An investigation into cultural factors associated to mental illness and the influence they have on help seeking behaviour.

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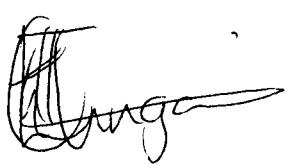
For mom and dad, your sacrifices were not in vain.

Declaration

Except for references specifically indicated in the text, and such help as has been acknowledged, this research report is wholly my own work. The research report is submitted for the degree of Master of Arts in Community-Based Counselling Psychology (MACC) at the University of the Witwatersrand Johannesburg. It has not been submitted before for any other degree or examination at any other Tertiary Institution.



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Abstract

Western theories of mental health and illness dominate current models of psychological intervention in South Africa. South Africa is a culturally diverse context and its residents make use of multiple African traditional meaning systems to organise and understand their experiences; including their beliefs about mental wellbeing and how to support and intervene.

The understanding of mental illness cannot happen only within the framework of Western paradigms. If there are to be more universal understandings of mental illness; it is imperative to take into account variations in how mental illness is not only understood, but also to understand culturally informed practices and interventions of mental illness. The intention of this study was to explore the influence of cultural beliefs and practices associated to mental illness and the influence they have on help seeking behaviour.

This exploratory qualitative study focused on eight caregivers' subjective experiences of childhood mental illnesses, which were gathered through individual, face to face semi-structured interviews. A thematic content analysis was used to analyse the data. Parents drew on both Western and African meaning systems to make sense of their children's mental health problems but there was a lack of integration of these understandings. Cultural practices and rituals emerged as potentially important to consider in understanding how parents conceptualise their children's mental health care needs. Parents seem open to alternative forms of help-seeking, including professional mental health care; however, such services are not always accessible or affordable which may result in perceptions of such services as unhelpful or irrelevant to parents.

It is evident how important it is to consider African approaches to mental health and well-being when considering the experiences of parents whose children have been diagnosed with a mental illness as this would enable health care professionals to understand children and

families through a more personalised and holistic paradigm instead of making generalised assumptions based on one social group.

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Chapter 1: Introduction

According to Matsumoto and Jaung (2004), culture plays a crucial role in the ways in which psychological disorders are expressed as well as more culturally specific syndromes. Numerous non-Western cultures do not follow nor necessarily ascribe to Western theories of psychological disturbances (Kleintjies, Flisher, Fick & Railoun, 2006). Therefore, not taking into account cultural beliefs, traditions and cultures of non-Western communities will limit the understanding of those afflicted in non-Western communities. Additionally, Larkin (2011) holds a similar notion that the view of mental health is a social construct and was influenced largely by the works of Focault, who argued that there is no single indisputable truth as society is constructed through one's ideas and conceptualisations. Summerfield (2008) argues that understandings of mental health cannot be viewed independent of one's culture. Furthermore, Busfield (2011) points out that mental health or illness as a social construct sets boundaries of what is to be considered as normal, acceptable mental functioning, which ultimately leads to regulating human beings

Girma and Tesfaye (2011) states that people suffering from mental disorders are prone to be receptors of various ranges of responses within their cultural groups. It is further argued that within the developing world, stigma and mistreatment are likely to be present. However, in contrast; some cultural communities are able to offer more community based structures (Girma & Tesfaye, 2011). Traditional belief systems that liken psychiatric disorders to moral indiscretion and misunderstand the dangerousness of patient's may result in feelings of shame and fear of persons with mental illness. Such beliefs and perceptions impact one's help-seeking behaviour, the results of treatment and ultimately decide the ways in which mental health is practiced and accessed (Girma & Tesfaye, 2011). Both natural as well as

supernatural causes are used to account for mental illnesses. This includes beliefs such as witchcraft and spirit possession (Girma & Tesfaye, 2011).

Igwe (2004) states that beliefs in witchcraft infiltrate the views, thinking and lives of many societies. According to Okello (2007), there is an evident delay in help-seeking or complete avoidance for people suffering from mental illnesses. These impact on treatment plans and care for those in most need. Contributing factors include fear, mistrust associated to the mental health system as well as low levels of confidence in health professionals, have been recognised as barriers to seeking help (Howerton, Byng, Campbell, Hess, Owens & Aitken, 2007). Most significantly to this study however; is the fact that seeking help also relates to the individual's view of how severe the mental illness is, how they interpret it and what meaning they place on it (Bebbington et al., 2000). Leaf (2001), writes that the importance that families have on providing support to those with mental illnesses cannot be minimised. Leaf (2001) adds that families with individuals suffering from mental illnesses tend to be isolated and marginalised; thus endangering relationships with friends, extended family members and neighbours. Therefore, these factors contribute to individual's desire to seek mental health services.

In addition, Leaf (2001) states that a lack of cultural understanding is a further determinant of the path of help seeking that one embarks on. This is supported by the argument that although many processes; including the physiobiological processes that take place in the brain, as a reaction to chemical exchange is universal across cultures; individual reactions to that are experienced very personally (Kleinman 1980). Despite the provision of diagnostic criteria within Western theories and practices; diagnosis is only one part of the ways in which the mental illness is experienced by an individual. The development of mental illness is dealt with in a variety of ways in different cultures. In addition to this, is the fact that there are various and alternative treatment options available. Therefore, explanations of mental illness cannot be separated from an individual's social and cultural context.

According to Gilbert, Selikow and Walker (2010), all communities understand health and illness in terms of their culture. Social constructionism argues that individuals and groups produce their own conception of reality and that knowledge itself is the product of social dynamics (Conrad & Barker, 2011). Medical professions understand mental illness as a biological condition, which is universal and unchanging; while social constructionism defines mental illness as the social meaning of that condition that is specific to different cultures (Conrad & Barker, 2011). Furthermore, Conrad and Barker (2011) argue that medical knowledge about illness is not given by nature but that it is constructed and developed by interested parties. One could argue therefore that through engaging and accepting the medical discourse of mental illness as fact; it limits new knowledge of mental health and illness coming to the fore.

Social constructionism places emphasis on the fact that human experience is influenced by history, culture as well as language. It therefore argues that what is perceived by individuals is never just solely an indication of the environment, but culture, history and language also need to be taken into account (Willig, 2001). It can consequently be deduced, within the constructionism paradigm, that there is freedom to explore the ways in which an individual's relational and social reality is impacted on through interactions with others, both socially and within organisational structures and the meanings people place on such interactions. The above mentioned therefore gives insight into how mental illnesses are handled and understood within not only the family setting but also in wider cultural groups. Adopting a social constructionist worldview offers ideas about how mental illness is negotiated in families and larger cultural groups.

1.1 Research Questions

1. How do parents make meaning of the causes of their children's mental health problems?

2. How do culturally-defined perceptions, attributions and norms influence parents' help-seeking behaviour?

3. What barriers are present when seeking mental health care?

1.2 Research Aims

This research sought to investigate the perceived cultural and familial influences on seeking help for mental illnesses in children; particularly looking into the degree to which each participants' familial and cultural experiences and attitudes towards mental illnesses impact on their choices and practises of treatment. In addition, there was a focus on the stigma associated to mental illness as a factor in on one's willingness to seek professional help as stigma has become characteristic of the unwillingness to seek professional mental health services, regardless of how detrimental the consequences of not seeking mental health services are (Vogel, Wade & Hackler, 2007).

1.3 Rationale

South Africa is ridden with many social ills marked by poverty, its social and political history and disease. Historically, policies have focused on communicable diseases that plague the African continent, such as HIV/AIDS (Whiteford et al., 2010). Due to these reasons, mental health has not been prioritised and is seen as a silent epidemic (Ornelas, Duarte, Jorge-Moneiro, 2014). This study is therefore interested in gaining insight into the cultural understandings of mental health that may be relevant to informing interventions to be more accessible and relevant within the South African context.

Additionally, this study argues that mental health is socially constructed, and that there are societal, individual, cultural and group variations when it comes to how diversely conceptualised both nature and causes of mental illness. Without clear knowledge of how mental illness is understood from a cultural perspective, mental health services may continue to be underutilised by a large percentage of the South African population as Lund et al (2011)

reported that 75% of people who live with a mental illness in South Africa do not seek nor get the care they need. Monteiro (2015) argues that mental illness has been characterised as a neglected and increasingly burdensome problem affecting all populations of Africa. Through more culturally relevant and explored understandings of what constitutes healthy and unhealthy states, more appropriate interventions and treatment pathways can be carried out, outside of the more Western discourses. It is important to consider African approaches to mental health and well-being when considering the experiences of parents whose children have been diagnosed with a mental illness as this would enable health care professionals to understand children and families through a more personalised and holistic paradigm instead of making generalised assumptions based on a limited sample.

The diagnosis of child mental disorders cannot be understood solely from a Western perspective (Thomas & Bracken, 2004). Deeply embedded cultural beliefs and values that differ from culture to culture; mental illnesses may be understood differently. Moreover; behaviour in children may also be influenced by cultural norms and standards, leading to the expression of behaviours in more culturally sanctioned norms (Thomas & Bracken, 2004). Although generally the same disorders exist throughout the world; the ways in which they are understood and interpreted cannot be summarised into one occurrence. This inconsistency in how mental health disorders are understood culturally is what underlines the rationale of this research project.

Due to the dependence that children have on their parents, the responsibility to recognise problems and solutions depend on the parents or caregivers. Therefore, it is up to parents to distinguish and be aware of mental health illnesses that are present in their children and to determine whether they require service and seek help on their behalf. Parental perception of problems plays a key role in determining mental health service use (Sayal & Taylor, 2004). Although mental health is contextualised differently in different low and middle income countries; the same challenges exist. These include the low priority status of mental health

and the lack of resources for mental health care (World Health Organisation, 2005). (Tomlison & Lund, 2012) argue that HIV/AIDS is seen as a higher priority, receiving a lot of public and government attention in comparison to mental health. Therefore, it appears that in different systems, mental health may be given less importance, both at a governmental level and perhaps at a parental level too.

Chapter 2: Literature Review

According to Sorsdahl, Stein, Grimsrud and Seedat (2009) mental illnesses, together with psychosocial disabilities, pose a magnitude of strain on national resources. In developing countries such as South Africa, the drain of mental disorders is even more significant on the already delicate economy and state of the nation. The World Health Organisation (2010) reports that a large population of the world's 650 million people who suffer from psychiatric morbidity may be found in developing countries and that of those with psychiatric morbidity; a mere 10% have access to mental health care. Although there has been a rise in the acknowledgment of mental health being viewed as a public health issue in South Africa, there is still a shortage of provision of mental health services to a vast majority of South Africans (Bradshaw, Norman & Schneider, 2007). Within the South African context, neuropsychiatric conditions are rated third in their impact to the burden of disease (Bradshaw et al. 2007). Common mental illnesses such as anxiety, depression and substance abuse are commonly reported by 16.5% of South Africans annually (Williams, Herman & Swern, 2008). Additionally, it is reported that the same percentage of children and adolescents suffer from mental illness (Draper et al. 2009).

Foucault (1974) suggests that meanings of mental illness change and are largely impacted by both beliefs and values that society holds; as well as current political climate. Definitions of mental illnesses have firm roots in Western ideologies and the biomedical paradigm. In one definition, mental illnesses are described as disorders of the brain that disrupt a person's thinking, feeling and moods and ability to relate to others (Fee, 2000). There are integral challenges, however, with the formulation of human emotions, relationships, and personalities as merely biological processes (Pettus, 2006). Scholars within the anthropological field have written extensively and provided knowledge to the understanding of relevance of cultural belief systems within mental illness. In his work, Kleinman (1981,

1985, 1991) took into great account the role of cultural belief systems and alternative systems when it comes to diagnosing, treating and symptomizing mental illness. Such explorations allow for a more holistic and diverse view of mental illnesses (Kleinman 1988).

