists about the perception of mental illness within the isiXhosa cultural context. Such information will be of help to the management of the Department of Health as well as to other departments.

4.2.1 Sampling Selection of Research Participants

The sample was selected on the basis of the researcher’s own understanding of the population. A non-probability purposive sampling method was used in this study. The researcher used purposive sampling to select nine mental health care practitioners who were all working at Komani Hospital, belonging to the isiXhosa ethnic group and were able to speak isiXhosa; both males and females who were working with mental health care users in their scope of practice with a minimum experience of three years. The selection process was easier for the researcher as she knows all the mental health care practitioners in the hospital and they were selected because
of some defining characteristics, and the purpose was to obtain the richest possible source of information to meet the purpose of the investigation.

4.2.2 Data Collection

The research methods and data collection tools were tested by means of a pilot study where the researcher asked the Independent Interviewer to interview one participant, so as to avoid bias information as the researcher is employed in the same hospital. A pilot study according to De Vos (1998:179) is a process whereby the research design for a survey is tested. Its purpose is to improve the success of the investigation and the effectiveness of the research tools. Conducting a pilot study assisted the researcher because the information she got from the pilot study was used to improve the research tools for data collection and to make the necessary changes.

The Independent Interviewer conducted semi-structured interviews in isiXhosa with each participant so that a clear description and exploration of mental illness can be obtained. Interviews were held in the researcher’s office and some in the participants’ office. An interview schedule was used to assist the researcher to probe beyond prepared questions. During the process of data collection the researcher accompanied the Independent Interviewer but the interviews were not conducted by the researcher so as to avoid bias information.

4.2.3 Data Analysis

Data was analyzed according to the eight steps proposed by Tesch (in Creswell, 1994). The services of an Independent coder were utilized to assist in confirming the themes and subthemes that were identified by the researcher.

4.3 SUMMARY OF THE RESEARCH FINDINGS

In this study eight participants were interviewed through semi-structured interviews. Data was analyzed according to Tesch’s (1994) eight steps. During the data analysis process, the themes and subthemes emerged and the Independent coder was appointed to verify the themes. The themes and subthemes were supported by relevant literature and quotations from the transcripts. The findings of the study can be summarized as follows:

The section that follows will focus on the summary of the main findings.
4.3.1 Mental Health Care Practitioners’ perception of mental illness

When asked how they perceived mental illness, mental health care practitioners responded in various ways and out of their responses three sub-themes were identified:

- Mental disturbance that is characterized by strange behavior
- Mental illness is a painful disease where one loses his/her dignity
- Mental illness develops from scientific causes

In this study it became evident that there is still discrimination against mental illness due to lack of knowledge and stigma attached to it. Mental health care users are isolated in their communities by their family members and the community at large. The causes of mental illness emanate from social, psychological, substance abuse and hereditary factors. Although mental illness is characterized by strange behavior, the manifestation of mental illness is difficult to understand because the interpretation of strange behavior varies from person to person and from culture to culture. It becomes not easier for mental health practitioners to diagnose mental health care users on the basis of singular symptom but a cluster of symptoms allows the mental health care practitioners to arrive at a specific diagnosis. Labeling of mental health care users with bad names has consequences of losing their dignity.

4.3.2 Perception of the causes of mental illness within the isiXhosa cultural context

In response to the question as to what is your view of conservative African perception of mental illness, the participants gave a variety of responses that were culture related. The participants expressed that in the isiXhosa culture some people are mentally ill because of neglecting their cultural customs, others are mentally ill due to witchcraft, still others are mentally ill due to the neglect of the calling and associated rituals to become a traditional healer i.e. ‘Ukuthwasa’ Participants expressed the importance of a good relationship between the person and his ancestors so that a person can be protected from diseases and misfortunes. They expressed that this relationship should be maintained by practicing cultural customs and if this is not done ancestors become angry and the person become sick and later punished. Participants cited neglect of the ancestors by failing to perform certain rituals as a reason for being mentally ill. The participants felt that some people become mentally ill due to witchcraft; people are bewitched by relatives and neighbours who are jealous of one’s achievement and success by
making the envied person mentally ill. Another cause of mental illness in the isiXhosa culture is due to the neglect of calling to become a traditional healer i.e. ‘ukuthwasa’. It was found that a person is being called by the ancestors to become a traditional healer. If the call is resisted or ignored it becomes worse and may lead to mental illness.