Within the South African context, there is growing recognition and interest surrounding issues of mental health. Statistics show that globally; up to 20% of children and adolescents suffer from an immobilising mental illness, thus the mental health of children represents a key area of concern (WHO, 2001). According to a study led by the World Health Organisation (WHO); findings suggest that regardless of the fact that South African policy and legislation support community-based mental health service provision within a Human Rights Framework; there is a wide disparity between availability and services dedicated to the mental health of children (WHO, 2005).

2.1 Defining mental health

According to Sadock and Sadock (2003) mental illness is conceptualised as an expression of behavioural, psychological or biological dysfunction in the individual. Additionally, mental illness is further defined as a behaviour or psychological syndrome that is clinically significant and which is related to distress (Sadock & Sadock, 2003). Furthermore, Millon, Grossman and Meagher (2004) argue that the phrase "mental illness" has medical model implications. A further argument exists that historically, mental illness implies severity of disorders including schizophrenia or mania and does not take into account less severe illnesses such as adjustment disorders, anxiety disorders, mild depression and post-traumatic stress disorder (Millon, Grossman & Meagher, 2004). However, Jorm (2000) states that to those within the field of mental health, it is easier to distinguish a range of mental illnesses, but for the lay person; mental illnesses are not easily distinguishable and both severe and less severe disorders are categorised as one.

2.2 Mental Health and children

Mental health issues are not generally seen as priorities in underdeveloped countries. While there is general acceptance of Africa's critical need for physical medicine services; the need for mental health intervention is largely ignored, or treated with skeptism. Research conducted by the World Health Organisation (2003) recognised the extent of neglect of mental health issues. A survey of various rural communities showed that there were between 5 to 10 cases per 1000 population suffering from a mental illness (WHO, 2003).

Only a small and underrepresented sample of psychiatric disorders in South African children are available, which are usually accompanied by diagnostic tools that are yet to be validated within the local South African context (Flisher, Dawes, Kafaar & Lund, 2012). Nonetheless, Kleintjies et al. (2006) provided prevalence estimates for children and adolescents in Western Cape, South Africa. Within the study, it was reported that due to high rates of exposure to violence in various settings, such as schools, the larger community as well as in homes, there was a high correlation to psychological disorders. Additionally, physical and sexual abuse, poverty and the HIV/AIDS pandemic leaves many children vulnerable and at risk of developing mental illnesses (Cluver, Gardner & Operario, 2007).

2.3 Culture

According to Williams (2006), the definition of culture encompasses values that are shared, learned and transmitted through generations as well as the account of norms and practices that guide thinking, actions and decisions. Definitions of culture have always centred on the uniqueness of cultures, the etiology of culture, and the impact of culture on attitudes and behaviour. This definition has been used in the health care field as a tool for understanding cultures and developing culturally competent services. This broad concept of culture with its dynamism and intersectionalities draws attention to the need to study culture as a constantly changing and evolving entity, subject to multiple influences, beginning from childhood,

influenced by group history and socialisation, and continuing through the lifespan of an individual, modified and challenged by life experiences (Williams, 2006). Such fluidity is especially relevant to understanding one's subjective experience of mental illness and how it impacts help seeking behaviours.

Saint Arnault (2002) argues that culture is a set of interrelating social processes that include four unified dimensions (Saint Arnault, 2002). Cultural ideology is the beliefs and values held by a people about what is good, right and normal. This includes understanding about what values are perceived to be important and what are acceptable and appropriate behaviours. The practice aspect of culture includes both power and ideals, and these two forces are acted out in even the smallest gestures, speech patterns, manners of dress, social distances, food choices, and health behaviours. In addition, Foucault (1982) argues for the notion that salient physical or emotional sensations, or relevant aspects of the social environment, are encouraged in individuals in early infancy through the processes of enculturation. The cultural model "tells" the person to attend to certain aspects of his or her experience, what to ignore, what things mean and what should be done about them. Understanding how a given cultural model might direct attention is a starting point for making predictions about how the sensations within the body, emotions and social situations will be perceived, and therefore how health is maintained, or distress is experienced. In short, the attention people give to any given physical or emotional sensation is "filtered through" cultural models (Williams, 2006).

Cultural beliefs and norms can be the perceived barriers to seeking professional services. Dialia, *et al.* (2001) states that seeking professional help may be viewed as inconsistent with certain cultural values as there may be a conflict between the values of some cultures and the values that are inherent in counselling (Root, 1985). Mojaverian, Hashimoto and Kim (2013) argue that due to systemic differences, people access help differently; within their own

cultural norms and values. It is therefore vital to understand underlying reasons for help seeking, in order to both maximize and make effective, professional mental health services (Mojaverian *et al.*, 2013). Cauce and Srebnik (2003) emphasises the fact that differences in relational patterns across various cultures has on implications for seeking help from professionals.

In some cultures; such as African and Asian cultures; there is an emphasis on interdependence and social harmony, with a fundamental interconnectedness within the larger social group and community (Mojaverian, *et al.*, 2013). Within more Western cultures however; there is an emphasis on independence, with individuals viewed as autonomous and separate from others (Mojaverian, *et al.*, 2013). Kim *et al,*. (2007) states that help-seeking behaviour may be impacted by cultural values in one of two ways, with the first being enculturation which is the process of holding onto cultural norms, values and beliefs. The other is defined as acculturation, which is the ability to adapt norms of a different culture while minimising the process of retention of one's personal culture. Research conducted by Mojaverian *et al.* (2012) found that families within the Asian cultural groups preferred to handle mental illnesses themselves instead of eliciting professional mental health services.

In addition, talking about specific types of problems may be seen as taboo in some cultures (Vogel *et al.*, 2007). This speaks to the fact that there may be reluctance in some cultures to seek help outside of the home as it may be perceived as shame that the individual is bringing upon the family. This may result in an individual feeling inhibited and failing to seek help from a professional source.

Within the South African context, culture has been used as the justification for the domination and the exploitation which occurred under the apartheid regime (Swartz & Foster, 1984). Webster (1997) argued that the ideology that segregated cultures require separate development obscures the relations of domination, which are crucial to the entrenchment of the privileges of the minority group. Academic researchers who use the concept of culture as

a basic tool for analysis tend to lend ideological support to apartheid (Swartz & Foster, 1982). Omer-Cooper (1972) argues that individual cultures cannot be analysed as if they are separate from the society as a whole.

Swartz and Foster (1984) presented analyses of the way in which the relationship between culture and mental illness was depicted in South African psychiatric literature, and concluded that the term culture was often used in a historic, uncritical and mystifying way. Furthermore, Swartz and Foster (1984) argue that "Culture is a word with a particular currency...it forms the basis for the justification of various apartheid policies, and regardless of the ideological orientation of the researcher, he or she can scarcely be unaware of the power attributed to the term" (Swartz & Foster, 1984, p. 18). Moreover; Swartz and Foster (1984) argue that approaches to South African research share a common romanticised view of black culture that leads to two false assumptions. The first being that 'Westerners' and 'Traditional Blacks' live in two separate and separable worlds The second assumption is that there is a natural passing between the two worlds that "inevitably leads to the loss of holism, security and an integrated universe (Swartz and Foster, 1984, p. 23).

For Swartz and Foster (1984), attempts to contextualise psychopathology by understanding culture, fail in that they presume black culture to be absolute and immutable. The view that 'westernisation' is the only source of change amounts to a failure that cultures are not static through history. Furthermore is the argument that a lack of recognition of the historical and contextual basis for definitions of mental illness results in 'the conjunction of the reified entity with another- the absolute of traditional culture (Swartz and Foster, 1984, p. 23). In addition, Swartz and Foster (1984) argue that researchers who see 'black society' in a dichotomous fashion also demonstrate a failure to recognise other obvious South African polarity and fail to therefore analyse the relationship between psychiatry and oppression. Oppression within more traditional help seeking modes dates back to apartheid as traditional health systems as for many years the African traditional health systems were seen as a threat

to more medical health systems (Nemutandani, Hendricks & Mulaudzi, 2016). Although the Witchcraft Supression Act of 1957 was abolished, and there was an implementation of The Traditional Health Practitioners Act (No 22 of 2007), there was and still are tensions between the acceptance and recognition of more traditional modes of mental health services (Nemutandani *et al.*, 2016).

Due to the fact that culture includes beliefs, rituals and norms of behaviour, it is important to understand how culture has an impact on mental illness. One of the first key anthropological figures who displayed interest in the underlying values and ideas that existed within cultures and the relationship between these cultural values and ideas argued that culture is the way in which social associations of a group are arranged and shaped; as well as, the way in which those shapes are experienced, understood and interpreted (O'Hagan, 2001).

2.4 Help-seeking

When there is perceived stress and psychological distress; ways in which the problems are dealt with as well as the coping is understood as help seeking (Mojaverian *et al.*, 2013). The importance of seeking psychological help is highlighted by Wilson and Deane (2010) who argue that if an individual seeks psychological help, it has the likelihood of decreasing the long term negative effects of the presenting mental health problems. Furthermore, help-seeking is a term that is generally used to refer to the behaviour of actively seeking help from other people, institutions or non-professional sources such as traditional healers; which are pathways to care in many cultures. It is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience (Villatoro, Morales & Mays, 2014). Moreover, help

seeking is a form of coping that relies on interaction with other people, and is therefore often based on social relationships and interpersonal skills.

Theorists (Sears, 2005) argue that help seeking involves a process, the conception being the necessity of services are felt and ends when the help has been received and the need has been met. Barriers to help-seeking as well as facilitators to help seeking have been identified (Hui, Wong, & Fu, 2014; Vogel, Wester, Wei, & Boysen, 2005) which are argued to play crucial parts in the help seeking process. Factors preventing someone from seeking psychological help include but are not limited to; the fear of stigmatisation, lack of knowledge, financial restraints, the inability to trust professionals as well as the belief that there will be a lack of cultural knowledge and differences (Topkaya, 2015). Factors Influencing Psychological Help Seeking in Adults: A Qualitative Study. *Educational Sciences: Theory and Practice*, *15*(1), 21-31.). Other research has sought to further refine the source of barriers that may affect whether or not people seek psychological help. Mohr *et al.* (2006) developed their own scale of barriers based upon previous research to assess participants' perceptions of what makes it hard to seek professional psychological services. The authors refer to some of the barriers as practical and others as emotional. Some of the identified practical barriers were time, cost, transportation, child or other care. Emotional barriers were identified as stigma and the discomfort in talking.

Practical barriers to seeking professional psychological help are those situations or circumstances in the environment that may decrease an individual's likelihood of seeking help. These include, but are not limited to, lack of money or insurance coverage that enable the individual to afford such services; access to counselling services presented by regional location (e.g. rural versus urban), or transportation difficulties; the availability of counselling services; or an individual's ability to make time for counselling in an otherwise busy schedule (Dearing, Maddux, & Tangney, 2005; Givens & Tjia, 2002). However; should the

barriers be overcome and the process of help seeking be successful; results include greater competency and well-being. When investigating culture in relation to mental illnesses; stigmatising attitudes towards people with mental health problems are widespread and commonly held. Mills (1993), stated that the understanding of mental illness has resulted in the alleviation of suffering for many people, but according to her, this has also resulted in a greater stigmatisation of mental illness, and has placed responsibility for the 'cure' of mental illness in the hands of professional psychiatrists and psychologists (Mills, 1993).

The Social Organization Strategy (SOS) framework has been used to conceptualise the ways in which people seek help. Through this framework, social context is considered which is argued to have an impact on an individual's decision making (Cauce & Srebnik, 2003). The social context includes interactions that occur within one's social network, such as with family members and friends. Such interactions are thought to convey attitudes, beliefs and social norms that influence the ability to recognise and understand mental health difficulties as well as their ability to not only seek help but also to comply with professional services (Bussing, Koro-Ljungberg, Gray, Mason & Garvan, 2005). Moreover; this framework takes into account that the individual does not exist in isolation but rather that social constructed patterns influence individual's decision making. Research by Bussing *et al.* (2005) and Cauce *et al.* (2002) in relation to SOS investigated the significance family has in shaping one's help seeking practices. They argued that the provision of support by one's social network shapes the way in which an individual accesses professional help. In this way, the family unit may either assist through the provision of care or may cause the opposite effect; such as perpetuating stigma by demoralising the access of formal resources. Murray (2005) argues that many help-seeking models are adult-oriented; therefore limiting relevance to children and adolescents help-seeking. This therefore speaks to the importance that the role of family members, the school system and the community attribute to the proper care of children (Cauce *et al.*, 2002). Although Murray (2005) argues that help-seeking models are mainly

adult-oriented; they take into account factors such as geographic region, education and finances, which are all characteristic of familial units.

According to Andersen (1995) and Sears (2004); help seeking involves stages with the first stage being: recognising that the problem exists and then deciding to seek help either from a professional or a nonprofessional. Each stage is however impacted on by various factors; including the social and economic status of the family, predisposing factors such as gender, accessibility and access to services and the need for help. The most prominent of these being the need for help. Andersen's (1995) model also considers a concept called 'mutability' which is used to ascertain variables which are most responsive to change which could be used as points of entry for interventions. Although some factors (such as gender, race, age and ethnicity) were reported to have little mutability and are deemed fixed and unchangeable; beliefs and attitudes held towards help seeking and professional resources are predisposing factors that can be changed and lead to behavioural change and healthier patterns of help-seeking behaviours (Andersen, 1995). Additionally, more tangible and concrete factors, such as provision of transport, access to information and social support can be changed in order to increase the likelihood of accessing needed services. As mentioned before, need is argued to be the most important factor in help-seeking variables and is also perceived to be unchangeable. However, with further conceptualisation; Andersen (1995) argued that if people's barriers to help seeking are alleviated; this may alter their perceived need for professional help. In this way, people may be more willing to access help should they be educated about the benefits of accessing care.

Various other models were adapted with the use of Andersen's Model, including the Youth Help Seeking and Service Utilization Model (Srebnik, Cauce & Baydar, 1996). With the use of Andersen's stages to help seeking; there was more of a focus on the family context within which child and adolescent help-seeking occurs. Srebnik *et al.* (1996) suggests that the child's symptoms, impairment and diagnosis; demographics and barriers to care such as

economic factors predict parent's need to resolve children's emotional and behavioural problems. Specifically, Srebnik *et al.* (1996) suggest that problem recognition (i.e., stage one) is directly influenced by need (i.e., clinically assessed level of need and subjectively assessed level of need) and predisposing factors, such as family size, structure, and organization.

When directly considering a parents role in help-seeking for children, Logan and King (2001) presented a six-step model of parent-mediated help seeking for adolescents. Within this model are stages that account for contemplating seeking help, actively seeking help and finally; seeking help (Logan & King, 2001). The model embodies the following six steps: (1) gaining awareness of a child's distress, (2) recognizing the problem as psychological in nature, (3) considering possible courses of action, (4) developing the intention to seek mental health services, (5) making an active attempt to seek services, (6) obtaining mental services for, or with, the adolescent.

Within these steps, there is an acknowledgement of factors that may either enable or hinder help-seeking at any stage. For example, parent-child relationships may affect the process of help-seeking (Logan & King, 2001). Unrau and Grinnell (2005) analysed data from the 1985 and 1986 wave of the Adolescent Health Care Evaluation Study according to predisposing, enabling, and need factors. The study was conducted in North America with adolescents ages thirteen and nineteen years old. Results indicated that female adolescents are more likely to seek help than males. Additionally, it was found that minority adolescents from families with lower socio-economic status were found to be least likely to seek help compared to minority youth from families with higher socio-economic status or White adolescents. It was further found that families from Black and low socio economic statuses were more prone to utilising informal help and relinquish professional help.

With an aim to examine parents' stages of help seeking for children between the ages of six and eighteen years; Douma (2006) asked parents about their responses to ascertain whether or not they had experienced any concerns regarding their children's emotional or behavioural functioning. It was found that the parents who were more prone to indicate a need for mental professional help were those who had identified their children's difficulties as psychological distress or psychopathology (Douma, 2006). Douma (2006) considered this the first stage of help-seeking. The second stage of help-seeking; is identified by Douma (2006) as the consideration to access professional help. This was assessed by assessing whether or not parents felt a need for a specific type of help to address their children's emotional and or behavioural difficulties. Those who were able to identify a particular source of help were seen to have taken the second step of help-seeking. Finally, the assessment of the third stage of help seeking was carried out by the accessing of the reported specific professional help identified. Successful attainment of the third stage was given to those parents who had actually sought the help needed.

In a qualitative study conducted by Saval, Coope, Ashworth, Day, Tylee and Simonoff (2010) whereby eight focus groups were run with parents of children between the ages of two and seventeen; it was found that parents' attitudes towards help-seeking were impacted by their understanding of mental health problems, the capability to cope with their children's problems, the ways in which they perceive mental health problems as well as the availability of professional services (Sayal *et al.*, 2010).

Additionally, some barriers reported towards help-seeking included the inconvenience of help-seeking; such as limited appointment times, as well as feelings of shame and blame. Furthermore, there was anxiety reported with reference to their children being labelled as well as the fear of children being removed from the care of the family. Del Mauro and Williams (2013) identified stigma and a lack of knowledge of mental health as primary factors to barriers of help-seeking. Corrigan (2005) argues that stigma is the most cited

barrier to help-seeking especially when it comes to seeking professional help for mental health difficulties. Stigma refers to the alienation, discrimination and loss of status that people experience due to negative perceptions of mental illness (Bryne, 2000). Corrigan and Watson (2002) present literature highlighting the social processes that are present when the public perpetuates stereotypes about individuals who suffer from mental health problems. It has been argued that people may distance themselves from individuals or even limit the rights of people with mental health problems (Corrigan & Watson, 2002). Additionally, Crisp, Gelder, Rix, Meltzer & Rowland (2000) added that people with mental health difficulties are perceived as dangerous, unintelligent and incapable of recovery. Furthermore, Corrigan (2005) argued that due to stigma; mental health problems are habitually misunderstood and are perceived to be a sign of weakness, a character flaw or failure to live a healthy lifestyle. All these may attribute negatively to patterns of help-seeking.

An additional factor of help-seeking is the fact that mental health problems may also be conceptualised as biological instead of social or psychological etiology (Deacon & Baird, 2009). Weiner (1995) found that family members tend to withhold help when it is believed that individuals suffering from mental illness are deemed to be responsible for their mental health problems. Generally therefore, it can be argued that public stigma creates barriers that hinder help-seeking, social integration as well as the possible recovery of individuals with mental illnesses (Corrigan & Wassel, 2008). Largely, it has been stated that the fear of being treated differently by others is a significant barrier to seeking professional help for mental health problems (Rickwood, Dean, Wilson & Ciarrochi., 2005) and that parents and professionals may often underestimate the role that humiliation has on help-seeking and the likelihood that individuals will seek help (Bohns & Flynn, 2010). To counter such arguments, Schomerus and Angermeyer (2008) carried out some intervention studies to illicit that reducing stigma through the use of public education, as an example could lead to an amplified willingness to seek professional help. Hinshaw and Stier (2008) argued that a

further factor of help seeking behaviour was that of stigma. It was found that when stigma is perceived, there were also greater barriers to help-seeking; making it difficult to acknowledge mental illness due to the shame that is associated with it. Additionally, if an individual experiences stigma, it also limits their willingness to increase knowledge on mental illness as it may feel too shameful to ask questions and acquire more information. This calls for increased anti-stigma campaigns in order to facilitate increased accessibility to mental health services.

Briggs-Gowan, Carter, Moye et al. (2001) argue that in spite of high prevalence rates in school-aged children, there is very little access of mental health services. In the consideration of early interventions for young children; parents play a critical role in seeking professional help for behavioural, emotional or mental difficulties for children (Sayal, 2006). The literature review in this study shows that their differences in attitudes and routes of help seeking that inform parental decisions in terms of their children's mental well-being. Ford, Goodman and Meltzer (2003) found that if attitudes towards help-seeking were negative, this would impede parents from accessing professional services for their children.

Pavuluri, Luk and McGee (1996) investigated parents' help-seeking process. Their study involved 320 preschool children that came from eight different preschool centres. The participants were studied using semi-structured interviews with both parents and children. In addition to the interviews, parents also completed various questionnaires including a service utilization questionnaire and a General Health Questionnaire. The results revealed that only 19% of parents of children with behavioural disorders crossed all the filters in the questionnaire about reaching for help. Through their study; Pavuluir *et al*,. (1996) suggested that were three stages that were present in parents seeking help for their children who presented with mental health difficulties. The first step involved the recognition that a problem existed. Parents then considered whether or not they needed help for the problem

and finally; if parents felt the need to seek help, the final step would involve overcoming any attitudinal or physical barriers to help-seeking.

Further findings indicated that the most common perceived barrier to help-seeking was the idea that the presenting problems would ease or get better by themselves and that parents should be strong enough to handle them on their own. In addition to the aforementioned were two barriers to help-seeking that persisted on two levels. The first was that difficulty or inability to recognise the presence of a problem in their children; and the second was overcoming barriers that may be present. Pavuluir et al (1996) found that parents were more prone to seek help from more informal agencies than from formal, professional places.

Oh and Bayer (2015) conducted a study where they investigated the process involved in seeking help for children with mental illnesses. Oh and Bayer (2015) followed up to 442 six year old children who were recruited through maternal and child health well-being appointments in Victoria, Australia. The participants came from socioeconomic diverse areas. There was a measurement of child mental health problems of the six year old children which was done using the Child Behaviour Checklist. Through this measure, 84 six year old children were found to have mental health problems. The results revealed that only one third of parents reported to have sought professional help for their child's mental health difficulties. Additionally, parents of only 14 children with mental health difficulties sought help from health professionals which includes psychiatrists, psychologists and telephone counselling helplines (Oh & Bayer, 2015).

Oh and Bayer (2015) further investigated the percentage of parents who rated themselves as highly likely to seek professional help if their child presented with mental health problems. A high number of parents reported highly positive intentions to seek related treatment if they thought their child had a mental health problem. In contrast, only 15% of parents reported that they were unlikely to or were ambivalent about seeking help for their child. When

exploring parental recognition of their child's behaviour being seen as more problematic than average; it was found that only one third of parents recognised their child's behavioural difficulties. A link was made between parents who reported as highly likely to accurately recognise their child's behaviour and those who showed highly positive intentions to seek help. A third of parents recognised their children's problematic behaviour opposed to 15% of parents who were unlikely or ambivalent about their help-seeking intentions (Oh & Bayer, 2015). Finally, Oh and Bayer (2015) found that less than one third of parents accessed professional services for their children. It was also reported that when there is an ability to recognise their child's behaviour as challenging, over half accessed professional help; compared to only 16% who did not perceive the behaviour of their children to be problematic.