4.3.3 Mental health care practitioners’ views on the management and treatment of mental illness

The importance of knowing cultural beliefs and values of mental health care users has been highlighted as a factor in managing mental illness by mental health care practitioners. It was found that such knowledge assisted them in communicating and listening to the mental health care users and their families and enables the mental health care practitioners to understand and treat the mental health care users accordingly. The management and treatment of mental illness in hospitals is done by various professionals who use their expertise. In managing and treating mental illness mental health care practitioners felt that the family as a support system cannot be excluded as it plays a very important role. Mental health care practitioners found that although they manage and treat mental illness, the mental health care users have already started from traditional healers but they do not discourage them in their beliefs, instead emphasize the importance of the scientific treatment as well. In treating mental illness it was found that both forms of treatment are allowed in order to ensure best possible care. Although African treatment was previously ignored and undermined, it is slowly being acknowledged.

4.3.4 Suggestions put forward

There were suggestions that were put forward by participants regarding the services rendered to mental health care users and these suggestions were identified as the fourth theme, and they embraced sub-themes as well:

- Teamwork – Participants felt that there is a need to work hand in hand with the traditional healers officially. South Africa being a multi cultural democratic society in the post apartheid era ought to be ready to work with traditional healers. Although their treatment was considered inappropriate and ignored previously, presently it is slowly being acknowledged.
- Public Education – Participants felt that there is a need for communities to be provided with education on mental illness. Communities do not know mental illness and this lack of knowledge results in ill-treatment of mental health care users hence they are isolated and excluded in their communities. Education can be in the form of mental illness awareness campaigns, open days and talking to media.

- Department of Health to take adequate responsibility of mental health care. Participants felt that mental health care services are a neglected component within the entire Department of Health. They are blaming the department of Health for its under funding. They felt there is a need to increase the budget to be equivalent to other Health components. Mental health care as a neglected field results into neglect of mental health care users as there is no provision made for homeless mental health care users who are in hospitals. There is a need for Halfway Houses to be built.

- Legislation – Participants felt that some legislation needs to be amended to benefit the mental health care users. Mental health care users need to be employed just like the physically challenged this can only be achieved if the laws could be amended. The misuse of their disability grants by the family members was of concern by the mental health care practitioners and felt that there are no laws that regulate their disability grant so that they can be protected.

5. MAJOR FINDINGS OF THE STUDY

In analyzing the participants’ responses one gathers that knowledge of cultural beliefs, needs and values of mental health care users is the key factor towards the understanding, managing, coping and treating of mental illness. Cultural competence by mental health care practitioners plays a major role towards managing mental illness. Findings of this study have shown that mental health care practitioners are able to communicate and listen to mental health care users and their families if they share the same cultural background and this will enhance in therapeutic communication.

In this study it has been established that lack of knowledge of culture of those people who have come for treatment posed as a challenge towards the treatment of mental illness. This lack of knowledge of culture results to mental health care users not being treated accordingly thus they relapse and cause several re-admissions. This lack of knowledge of culture results to mental
health care users being alienated and distressed. The Strength Perspective by Gray (2002) would be applicable in this situation because in this approach Gray mentions the importance of taking into consideration cultural factors as some strengths are seen differently from culture to culture. Within the context of this study the researcher has established that some are mentally ill due to failure to observe customary practices which could not be understood due to lack of understanding one’s culture.

Findings of this study revealed that mental health care users may present similar symptoms but the interpretation of symptoms may be expressed differently from culture to culture. In this study it is evident that within the isiXhosa culture there are culture bound syndromes like ‘amafufunyana’ and ‘ukuthwasa’ which may be misinterpreted as mental illness if a mental health care user is treated by mental health care practitioners who lack cultural knowledge and competence.

In the isiXhosa culture ‘amafufunyana’ can be seen as a culture bound syndrome which is due to sorcery. From the findings of this study a person who is possessed with amafufunyana presents similar symptoms with that of schizophrenia and ‘amafufunyana’ can be mistakenly regarded as a mental disorder. Ukuthwasa is another culture bound syndrome within the isiXhosa culture. It can be seen as a state of emotional turmoil a person goes through on the path to become a traditional healer. It is associated with a positive relationship with the ancestors and a calling to be a healer. A person undergoing ‘ukuthwasa’ may present with many antisocial features, dreams and depressive symptoms which may be misinterpreted as a mental disorder. A person who is undergoing ‘ukuthwasa’ will have to accept the calling by performing certain rituals and being instructed by ancestors in his/her dreams, and defaulting to do that an ancestor may cause mental illness to that particular person.

However, this study has revealed much about isiXhosa culture and mental illness. Findings of this study have shown that, good relationship with the ancestors is of significance so that a person can live a healthy life and this relationship is being maintained by performing certain rituals; if this is done the ancestors will support and protect the person from misfortunes and diseases. If rituals are not performed the ancestors may become angry and may cause illness and misfortunes. Participants in this study cited neglect of cultural customs as a common reason for mental illness.
The findings of the study revealed that in the isiXhosa culture witchcraft plays a role in the causation of mental illness. Witchcraft is caused by relatives and neighbours who are jealous and envious of one’s achievements and successes and they resort to witchcraft to make the envied person mentally ill. Participants revealed that amaXhosa are possessed with jealous toward those who are fortunate than others. AmaXhosa can bewitch those who are fortunate by means of ‘idliso’ by slipping poisonous substance into food and that can kill or cause mental illness. However, it is prudent for mental health care practitioners to be aware of these cultural variations as not all of them represent mental illness.