The above study (Oh & Bayer, 2015) as well as that of Pavuluri et al (1996) speaks to the importance of parent recognition of the children problematic behaviour. This is due to the fact that it is a significant factor during the help-seeking process. Alexander, Brijnath and Mazza (2013) argue that there is a prevalent lack of awareness about childhood mental health problems and the usefulness of early interventions. Oh and Bayer (2015) suggest that there need to be interventions that address parents' mental health awareness. A likely solution is to target families who make use of early child healthcare services. Oh and Bayer further provide information that due to the home visits that families with new-borns are offered, it may be a beneficial space in which nurses could provide parents with mental health information, especially in relation to childhood which may increase the reporting of mental health difficulties to mental health professionals (Oh & Bayer, 2015). Furthermore, Oh and Bayer (2015) propose a screening for emotional and/or behavioural problems within primary health care services in order to heighten mental health difficulties in children.

On the exploration of physical barriers to accessing help; it was reported that such barriers included not knowing where to access professional help as well as financial barriers that were

widely reported (Oh and Bayer, 2015). In order to tack this; Oh and Bayer (2015) suggest that maternal child health nurses or GP's could familiarise themselves with services in order to better facilitate an already fragmented referral system to mental health professionals; thus decreasing some perceived barriers to access. Furthermore, forming stronger links between education providers and mental health services may increase the number of children being recognised and treated for their mental health problems. Children and adolescents in schools have regular contact with school staff; and if they are more likely than parents to recognise mental health difficulties; they could encourage parents to seek help for their children.

Oh and Bayer (2015) acknowledged the complexity of childhood help-seeking routes and argue that solely taking into account parents' help-seeking beliefs may not be as effective as addressing mental health awareness of childhood mental illnesses. If the ability to recognise mental health difficulties in children is present; then not only will parents have an intention to seek help; but also to actually get the help their children need. Pathways for children are more complex as they rely on adults such as parents and teachers to identify their problems and initiate service use.

2.4.1 Parental perceptions of mental illnesses

A lack of knowledge of mental health has been steadily identified as a major barrier to seeking help for mental health difficulties (Corrigan et al,. 2002) as inadequate knowledge was identified as a reason for not seeking professional help. A lack of knowledge therefore may obstruct, if not completely terminate any help-seeking attempts. First of all, there needs to be recognition of a difficulty, which is ascertained by an awareness of symptoms of distress. Without this insight, the help-seeking process is unlikely to be carried out at all (Wilson & Deane, 2010).

2.4.2 The Role of Social Norms in Help Seeking

Through investigating differences in gender attitudes towards help-seeking behaviour; Vogel *et al.* (2007) found that gender was indeed a predisposing factor to help seeking. In a study conducted by Cometto (2014); it was found that negative attitudes towards seeking help were held more by fathers than mothers. Additionally, Rickwood *et al.* (2005) conducted a study which explained that males are less likely to seek professional help seeking services as they lack inadequate skills to enable the process. These skills include the inability to identify and describe emotions as well as understand and regulate emotions. For males, this could result in the process of help seeking being a frustrating one. This could also be understood in light of more 'traditional' male roles in which accepting help can be connected to feelings of weakness and dependency (Vogel *et al.*, 2007).

Research suggests that a potential avoidance factor to help seeking is social norms; which can be described as the implicit standard of those close to an individual (Rickwood, 1994). Attitudes transmitted by family members and by their friends have been suggested to play an influential role in how an individual defines and acts upon distressing symptoms (Schomerus, Matschinger & Angermeyer, 2001). Additionally, Schomerus, Matschinger and Angermeyer argued that having a social network that accepts and encourages help seeking for a problem is necessary for the person to seek help. Therefore, if significant people in a person's life see counselling as a negative event, then the individual may be less likely to seek help for fear of exposure and loss of social standing.

Additionally, studies suggest that the attitudes of family and friends cannot be underestimated because people generally talk to members of their social network before seeking professional help and that 92% of individuals who sought medical care, reported talking to at least one person about their problem before seeking help (Cameron & Leventhal, 1993). Cameron *et al.* (1993) also found that many of the individuals who finally sought medical treatment

consulted another person to find out what to do and 50% of those who sought treatment were told to see a counsellor by their significant others.

Furthermore; studies show that people who knew others who had sought therapy had positive orientations toward therapy and were more willing to seek counselling themselves (Tijuis, Peters & Foets, 1990). Vogel *et al.* (2005) found that people reported greater intent to seek professional help when they believed that important people in their lives would approve such an action. Leaf, Livington and Tischler (1986) found that the anticipation of upsetting a family member was a significant predictor of not seeking psychotherapy. King *et al.* (1973) found that 67% of the study participants would be embarrassed if their family or friends found out that they had sought help from a mental health professional. Lastly, Diala *et al.* (2000) found that the violation of social norms was a perceived barrier to seeking help for an emotional problem. Given the above studies, it is clear that social norms play some role in the help-seeking process. Thus, more research is needed to determine the degree to which these norms affect an individual's decision to seek help and the relationship of these norms to other approach and avoidance factors.

2.4.3 Stigma in Relation to Help Seeking

Stigma is defined as 'a feeling of being negatively differentiated owing to a particular condition, group members or state of life' (Arboleda-Florez & Stuart, 2012). Stigma may be viewed as social oppression as a result of the complex social-political process that occurs between people who exploit and stigmatize others (Arboleda-Florez & Stuart, 2010). Additionally, stigma is stated to operate on numerous levels; including within individuals, families, education systems, communities, health care sectors, media and within social policies (Hinshaw and Stier, 2008). Research points to stigma and a culture of silence around mental health problems, which impacts help seeking (Sanchez & Gaw, 2007). Most studies consider stigma as a static entity, thereby perhaps overlooking changes in cultural perceptions over time and the impact of such changes on stigma and help-seeking. Corringan *et al.*, 2000

argue that when it comes to mental illnesses, stigma is more evident as regardless of diagnosis; those labelled as mentally ill are often stigmatised more than those with other health conditions. Within a South African context, although there are policies surrounding mental health; Gordan (2013) argues that culturally; mental illness is still taboo, carrying stigma with it. Such experiences would, according to Goffman (1963), motivate the efforts by the stigmatised individual, to conceal the stigmatising mark. In a study investigating knowledge and attitudes of the general South African public towards mental illness, Hugo *et al.* (2003) found that when knowledge was low, stigma was high. Such stigma appeared to be associated with the fact that mental illnesses were understood as a lack of willpower and stress-related, rather than medical illnesses (Hugo *et al.*, 2003).

When considering stigma in relation to children; Mukolo, Heflinger and Wallston (2010) argue that little is documented about stigma related to child mental illnesses and how stigmatization impacts on them. Additionally, Mukolo *et al.* (2010) argue that public stigma towards child mental illnesses as well as that related to adults is equally as unforgiving. Pescosolido *et al.* (2007) found that when people harbour negative responses towards children with mental illnesses; they held a preference for maintaining social distance from the child and family, the distancing of the child from other children, blame being expressed towards the parents for the child's illness as well as a preference for restricting treatment services for the child. Furthermore, individuals were reported to be more empathic towards parents and children who had more physical illnesses; such as asthma. Some of the stigma related to parents and carers of children with mental health problems can give rise to the belief that the illness has been perpetuated by poor parenting skills and dysfunctional families (Mohr *et al.*, 2000).

Additionally; Walker, Coleman, Lee, Squire, Friesen (2008) suggest that the conceptual frameworks that apply to and were developed specifically for adult mental health stigma are exchangeable to and explanatory to the stigma of children's emotional and behavioural

mental illnesses. Damaging effects of stigma for adults who seek mental health services; such as social withdrawal and secrecy, socio-economic exclusion as well as the reluctance to seek help apply to children as they do to adults. A study conducted by Woolfson, Menary, Paul and Mooney (2008) that aimed to understand how young people experience stigma found that, due to their experience of stigma, young people were reluctant to disclose any information about their mental health problems because if they did; they were excluded from their peers. In addition to exclusion, there were reports of both physical and verbal abuse (Woolfson *et al.*, 2008). Additionally, the participants reported stigmatisation not only by their peers, but also from teachers, general practitioners as well as mental health professional. Gale (2006) argues that just by virtue of being associated to people with mental illnesses; individuals can experience stigma, which can in turn elicit feelings of shame. When a child is diagnosed with a mental illness; the closest and most influential people in his or her life are his family and this group of individuals are the most influential on the life of the patient (Cutting, Aakre & Docherty, 2006) Gale (2006) argues that when a child displays emotional as well as behavioural difficulties; the self-blame parents put on themselves may ultimately prevent parents from seeking help on behalf of their children as they may be judged and labelled as a 'bad parent'. Because young children are mostly reliant on their parents to seek help on their behalf; if their parents fear being stigmatised; then they are less likely to seek help at an early stage. A study conducted in the United Kingdom (Rose, Thornicroft, Pinfold, & Kassam, 2008) that involved 400 fourteen year olds found that 250 different labels were commonly used to describe mental health and that the vast majority of the negative terms were derogatory; with only 4% of the study sample using labels that were compassionate. The aforementioned study highlights the fact that there is a lack of knowledge and understanding about mental health difficulties which further stigmatises children with mental illnesses. Additionally, in a survey by the YoungMinds (2009); that included children and young adults between the ages of 9 and 25 years old; 52% of the participants reported that

they had heard classmates call their peers who displayed emotional difficulties with derogatory names.

According to Voel *et al.* (2005), if people fear that others will judge them negatively for seeking professional help, then they are less likely to seek that help. There appears to be negative perceptions that society holds towards mental illness and those seeking professional help. A study by Bailey (1999) found that there are four root causes of unfavourable views of mental health problems: the first is that individuals with mental health difficulties are viewed as dangerous. Secondly is that people are seen as having sole responsibility for their mental health problems. The third is the perception that mental illnesses are chronic and therefore have a prognosis; which leads to increased stigmatisation. Lastly is the disruption that the mental illness may have on normal social interactions and the change is social roles; which people often try to protect.

Corrigan (2005) suggests that there is a need for counsellors to be vocal in sending messages to the media and other sources to stop portraying mental illness in an inappropriate way. Furthermore, education should be given about mental illness and treatment to reduce the negative stereotypes in order for people to make informed decisions; with Pinfold *et al.* (2003) suggesting brief education programmes to change people's attitudes. A study by Reed and Law (1999) suggests that meeting someone who has sought counselling before is a way to change one's perception of social stigma. Studies have shown that individuals who had more contact with people who experienced a mental illness tended to have positive attitudes regarding mental illness. Although the goal for society is to have more positive attitudes about help seeking, social attitudes tend to change slowly and currently; people are negatively affected by stigma. In one study; 75% of family members believed that stigma negatively affected the self-esteem of their child when treatment had been sought for a mental illness (Wahl & Harman, 1989). As argued by Sirey *et al.* (2001); there is a need to

address the effects of being or becoming part of a stigmatized group; therefore; an approach may be to provide direct information to individuals who may be experiencing a mental health problem. This could help people identify stigma and develop coping strategies.

2.4.5 The Role of Parenting

Culture, shapes the expectations and hopes parents have for their children and how they understand messages about being parents (Hill, 2006). When trying to understand how parenting beliefs and practices are shaped, one needs to pay closer attention to the separate effects of parents' ethnic background, their social economic status and to the matrices of cultural communities in which they participate (Bornstein, 2002).

Forty years of parenting research has produced consensus regarding the importance of several dimensions of parenting behaviour, including behaviour control, psychological control, and support (Gray & Steinberg, 1999). Yet the precise nature of the relation of these parenting dimensions to child psychopathology remains unclear. For example, there is not yet consensus as to whether parenting behaviour dimensions are best considered as categorical parenting styles.

Baumrind (1966) introduced the role of parenting styles and differentiates between their methods of controlling performance by identifying 3 different parenting styles.

Within the authoritarian parenting style, parents have high expectations of their children and have very strict rules that they expect to follow unconditionally (Davies, Kildea & Wright, 2011). This style is low in acceptance and involvement, high in coercive control and low in autonomy granting. The second is known as permissive parenting, whereby parents make few demands upon their children. Because these parents have low expectations for self-control and maturity, they rarely discipline their children. Authoritarian and permissive styles of parenting are more likely to aggravate the situation and have detrimental effects on the family and parent-child interactions (Abdolahian, Far & Yousefia, 2011). Authoritative parenting

refers to be the favoured parenting style due to the fact that these children are generally said to have high levels of self-reliance and self-esteem, are socially responsible, independent and achievement-oriented (Davies, Kildea & Wright, 2011; Husain & Phoenix, 2007). Furthermore, parents and caregivers that use an authoritative means of child-rearing are more intimate with their children and monitor their behaviour.

According to Borenstein (2013), the outcome of children's development is highly reliant on the ways in which they are parented, and thus affects and influences; to a large degree, children's mental health. Just as children's development is influenced by the key role that parenting plays; parenting itself is also highly influenced and shaped by culture (Bornstein, 2013). Bornstein (2013) adds that cultural variations employ significance over emotional, mental and social development of children. A further notion that Bornstein (2013) proposes is that just as culture dictates/prescribes what language a child will speak, so does it influence mental, emotional and social development of children. Furthermore, Bornstein (2013) argues that cultural beliefs and behaviours shape the ways in which parents raise their children and that cultural norms construct one's upbringing, as it does mental health. Furthermore,

Harkness, Super and Moscardino et al. (2007) argue that cultural norms are upheld by in turn transmitted through the impact they have on cognitions that inform parenting practices. Therefore, there is a reinforcement of culturally appropriate and acceptable patterns of beliefs and behaviours. As a result, the intersection that exists between parenting and culture are significant and relate pointedly to child mental health. Parental ideas, values, goals and attitudes therefore have a place in child mental health (Holden & Buck, 2002). Additionally, as Bronfenbrenner (2006) states that one does not exist in isolation, so do adults not parent in isolation, but rather do so within multiple contexts, and one such context of parenting is culture and its relation to mental health that Bornstein (2013) argues that environments that stipulate and harness child development are fundamentally guided by childhood experiences

informed by parents. Although there is a large portion of biological genetic makeup in children that are inherited from their parents; parents also directly create their children's experiences and as long as parents belong to a particular cultural group; they are likely to subscribe to norms within that cultural group that offers guidelines on childrearing. Cross cultural studies attest to the fact that all aspects of parenting are cognisant of culture, influencing aspects such as how much freedom is permitted to explore, how nurturing or limiting parents are, as well as which behaviour is emphasised.

Bornstein, Tamis Le-Monda and Pascaul et al. (1996) argue that due to cultural practices, parents hold varying beliefs about their parenting and about their children. Additionally, Bornstein (2013) states that due to modernisation and more homogeneity of cultures, largely influenced by the Western practices; there has been an increase in the dissolution of traditional cultural patterns. It is imperative to learn more about culture and parenting, so that scientists, educators, and practitioners can effectively enhance child mental health. Insofar as (some) systematic relations are established in a culture between how people parent and how children develop, the possibility exists for identifying some "best practices" in how to promote positive parenting and positive child mental health. Some parental practices are perceived as offensive in some cultures, but in others the same behaviours are thought to be benign to children's adjustment. For example, parenting practices in some cultural contexts include folk remedies, which are meant to help children recover from illness, but leave burns or other marks in the process (Bornstein, 2013). Variations in what is normative in different cultures challenge our assumptions about what is universal and inform our understanding of how parent-child relationships unfold in ways both culturally universal and specific.

Culture influences some parenting cognitions and practices and, in turn, child mental health from a very early age, through such pervasive factors as what parents expect of children,

when and how parents care for children, and which behaviours parents appreciate, emphasize, and reward. Parents are influenced by conventionalized images of what is and what ought to be proper childrearing, and so they (even unconsciously) seek to implement an agendum derived from concepts that characterize their culture-specific milieu.

It is the continuing task of parents to nurture as well as to prepare children for the physical, psychosocial, and educational situations that are characteristic of their specific culture. (Bornstein, 2013). As a consequence, even in the face of some shared goals, parenting children varies dramatically across cultures. There is, therefore, definite need and significance for cultural approaches to parenting and child mental health.

2.5 Etiology of Mental illness

2.5.1 Western models of Mental illness

Within Western modes of understanding psychopathology is the bio-psychosocial model (BPS), a framework that was developed by George Engel (1977). Through this model is the consideration that mental illness is the result of interactions between biological, psychological and social factors (Shirk, Talmi and Olds, 2000). These interactions determine the causes, manifestations and outcome of wellness and disease. Although, historically, arguments taking on the nature versus nurture debate suggested that any of the aforementioned factors was enough to change the nature of development; the BPS model argues that a singular factor is insufficient but that rather; it is the interplay of genetics, mental health and behaviour as well as the social and cultural context that ultimately determines health-related outcomes (Yeh, Hough, McCabe, Lau, Garland, 2004).

Kazdin, Holland, Crowley (1997) argue that these factors can act as either a protective or a risk factor in the development of psychological disorders, which causes difficulty in clearly identifying a single cause if pathology is present. Within the BPS model are the notions of equifinality and multifinality. The former accounts for the fact that there are multiple

pathways present that can lead to a single disorder or a similar outcome (Hudson, Kendall, Coles, Robin, Webb, 2002). The latter, accounts for the likelihood that one risk factor may lead to multiple outcomes (Hudson et al, 2002). Abera, Robbins, and Tesfaye (2015) argue that the BPS model is universal as it is understood as a model of causation and pathway for mental illness which are unanimously understood by mental health professionals globally regardless of their culture and/or belief system. Due to such a universal understanding, there are similarities in diagnosis, understanding and ultimately the management of mental health disorders by mental health professionals.

Abera et al. (2015) argue that even though the BPS model is more commonly referenced to within the mental health professional field; parents (especially those from developing countries) are more likely to utilise either a disease model or a simple causal model in order to understand and explain cause of mental illnesses in their children. Within the disease model; illness is described as a syndrome that is either present or absent. On the other hand; a simple causal model suggests that there is only one cause of illness and that should the cause be absent; then the illness wouldn't exist (Sroufe, 1997). This perhaps is easier for parents to believe that there is a primary cause for their child's mental illness. Ultimately; the ways in which parents understand the causes of their children's mental health problems could impact on their ability to become aware of different psychopathology; thus influencing the preferred treatment methods as well as their help seeking behaviour (Abera et al. 2015). Contrary to more contemporary understandings of causes of mental illness are the traditional explanatory models of mental illness. Cultural beliefs about some of the causes of mental illness are a phenomenon in many African countries (Abera et al. 2015). These too, have an impact on the treatment choices and avenues available and those that are sought.

2.5.2 Traditional health practices

Due to the fact that it is difficult to ascribe one single definition to the broad elements of traditional belief systems and traditional medicine; Richter, (2003) states that traditional medicines include health practices, approaches, spiritual therapies, beliefs incorporating plant, animal and mineral based medicines as well as manual and physical techniques applied singularly or in combination to maintain well-being as well as used to treat, diagnose or prevent illness. Additionally, African traditional medicine encompasses practices, explicable or not, to eliminate physical, mental or societal imbalance relying exclusively on practical experience and observation that is passed on from generation to generation either verbally or in writing (Richter, 2003). Unlike western medicine which only focuses on the biological causes of illness and disease, traditional medicine emphasises spiritual dimensions of the self. Within the traditional healing system the role of the individual's ancestors is of importance in the diagnosis and treatment of illness (Gilbert, Selikow & Walker, 2010).

According to Pretorious (1989), throughout the world, traditional healers are an important source of psychiatric support. Gilbert, Selikow and Walker (2010) argue that the notion of traditional medicine survived the introduction of modern medicine due to the fact that the people with a traditional orientation were able to determine between illnesses that could be treated by biomedicine and those that needed to be attended by traditional healers. It is estimated that 80% of the African population make use of the services rendered by traditional healers as, Sodi (1996) argues that the proponents of indigenous healing practices argue that it is physically, socially and culturally more available than western health care. Freeman (1992) argues that traditional healers are often consulted in sub-Saharan Africa for mental health problems at all life stages. Estimates of the proportion of African adult patients in community samples that have consulted a traditional healer range from 41% to 75% (Freeman, Lee& Vivian, 1994). Sorsdahl et al. (2009) examined the role of traditional healers in mental health seeking behaviour within a nationally representative community sample of

adults. Results revealed that traditional healers were consulted by 9% of the respondents and 11% consulted a religious or spiritual advisor. In addition, a proportion of children and adolescents with mental health problems were found to be very likely to receive interventions from traditional healers. Skuse (2007) noted that traditional healers offer a parallel system of belief to conventional medicine regarding illness and disease because they consider the body and social being as one integrated system which cannot exist independently of each other. In addition, Pretorius (1989) states that the healing practices of traditional healers are informed by a cultural framework that is common and understood by African communities to be powerful and effective. The prevailing justification of their interventions is that disease is a supernatural phenomenon (Skuse, 2007). Patel (1997) writes that one important reason that traditional healers are consulted is that they offer interventions that are congruent with the culture of the service user. The argument is that within many traditional African belief systems, mental health problems are attributed to spiritual sources. Therefore ancestors and traditional healers are viewed as having more expertise to address these causes (Dawes & Cairns, 1998). Furthermore, traditional healers are often more accessible than western mental health care. It has been estimated that there are approximately 200 000 traditional healers in South Africa, with approximately 1 per 500 South Africans. (Stein & Flisher, 2010).

Ensink and Robertson (1999) conducted a study whereby they attempted to classify culture-bound syndromes based on Western criteria. This was achieved by assessing categories of distress according to traditional healers among children and adolescents. Ten traditional healers were interviewed at first in order to identify categories of distress and dysfunction. In order to gain more information, a further sixteen traditional healers were interviewed. All of the categories were recognized and had specific indigenous names. These included: ukuthwasa (calling to be a healer); amafufunyane (possession by evil spirits); ukuphambana (madness); isinyama esikolweni (bewitchment at school); and ukuphaphazela (episode of fearfulness). Although ukuthwasa is not necessarily believed to be a disorder or illness, it can

progress to another illness such as amafufunyane or ukuphambana if the calling to be a healer is not fulfilled. Results indicated that Isinyama esikolweni (bewitchment at school) and ukuphaphazela (episode of fearfulness) can be considered as cultural variations of DSM IV disorders. Isinyama esikolweni met the DSM- IV criteria for conversion disorder with sensory deficit (similar to brain fag syndrome), and ukuphaphazela being similar to sleep terror disorder. However, ukuthwasa (calling to be a healer), amafufunyane (possession by evil spirits) and ukuphambana (madness), were identified in both adults and children and were characterized as culture bound syndromes as they did not correspond to specific DSM-IV disorders. Along with the fear of witchcraft, belief in possession by spirits is common in many cultures, both Western and non-Western (Stafford, 2005). Evil spirits are defined as, "...more or less intelligent beings with a will of their own, seem to bother or oppress us, or in rare instances, possess our bodies" (Stafford, 2005, p. 14).

People who perceive themselves to be possessed by such spirits may at times exhibit paranormal strength and may be able to behave in manners that are self-destructive. Additionally, such said individuals may portray signs that include fetid smalls and screams as well as rolling of eye (Stafford, 2005). Additional indications would be of changes to one's personality as well as an audible possessed voice that is unlike that of their normal nature (Padayachee & Laher, 2014). Often, the perception is held that once an individual has recovered from being possessed; they may not remember their behaviour (Padayachee & Laher, 2014). In those ways, it is plausible to state that experiences of spirit possession hold similar states of psychological states that are suggestive of altered states of consciousness.