The findings of this study have shown that cultural competence by mental health care practitioners facilitates communication and listening to the mental health care users and their families and when there is an open communication between these parties the family or the mental health care user will be able to share and give history of mental illness with mental health care practitioners which will lead to proper diagnosis and appropriate treatment. Participants in this study revealed that mental health care users although treated in the hospitals by various professionals, have consulted traditional healers prior their admission. In the isiXhosa culture both forms of treatment are being utilized to ensure best possible care. In treating the mental health care users mental health care practitioners use their expertise and are not treated by medication only but psychotherapy is also used. In the treatment process the family is regarded as the most important form of support system and it becomes part of the treatment process.

However, there is still a lack of knowledge about mental illness among families and communities which leads to social exclusion and discrimination of mental health care users and this lack of knowledge is associated with the stigma that is attached to mental illness.

6. LIMITATIONS OF THE STUDY

The limitations identified in this research can be stated as follows:

The research study was restricted to mental health care practitioners’ perceptions at Komani hospital, interviews were conducted with mental health care practitioners at Komani hospital where the researcher is currently employed therefore the results cannot be generalized to all South African mental health care practitioners’ settings.
7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusions

The study assisted the researcher into gaining more insight about mental illness itself and the cultural beliefs of amaXhosa as perceived by mental health care practitioners. From the interviews conducted the researcher learnt that it is important for all mental health care practitioners to understand and respect the cultural beliefs of mental health care users and their families so that they can be able to treat them holistically.

From the experience acquired through interviews, it is the researcher’s belief that Xhosa psychiatric patients would always associate their mental illness with cultural beliefs hence they start from traditional healers before being admitted to the hospital and would regard hospitals as the secondary form of treatment. The researcher also established that cultural factors are of significance for both mental health care practitioners and mental health care users in any psychiatric setting as they have meaning in the environment of the African people and allow mental health care practitioners to intervene positively in the treatment of mental illness.

However, the researcher gathered that professional effectiveness in the multi-cultural environment like that of South Africa requires mental health care practitioners to understand and respect cultural differences.

7.2 RECOMMENDATIONS

This study explored the perceptions of mental illness by mental health care practitioners within the isiXhosa cultural context. Based on the findings of the study, the following recommendations are presented from a policy and service delivery perspectives.
• **Policy Perspective**

The Mental Health Care Act (17 of 2002) does not cater for homeless mental health care users admitted to hospitals; even if they are rehabilitated they are kept in the hospital. It is recommended that the Act could be amended so that Half Way Houses can be built for those mental health care users who are rehabilitated so that they can stay independently.

Mental health care users are not able to compete in the open labor market with other workers long after they have been rehabilitated. In this study it has been established that mental health care users are faced with unemployment; thus it is recommended that policies should be changed so that a certain percentage of them can be employed in the government institution or private sectors as is the case with the physically disabled.

Whilst mental health care users are faced with unemployment they are being recommended for disability grants, they do not enjoy these grants as they are being misused by family members or other financial stakeholders through loans. It is recommended that the government should have laws that can protect mental health care users from making loans.

All traditional healers will have to register with their Traditional Body in order to regulate them and to meet certain standards in order to distinguish between those who are trained and those who just do it for ulterior motives. Mental health care practitioners are required to register with their Health Council as well.

• **Service delivery perspectives**

In the isiXhosa culture there are culture bound syndromes like amafunyunyana and ukuthwasa that can be misinterpreted as mental illness. In order for these culture bound syndromes to be clearly identified during their initial stages, it would be proper if there could be co-operation between mental health care practitioners and traditional healers by working together as a team so that those who do not respond to psychotropic medication can be referred to traditional healers. This co-operation could also assist traditional healers to refer other mental health care users to psychiatric hospitals.
There is lack of knowledge regarding mental illness by families as well as communities. There is a need for a vigorous drive for Public Education. This can be in the form of quarterly Mental Illness Awareness campaigns targeting schools, clinics, and churches. Open Days could also be held on regular basis and not only once a year. Media as a means of communication can be utilized to educate the public about mental illness.

The Department of Health will have to take adequate responsibility for Mental Health Care and refrain from underfunding it. There is a great need to increase the budget to be on par with other Health components so that more specialized staff can be employed.

8. CONCLUDING REMARKS

The aim of the study was to determine the perceptions of mental illness by mental health care practitioners within the isiXhosa cultural context. It can be concluded that the following findings were identified.