Within Western understandings of mental illnesses, such symptomology may be understood as psychological dysfunction, but in more traditional African ideologies, such behaviour is understood solely as bewitchment or the influence of a spiritual entity. Igwe (2004) argues that Western frameworks hold limitations in more non-Western communities as "there is a tradition among Africans of applying spiritual or supernatural explanations and

interpretations to anything that happens... every misfortune is the spiritual handiwork of some enemy" (p. 74). Hence explanations attributing more Western psychological and psychiatric explanations have little to no relevance in societies that uphold supernatural belief systems as these provide more culturally accessible and acceptable understandings and meaning (Bakker & Mokwena, 1998). This is particularly so when individuals in these communities are confronted by adverse or apparently inexplicable events. Kapferer (2003) suggests that Western ideas of rationality do not permit belief in witchcraft and sorcery as these "reach beyond the limits of reason" (p. 21).

However, Kapferer (2003) adds that in parts of Africa and elsewhere in the world, fear of witchcraft is on the rise. This is also reported by Smith (2003), who acknowledges that the influence of witchcraft and sorcery in New Guinea, India, Europe and America also seems to be growing. Thus, despite the influence of Western ideologies, cultural and religious influences continue to shape the beliefs that many people hold with regard to psychological disturbances. However, it is imperative to consider that culture is exposed to the influence of modernisation and globalisation and, consequently is not static. Thus, cultural and religious beliefs are subject to ideological shifts over time (Igwe, 2004). In this regard, folklore beliefs in witchcraft and spiritual entities can be thought of as out-dated or pre-scientific.

2.5.3 Paternal Impact

Fatherhood in South African cultures may appear to be a contentious subject, with many absent fathers (Nduna, 2014). Ratele (2010) further argues that the impact of absent fathers, or fathers who fail to play a nurturing role in their children's lead to high levels of poverty, inequality, gender inequalities and a high number of orphaned children. Statistically, it is estimated that South Africa has one of the highest rates of father absence in the world, with only a third of South African preschool children living in the same homes as their fathers and mothers (Statistics South Africa, 2011). In order to account for such high numbers of children

living without their father in their homes is migrant labour and the variability of family life, including prolonged marriage due to *lobola* requirements (Ritcher et al., 2011). Richter, et al. 2010) state that the absence of fathers has severe consequences for not only children, but the entire family unit. Ritcher et al. (2011), Carlson (2010), and Schacht et al. (2009) propose that children whose fathers are present perform better at school, have healthier self-esteem and are more secure with partners of the opposite sex. Furthermore are the findings by Richter et al. (2011) who state that with the support and presence of fathers, the family unit is more likely to experience lower levels of family stress and are less prone to suffer from mental health problems. Other scholars have conducted studies on the impact of absent fathers (Desmond & Desmond, 2006). It was found that men are perceived to have more access to community resources and social positions. Furthermore is the notion that 'fathers who acknowledge and support their children confers social value on them, thus enabling children to become part of a wider circle of family. Furthermore, Ritcher et al. (2011) argue that fathers also offer the family unit protection from potential exploitation and abuse. The question therefore arises as to what cultural understandings are on fatherhood and how absent fathers are perceived by mothers and the perceived impact their absences may have on their children, their development and mental health.

Without the execution of the rituals, the bearing of the father's surname by the child is unheard of. This leads to the concerns held by mothers, fathers, guardians and children alike of the belief and worry that not using a biological father's surname could have negative repercussions for the child and may cause personal problems and bad luck (Nduna, 2014). Due to the large numbers of absent fathers, such rituals are not always performed, leaving many children to grow up without the use of the father's surname, leaving them prone to anxiety and stressors about the consequences that may carry. With large numbers of single-mother-parented households in South Africa, only 35% of children were living with both their biological parents in 2008. Some 40% were living with their mother only and 2.8% with

their father only, which leaves 22.6% of children who were living with neither of their biological parents (Statistics South Africa, 2011).

2.5.4 Conclusion

The strain that mental illness has on national resources is undeniable. There is a high magnitude of people who suffer from mental illnesses and this leaves an impact on many systems in society as well as those on interpersonal levels. Although Western paradigms of mental illnesses dominate understanding; it is important to also take into account more culturally relevant and accepted understandings and practices of treatment of mental illness (Pettus, 2006).

Within the South African context; the prevalence of mental illness in children is impacted largely by significant trauma that is often associated to violence, sexual abuse, poverty and HIV. The dominant practices for intervening in child mental health are informed by Western theories such as biomedical theories. Child behaviour is understood as having deeper psychological meaning and psychological well-being is directly related to parent-child relationships.

The culture that a person belongs to informs the structure of their psyche and thus cultural meaning systems are important in understanding child development and health. African cosmology emphasises the spiritual realm, the importance of connections with ancestors, collective identity, the role of the paternal family and the role of traditional healers.

Culturally meaningful help-seeking practices involve consultations with Sangomas and various symbolic rituals. These practices are used to counter the external forces perceived to account for mental illnesses. In some ways this resembles religious help-seeking behaviours such as prayer, consultations with the elders and conforming to religious rituals.

The mental health services offered within the South African context are often unresponsive to the needs of South African residents. Models have not been sufficiently adapted to cultural relevance. Services have not been expanded to make them equally accessible to all members of society who need them. For many South African families, there are barriers; both perceived and real, to getting the appropriate mental health intervention.

Chapter 3: Methodology

The current chapter sets out to provide a synopsis of the research design employed by the present study. This will be outlined by a detailed description of the procedure, the instrument used as well as the participants' demographics. As a final point, the ethical considerations will be noted.

3.1 Research Design:

A qualitative method was used for this research report due to the fact that the paradigm involves investigating people's subjective experiences. A qualitative approach is fundamentally interpretative and exploratory. Contrary to quantitative research, qualitative research does not aim to control or predict, but rather the focus is on description, analysis and interpretation (Rossman & Rallis, 2011). Additionally, qualitative research can be used as a tool to investigate the breadth, complexity and range of data in order to generate and enhance the results of the research. As the current study aims to understand parents' understanding of mental illness; the research method needed to allow open and detailed expressions. Due to the aforementioned, it was deemed that using semi-structured interviews was the most appropriate method as it allows for conversational exchange which reflected the views of participants towards culture, mental illness and help seeking. Qualitative researchers aim to make sense of feelings, experiences and social experiences of individuals. This is best understood within the participant's natural setting (Terre Blanche, Durrheim & Painter, 2009).

According to Lincoln and Denzin (2003), through qualitative research, an opportunity is provided to explore questions that are ill exposed. Qualitative research was deemed to be the more appropriate research method for this study as this paradigm represents people as persons living in dynamic, complex social arrangements (Rossman & Rallis, 2003). Additionally, qualitative research allowed the researcher to access parent's experiences and

interactions in their natural context and in a way that gave room for the participants to share their experiences. Qualitative research was beneficial for this study due to its flexibility as it encompasses a variety of accepted methods and structures which enable interviews to be well constructed. A qualitative approach was therefore deemed appropriate as it enabled the researcher to use direct elicitation to obtain data directly from the informants (Terreblance & Kelly, 1999). Terreblance and Kelly (1999) postulate that qualitative design allows for a thick description and deep understanding from the perspective of the participants. The qualitative research design used for this study in turn informed the methods of sampling, data collection and data analysis employed. It also informed the overall process followed in conducting the research and the format in which the data was written up and presented.

3.2 Procedure

Firstly, ethical approval was obtained from the Ethics Committee of the University of the Witwatersrand. Once the ethical approval had been obtained, the interview questions (See Appendix E) used in the study were developed based on literature search. In recruiting participants, individuals were approached at a Non-Governmental Organisation (NGO) and voluntary participants were requested. Three of the participants that were used in the study then referred other parents to participate. Thus a snowball sampling procedure was adopted which led to the recruitment of the remaining five participants. The participants that volunteered to take part were contacted both telephonically and in person and a meeting was arranged to conduct the interviews at a convenient time for the participants. All interviews were conducted between December 2015 and February 2016 and were held at an NGO which was within easy access for the participants. All the interviews were conducted primarily in English, although there was occasional use of vernacular. The interviews lasted between 25-50 minutes. Demographic information as collected at the start of the interview and the consent process was adhered to (see Appendix B and C). Due to the flexible nature of the interviews, the researcher used probing questions although the participants' responses played

a crucial part in the direction of the interview. Through consent given, the interviews were audio recorded and then transcribed verbatim. Transcribed interviews were stored and utilised for analysis, interpretation and analysis.

3.3 Participants

Kerlinger (Cited in Terre Blanche, 2006) states that purposive sampling is used to obtain a representative sample of a typical group. A sample of eight participants were identified based on the following inclusion criteria: parents to children between the ages of five to eighteen years of age and those who identified as black. Most participants were selected from the Alexander community, Johannesburg. The first few participants that were used referred other parents to participate in the study. Thus, elements of snowballing sampling were used. Snowball sampling is a non-probability sampling method often utilised in field research. Each individual that was interviewed was asked to suggest additional people for interviewing that were in a similar position (Babbie & Mouton, 2001). Participants were approached firstly at a Non-Profit organisation. They were informed of the nature and purpose of the study and those who showed interested were later contacted to arrange an interview time. Out of the eight participants; only two men agreed to take part in the study. All eight participants self-identified as black. Two of the participants belonged to the Tswana cultural group, another two belonged to the Ndebele cultural group, two were Zulu (including one of the male participants) and two participants belonged to the Pedi cultural groups (including one male). All eight participants made inferences to behavioural difficulties that they noticed with their children, but none of them labelled their children as suffering from a mental illness. All participants were between the ages of 28 and 34.

3.4 Instruments and data collection:

Terre Blanche et al. (2009) suggest that during the collection of data through qualitative research, it is important for the researcher to not disturb the context unduly but rather attempt

to become a natural part of the context. This can be done by entering the research settings with necessary care and engaging participants in an open and empathic manner. The data collection was done by means of semi-structured interviews with the use of a vignette (See Appendix F). According to Gourlay, Annabelle, et al. (2014) vignettes are short stories about a hypothetical person that are presented to participants during qualitative or quantitative research, to gather information about the individuals set of beliefs. This style of interviewing is sometimes described as non-directive although it is important to remember that the research question drives the interview. Therefore, a carefully constructed research agenda helped the researcher to stay close to and lose sight of the original research question (Willig, 2001). The face to face interviews were conducted on a one to one basis between the researcher and participant. Interviews allowed for personal communication which was informal, allowing for extensive exportation when collecting detailed information. Face to Face Interviews afforded the participants and researcher greater opportunity to clarify questions while ensuring the participant felt at ease during the interview. For the purposes of maintaining consistency in the researcher's understanding; responses that were offered in vernacular were translated and back-translated by someone who is familiar with the participant's home language. Vignettes are generally developed by drawing from prior research or examples of situations which replicate the local context, thus creating a story that participants can relate to. The central feature of this method is to allow the exploration of participants' subjective belief systems (Bloor and Wood, 2006). Due to the explorative nature of this study, vignettes were deemed appropriate to use as they served the purpose of allowing participants to engage with the provided scenario while referencing it to their cultural beliefs and values. The respondents were invited to imagine, drawing on their own experiences on the central character of the vignette.

In this study, participants were asked to comment on what they thought the problems the child (Sipho) was facing were. Furthermore, they were asked to use the story to illustrate how

they would understand the child's mental health difficulties and further express how they understood such said difficulties within their cultural framework and where they would seek help. Renold (2002) states that vignettes have been customarily used in research in psychology and potentially sensitive social and health issues such as sexual health, HIV, mental health, stigmatisation, violence and in vulnerable populations such as children. The vignette used in this study was used as a technique to mirror social reality. The vignette used had to be viable; for example, culturally appropriate, with listing of symptoms that could be easily identifiable to the participants, with the aim to present a story that would be familiar to the participants by touching on experiences that they could possibly face with their children.

Scenarios that were likely to charge high levels of emotions, or events which may have disrupted the interview were avoided. The key objective in using vignettes was to elicit hypothetical characters on a given domain that reflect individual norms, values and beliefs (Bloor & Wood, 2006). The researcher developed a hypothetical scenario of a child experiencing emotional difficulties. This was then used as part of a semi-structured interview and qualitative topic guide where participants were presented with the scenario in the later stage of the interview, having first answered biographical questions. Due to the nature of the study, it was important to ask biographical questions such as the age of the participant's children, the ages of the participants as well as their cultural affiliations (See Appendix E). Once developed, the vignette and associated questions were incorporated into an interview, along with semi-structured, open-ended questions about the understanding of mental health in relation to the character and his parents and what they personally thought they would do in that given situation. Through the use of probing, participants were encouraged to reflect on the vignette from a cultural perspective. The same vignette was used in all interviews, and was read out to participants. Interviews lasted between 25 minutes to 50 minutes, and were audio-recorded. The audio recordings were transcribed verbatim and; where required, translated into English, as some participants spoke both English and Zulu. The transcripts

were then analysed in order to generate findings about cultural understanding of mental health and their impact that they have on help seeking.

3.5 Data Analysis:

The method of data analysis used was thematic content analysis. Braun and Clarke's (2006) model was used to identify, analyse and report themes providing a rich, detailed and organised analysis of the data (Braun & Clarke, 2006). It can be used to highlight differences and similarities across the data set, summarise key features in a large data set as well as allow for rich interpretations of the data (Braun & Clarke, 2006). Each interview was audio recorded and transcribed verbatim. The transcriptions were then analysed by means of interpretive analysis (Terre Blanche, Durrheim & Painter, 2009). The point of interpretive analysis was to stay close to the data and interpret it from a position of empathic understanding, which involved a thorough description of the characteristics and processes. Braun and Clarke (2006) outline a six phase guideline as to how themes are created in thematic content analysis and these steps were followed when analysing the data. The first step of the data analysis was data familiarisation. Potential themes and all the relevant coded data extracts were collated within the identified theme. This led to the identification of main themes as well as sub-themes and all the data extracts that had been coded in relation to them. The fourth step involved reviewing the themes and checking to make sure the themes worked in relation to the coded extracts and the entire data set before finally refining the specifics of each theme and generating clear definitions and names for each theme. The final step of the data analysis involved selecting vivid and compelling extract examples and conducting a final analysis of the selected extracts whilst relating them back to the analysis of the research questions and the existing literature (Braun & Clarke, 2006).

3.6 Ethical Considerations

The essential purpose of research ethics is to protect the welfare of research participants. Research ethics is a field fundamentally concerned with assuring that the dignity of human participants is respected and is not abused or violated in the search for knowledge. The

researcher enforced a number of measures in order to ensure that the participants were not harmed in any way as a result of their participation in this study. Firstly, all participants were required to be 18 years of age and older and each participant was required to sign a consent form before the commencement of the interview. The process was voluntary and participants were allowed to withdraw from the study at any time without any consequences. Participants had the right not to answer questions they felt uncomfortable answering. The participants were advised that while anonymity could not be completely ensured between the researcher and the participants as they interviewed face to face, anonymity would be upheld at all times with participant's in the written research report. No identifying information was included therefore safe guarding participants' anonymity through the use of numerical coding. Regarding confidentiality, all the participants' responses were kept confidential; however, confidentiality was limited as the interview material was shared with the supervisor. Furthermore, all the participants were given the option to receive counselling services through Life Line should the interview illicit any negative consequences. All data was stored in a password-protected laptop. All this information was documented in the participant information letter and various consent forms (see Appendix A, B and C). Participants gave their consent for the use of direct quotes and to be audio recorded.

3.7 Self-reflexivity

Denzin and Lincoln (2003) argue that as a researcher, one must declare morals and scientific authority and take into account their own personal lived experience. Additionally, psychological approaches require self-reflexivity and thoughtfulness and awareness on the part of the researcher on their preconceptions and expectations of their research (Uzzel & Barnett, 2006). Due to the aforementioned, it is important to state that this is a study about black African cultural norms conducted by a black African woman. Additionally, I am a training psychologist who has been accustomed to Western paradigms and ideologies throughout my studies. Understanding cultural norms in a different way that mental health

could be understood was something that I had to be constantly aware of. Participants were aware that my research interest was informed by a psychological perspective. This may have influenced their responses in the direction of what they thought the researcher deemed desirable. Additionally, being a foreigner in South Africa, conducting this research with cultural groups that I did not know and value as my own played a significant role. I did however avoid giving my own personal opinions and was wary to lead participants to give responses that I thought were useful. Although I did recognise that I had my own preconceptions, I acknowledged through a continuous process of refection that I had to interpret the data that was ultimately presented (Uzzell & Barnett, 2006).

3.8 Conclusion

In order to explore how parents understand the causes of mental health problems in their children, the influence that cultural norms have on help-seeking behaviours, and the perceived barriers to accessing help, a qualitative study was conducted. This study was interested in the views held by black South African parents who have at least one child between the ages of 5 and 18. Eight individuals who met these criteria participated, coming from various South African cultural groups. Semi-structured interviews were conducted, recorded and transcribed. The transcribed interviews were analysed through means of a thematic content analysis. The appropriate ethical guidelines were followed, as according to the Health Professions Council of South Africa's ethical guidelines for psychological research. Self-reflexivity was considered, as the researcher has also attempted to show transparency in, and account for her role in the process of gathering and analysing the data and themes that emerged from it.

Chapter 4: Results

This research sought to understand how cultural factors influence the understanding of mental illnesses in children and the ways in which these understandings impact parents' help seeking behaviours. The first research question sought to understand how parents make meaning of the causes of their children's mental health problems. Help-seeking practices in response to children's mental health needs were also explored, as well as the perceptions of and barriers to the uptake of mental health services. The themes which emerged in participants responses are discussed here.

4.1 Understandings of Mental Illness

Participants identified a form of disturbance or abnormality in the case outlined by the vignette. In making meaning of the vignette, there was evidence of understandings based on traditional cultural beliefs, attributing the disturbance to supernatural causes. However, culturally informed meaning systems were not the only way of understanding the disturbances in the vignette and some participants gave evidence of more Western-informed understandings. These two meaning systems are unpacked in terms of how the participants aligned themselves and their beliefs about child mental health and illness.

4.1.1 Culturally informed meaning-making

Most participants revealed culturally-informed beliefs about how abnormality can be attributed to supernatural causes. An acceptance of the supernatural realm and its impact on human functioning seemed to be held firmly by the participants, and this was used as a common frame of reference for making sense of child development and disturbance. Supernatural forces are understood to have the power to impact human development and wellbeing. Conversely, human action in the physical world has consequences for spiritual repute. Important rituals were identified at critical developmental periods in children's lives.

Cultural practices were identified as fundamental to the support of child development in particular. Most participants identified the importance of the child's place in, and connection to their paternal lineage as significant. Without proper introduction to the paternal family and ancestors; participants expressed that they would feel anxious that this could upset spiritual harmony and negative consequences might be expected for not following practices that acknowledge the traditional order of things and accountability to the ancestors, who are the gatekeepers to the spiritual realm.

> Participant 1 said *"in a cultural way, maybe there is a ritual thing going on, maybe that the child needs to be introduced to the ancestors and all those kinds of things. In our own culture (Tswana), I have seen a lot of children who are going through those kinds of things. People would think that they are going through those things because the child has not been introduced to the father's family, or that the child is not bearing the same surname as their father, or that the child needs a cultural name and that the ancestors need to be brought together. In this kind of story; they would need an introduction to the ancestors".*

Ritualistic practices were emphasized for formalising the introduction of children to the family's ancestors, as expressed by Participant 3:

> *"Sometimes the grandfather and grandmother (ancestors) would want to talk to Sipho but they wouldn't know how to because they haven't been told that there is a new baby in the house. The Sangoma's would tell them about the child and maybe they would request that the child has to change his name to his grandfather's name, and until he does this; he will continue to act the way he is acting – not sleeping, eating, not listening".*

Without the spiritual protection of ancestral acknowledgment, children are seen as spiritually vulnerable. Culturally sanctioned rituals and connection to the paternal family and ancestry is

thought of as having life-long significance and when these are lacking, mental disturbance could extend into adulthood. Participant 5 stated

> *"You might find that maybe I haven't taken the child to his homestead, that maybe they have to do rituals for him and they haven't done that. Or if the father has run away and hasn't told his side of the family about the child- you will find that when the child grows up; some of those cultural things will return back to him to haunt him and disturb him until you go to the paternal side and do rituals".*

This highlights that within culturally-based models of child development, childhood distress is seen as having consequences for later stages of development if not appropriately resolved.

Negative consequences for failure to follow the culturally appropriate requirements for belonging in the paternal family could be thought of as punishment from the ancestors, as suggested by Participant 2:

> *"Sometimes people say that your ancestors are angry with you and they are lashing out at your child. Or they are angry with your parents—and then the ancestors take it out on the child...as punishment".*

If applied rigidly, this belief could lead to stigmatising children and families who are in psychological distress. When reflecting on the vignette presented, one participant reflected: "*other people would neglect him and stop their children from playing with him because they would be afraid that the curse would rub off on their children*".

Aligned was participant 2's comment that: *"this child will not be treated nicely; they would think that he has a big problem and that because he cries at night he would be seen as having evil spirits.*" The whole family may be judged as spiritually unwell, as stated by another participant:

> "*People would think that his family has a spell of madness, that they have a curse, a spirit of madness, or that there is a curse upon them. They would even go as far as*

believing that if their child gets married into that family, their offspring will also be mad, so people wouldn't risk that, they would rather just reject the whole family".

The risk of being alienated may lead to a lot of anxiety for parents when their child's behaviour is perceived as abnormal. The participants of this study seemed to fear judgement discriminating consequences, and mental illness is treated as a taboo.

Participants revealed their traditional cultural belief that other human beings who may hold harmful intentions toward a child or a child's family may succeed in manipulating spiritual forces to harm a child. This was offered as a potential aetiology for the psychological difficulties participants were confronted with in the description of the vignette. Spiritual possession and witchcraft were offered as legitimate external forces, which could have powerful and noticeably negative influence on children. Participant 7 stated that *"we still see mental health issues as a person being possessed"* in reference to her cultural beliefs, suggestive of the propensity to externalise the source of mental disturbance, locating it in the supernatural realm.

Most participants referenced the notion of *"bewitchment"*. Reasons for bewitchment could be understood as an envious attack, as stated in this example relayed by Participant 7: *"Like your uncle doesn't want to see you successful so they use muti on you. These are just spiritual things; they cannot be understood in a natural sense"*.

Participant 6 explained that:

> "*Bewitching means to put a curse on someone and people will do that to other's children because they are jealous of that family. You never know, maybe Sipho was a very clever child and they are jealous of that, so they use muti to bewitch him. To make him behave like this"*.

Participants also highlighted retribution as a reason for bewitchment if : *"the individual has done something wrong in the community"* such as *"stealing", "telling lies", "committing atrocities with other innocent people"* or *"getting with another man's wife"*.

Participants believed that punishment for actions deemed inappropriate in a community could be taken on by family members; thus making children vulnerable to bewitchment even if they themselves are not perceived as the perpetrators of the deviance.