Perceptions of mental illness by mental health care practitioners within the isiXhosa cultural context.

Perceptions of the causes of mental illness within the isiXhosa cultural context.

Recommendations based on the research findings were made.

This study could be extended to various participants including traditional healers and mental health care users in order to establish how mental illness is perceived by service providers and service users. This study cannot be restricted to mental health care practitioners at Komani Hospital only but could be extended to other mental health care practitioners in other psychiatric hospitals.
It is of significance to note that the findings of this study add to the body of limited knowledge of previous similar research done about the perceptions of mental illness within the isiXhosa cultural context.
REFERENCES:


Kahn, M.S. & Kelly, K.J. (2001). Cultural Tensions in Psychiatric nursing: Managing the interface between Western Mental health Care and Xhosa Traditional Healing in South Africa. [online] available: http/tps sagepub.com/cgi/content/abstract/38/1/35.


Mental Health Care Act. (No. 17 of 2002). South Africa


Port Elizabeth, University of Port Elizabeth. Degree/Project Status: Mcur. Completed.


APPENDIX 1

INTERVIEW GUIDE

Biographical Questions:

1. What is your Occupation?
   Usebenza msebenzi mni?
2. How long have you been working at the hospital?
   Unexesha elingakanani usebenza apha?
3. What is your home language?
   Uthetha oluphi ulwimi?

Content Questions:

4. How do you as a mental health care practitioner of Komani Hospital perceive mental illness?
   Njengoko uxelela apha esibhедlele ungathi yintoni ukugula ngengqondo?
5. What are the factors that should be considered in assisting a mentally ill person cope with mental illness?
   Ucinga ukuba angancedwa njani umntu ogula ngengqondo?
6. What is your view of conservative African perception of mental illness?
   Luthini uluvo lwakho malunga nokugula kwesiXhosa?
7. What suggestions can you put forward for understanding and treating a mentally ill person?
   Ungacebisa ntoni malunga nokunyanga umntu ogula ngengqondo?
Dear Sir/Madam,

**RE: REQUEST TO INTERVIEW MENTAL HEALTH CARE PRACTITIONERS FOR THE PURPOSE OF A RESEARCH STUDY**

My name is Nocawa Lombo and I am working at your hospital as a Chief Social Worker. I am currently doing a Masters degree in Social Development and Planning at Nelson Mandela Metropolitan University (NMMU). As part of my course, I am conducting a research study into ‘Mental Health Care Practitioners’ Perceptions of Mental Illness within the isiXhosa Cultural context’. The objectives of the study are:

To explore and describe the perceptions of mental illness by mental health care practitioners. Based on the research findings, the study will draw conclusions and make recommendations on appropriate policies and services to be rendered in respect of mental health care users.

Mental health care practitioners will participate voluntarily and all the information supplied above will be conveyed to them on the first day of the interviews. Each participant will be given a consent form that will be fully explained to him/her and this will be to ensure that the participants participate voluntarily. All information provided during interviews will be treated confidentially and will not be used for any other
research study. After the study is completed the researcher will give Komani Hospital a copy of the report and share the research findings with management.

I would like to ask your permission to allow me to interview mental health care practitioners to enable me to gather data for the research study.

I strongly believe that the findings and recommendations of this research study would benefit everyone involved in an effective mental health care delivery.

Your co-operation will be appreciated.

Yours faithfully

N P LOMBO

Tel. 045 839 4945 (H)
Cell. 0724 0708 66
APPENDIX 111

ASSENT BY PARTICIPANT

I, the undersigned …………………………………………… (Name of participant)

ID …………………………………………………………………

The participant of ………………………………………………. (Home address)

HEREBY CONFIRM AS FOLLOWS:

1. I was invited to participate in the abovementioned research project, which is being undertaken by Nocawa Lombo of the Department of Environmental Health and Social Development Professions in the Faculty of Health Sciences, Nelson Mandela Metropolitan University.

2. The research aims to gain insight into the perceptions of mental illness within the isiXhosa cultural context. The information will be used as part of the requirements for an MA Degree in Social Development and Planning. The results of the study may be presented in scientific conferences or in specific publications.

3. I understand that I will need to complete the consent form and return it to the researcher on completion. I will be interviewed and will attend interview sessions.

4. My identity will not be revealed in any discussions, descriptions or scientific publication by the researcher.

5. My participation is voluntary. My decision whether, or not, to participate will in no way affect my work.

6. No pressure was exerted on me to consent to my participation and I understand that I may withdraw at any stage without penalization.

7. I give the researcher the permission to have the interviews using recorded audiotape.
I CONSENT VOLUNTARILY TO PARTICIPATE IN THE ABOVE-MENTIONED PROJECT.

I grant this as a voluntary contribution in the interest of training and knowledge.

Signed ...................................... on ..............................................................

Signature of participant .................................................................