Notions of bewitchment too, can lead to heightened fears of mental illness. These fears may be perpetuated by the externalisation of the cause, as this limits parents' perceptions of their power to influence the mental wellbeing of their children.

4.1.2 Understandings aligned with Western meaning-making

The beliefs presented by the participants in this research showed that culturally informed understandings and western concepts of child mental health were not polarised. Without necessarily making use of a psychiatric discourse, participants made use of aspects of bio-psychosocial formulations in their understandings of child mental health and illness.

Some participants hypothesized that something that had *"gone wrong in the brain"* in ascribing the causes for the disturbance outlined in the vignette. Such understandings suggest an acknowledgement of interpretations aligned with a medical model; a biological cause is attributed to mental illness. Most participants offered vague understandings of brain functioning and mental illness, and some made mere references suggestive of cognitive functioning such as *"being slow"*. The impact of environmental factors and external stimulation on brain development was presented in attributing causes to mental illness. For example, a participant described a child with a mental illness as *"someone who is not developed enough because you need to develop the child's brain, mentally help them develop. You can do this by allowing the child to explore, and through puzzles"*. Participants

expressed beliefs about cognitive stimulation which are consistent with some of the ideas that have emerged in western knowledge systems of child development.

Interpretations of the vignette also showed some understanding of the impact of social factors on children's functioning, with an emphasis on potential abuse as a cause for dysfunction: *"I think this child is being abused, maybe sexual or physical abuse and that's why there has been a change in behaviour"*; *"I don't know which abuse, but maybe sexual or through corporal punishment, but there is abuse for sure"*.

Although environmental and developmental experiences were acknowledged in these participants' formulations of the vignette, only two participants made attributions to mental states and emotional experiences where one stated:

> *"I think he is stressed because you see a child who is not eating and is not doing homework and he doesn't want to wash the dishes... you should ask what's going wrong with his parents"* and another: *"If someone has emotional difficulties, the way that it would affect them, their mental state would therefore also affect their concentration and performance levels. The normal tasks that they have to do would be affected because their emotions would affect their mental state"*.

It seemed that the emotional and relational dimensions of mental illness were less emphasized by most of the participants. Participant 2 made a point of excluding psychological distress when conveying her interpretation of mental illness, saying *"I associate mental illness with brain problems. Not depression, not guilt. That's why I separate emotional and mental problems or whatever the case"*.

The personal distress reflected in the vignette was normalised by some of the participants who didn't find the description of symptoms concerning. Participant 8 stated that *"Sipho is*

fine, he is just going through something and he is taking it in his own way". Behavioural changes and signs of distress were not thought of as indicators of mental health concerns, and more severe symptoms seemed to be associated with the concept of mental illness. Participant 6 explained: *"Maybe, somebody who is not able to walk or talk is disabled and you know, able to talk and all that, I would say that person is mentally ill."* The meaning and consequence of symptoms outlined in the vignette were minimized by comparison to potentially more extreme manifestations of mental illness, as echoed in participant 1's argument: *"He is not like those people on the street who are full of oil who are just picking up papers; talking to themselves".* While some participants accepted the notion of mental illness, they did not all find it to have relevant application to the vignette described to them.

These frameworks of understanding mental illness could prevent the recognition and intervention of child mental illness. Deviant or non-compliant behaviours in children appeared to often be decoupled from psychological distress.

Many of the participants read the meaning of the problems outlined in the vignette as stemming from the child's intention to be uncooperative. Participant 4 shared these thoughts:

> *"The way we describe Sipho; he doesn't want to play with other kids and he doesn't want to talk. So we can say that he is lazy or he's not friendly he is somebody who doesn't want to talk".* Participant 6 suggested misbehaviour: *"They would just think that that child is just trying to be naughty, just being an attention seeker".* Laziness or rudeness were also suggested: *"he is too lazy to even eat" and: "They will think that he is being rude and not wanting to talk to people".*

A common theme seemed to be the perception that children have a tendency to go against the wishes of their parents with conscious intention. Behaviours which may be interpreted by

psychological models as involuntary communications of distress could therefore be seen as controllable by the child.

In summary, culturally informed beliefs of the supernatural world, the role of the ancestors and rituals for maintaining order, protection and wellbeing were found to be important guiding frameworks for thinking about and raising children. Cultural beliefs tend to externalise the factors leading to mental health or illness. Conceptualisations of mental health and illness drawn from traditional culture and westernised formulations did not represent a polarity, and areas of alignment or integration of the different worldviews were evident in participants' responses. Many of the participants seemed able to hold these two frameworks of understanding in mind concurrently. Mental illness in children was seen as having potential biological, social and developmental origins. However, while severe manifestations of psychiatric symptoms seem to be accepted as signs of mental illness such as disability or delusional thinking, children's behavioural cues did not seem to be commonly associated with psychological distress. While participants demonstrated an openness to thinking about western theories for understanding child mental health and illness, they showed limited psychological and developmental western-based knowledge that could inform their decisions of how to integrate these understandings in a culturally meaningful way.

4.2 Help-Seeking Behaviour

This research endeavoured to explore the help-seeking practices of parents and the impact of culturally-informed perceptions, attributions and norms for responding to their children's mental health needs. Participants were asked about how they would act, whether they would seek help, and from whom.

Externalised cultural rituals and spiritual intervention:

Consistent with external attributions to supernatural causes of mental illness was the tendency to base intervention on traditional or religious help-seeking beliefs. All of the participants acknowledged practices affiliated with meaning systems informed by culture or religion or both. The help-seeking behaviours that were reported suggested that participants sought multisystem approaches; that is to draw on what is deemed as helpful according to cultural norms or group beliefs, the role of the family (and extended family) and more particularly, parenting styles and practices.

All participants talked about a visit to the Sangoma as a common port of call. Strong beliefs were expressed about how important and influential ancestors are in not only causing mental illness; but also in curing it. Participants believed that they could access the ancestral healing through consulting with Sangomas, who would then be able to "*make contact with*" ancestors to get their advice and assistance. It was acknowledged by participants that before they would seek any help from mental health practitioners, they would be more likely to consult with a Sangoma.

Help offered by Sangomas seems to be an acceptable, familiar, trusted and accessible mental health intervention. One of the key factors that contributed to consultation with traditional healers was their availability. Participant 6 stated, *"in my culture and my area, people would go to a traditional healer for help. Going to a Sangoma would be easy to do because there are so many"*. Furthermore, Sangoma's are seen as the only people who can communicate directly with the ancestors; people who have sacred information that could heal their child. Participant 8 stated:

> *"Sangomas can communicate with ancestors and the ancestors will then tell the Sangoma what is wrong with Sipho and the Sangoma will be able to tell you what is*

wrong with Sipho. The Sangoma will also tell you what we can do, like maybe buy a chicken and slaughter it and Sipho will be fine".

As seen here, cultural rituals were cited as common recommendations that Sangoma's might make when assessing the client's presenting problem. Participant 4 shared:

> *"A Sangoma would talk to the dead people by using bones and beads, sometimes even traditional medicine. They would tell you that the problem is that you didn't do ceremonies or rituals and that you must make traditional beer and slaughter a goat".*
>
> Sangoma's were thought to be able to *"... foretell everything, that they would have access to information even before the parents explain what was troubling them".*

Sangoma's are evidently seen as having the appropriate cultural understandings and spiritual insight, leading to them being trusted by the community.

Similar authority appears to be given to other spiritual leaders. Many participants said that they would seek help from the church if they were concerned about their child's behaviour or mental state. Some suggestions were: *"I would start at church if my child had such a problem"* and *"at church they would pray for my child. They would also offer counselling through the Bible and try and relate to the child".* Church leaders may be experienced as available and helpful, with the power to intervene through intercession or spiritual guidance.

Generally accepted spiritually sanctioned interventions seem to include prayer and the role of discipline:

Prayer was a familiar help-seeking behaviour for many participants, as emphasized by Participant 5's response: *"I would definitely take my child to church, to the pastor to be prayed for".* Participant 1 shared, *"I got down on my knees and prayed for my child"* when conveying an account of a time when she was worried about her child's psychological

development. Parents understood it as their responsibility to present their children's mental illness for divine intervention. Discipline was cited as a religious practice by Participant 8 who said *"I'm from a very Christian background, and my father always used to say "spare the rod, spoil the child" and I believe that too"*.

Supernatural aspects of traditional cultural worldviews seemed to be able to be held simultaneously with religious spirituality, as is suggested by the concurrent uptake of the help-seeking practices commonly accepted by these meaning systems. The guidance offered by culture and religion entails generalised rules and practices for child rearing, and interventions appear to be directive.

4.3 Family Responsibility and "Parental Powers"

All of the participants thought of the role of the family in some way in responding to potential mental health difficulties. Family members were thought to be the source of wise advice, directing parent behaviour in a particular way. Many participants seemed to believe that mental health difficulties could be brought to resolution by parental intervention of some sort.

Talking to family members seemed to be an acceptable help-seeking avenue explored by the group of participants. Participant 1 shared: *"whenever I am facing a problem with my child;I always go to my aunts to get advice first, before I do anything else"*, while Participant 7 stated *"I would first consult with my family members; some of them - the ones I can trust"*.

He added that he would turn to family before *"letting everybody in on [his] business"*.

Seeking support within the family was deemed to be important for protecting information about the family, as explained by Participant 8's account: *"Well there is - in my culture - there is what we call 'family secrets', so what happens here at home it must stay with us. Taking it to the neighbour or to another stranger, it's like a no-no"*. There seems to be much

caution exercised in terms of whom to talk to about problems, and reluctance to open up the difficulties within a family to non-family members. This secrecy seems to serve a protective function, perhaps so as not expose vulnerabilities to perceived outsiders as this could feel unsafe. When there is a concern about a child's mental health, resolution within the family may be seen as ideal and is often the first port of call in parenting decisions.

Solutions may also be sought within the parent-child dyad. Thoughts about what parenting practices would be helpful were varied. The fathers who participated emphasized discipline as important to resolve behavioural concerns.

> Participant 8 said: *"discipline solves all behaviour in children. The lack of discipline; or the discipline itself will determine how children will behave; because this Sipho kid is acting out, and he needs discipline and he will be fine"*. Participant 7 stated the need for *"discipline in whatever form, obviously not abusive but there needs to be discipline for this sort of behaviour. I mean the child isn't doing his chores, he's not doing his homework. That needs discipline"*.

These responses seem to suggest a recognition of parental roles in contributing to child behaviours, and these fathers have described how they take up that responsibility through attempts to alter their children's behaviours through behavioural intervention. Deviant behaviours seemed to be considered as unacceptable and parental authority may be used as a means to control this. This notion was challenged by some of the mothers' voices.

> Participant 5 argued that: *"when there are changes in a child; sometimes us parents use our parental powers wrong. We sometimes use them for shouting and bullying our children into what we want them to do. But we can also use these parental powers in a better way; like talking nicely to our children and understanding how they are feeling"*.

This stance suggests a recognition that undesired behaviours are could have deeper meaning, and a willingness to understand and empathise with their children's experiences. Parents who realise their role in impacting their children's behaviour, as well as a responsibility to help their children process internal experiences; may be more open to acquiring and integrating information about child development and parenting practices that are from outside of their family, cultural or religious groupings. An openness to learning to understand the internal experiences of children was held by some participants, even when they also stated their commitments to cultural beliefs. While some parents may value culturally prescribed parenting practices as fundamentally important for the holistic well-being of their children, they did not necessarily use those understandings to apply certainty to the meaning of difficult behaviours and what the "right" parenting responses should be. Even though they saw cultural practices as pre-requisites to the mental well-being of their children, they were also able to wonder about the communications behind their children's behaviours. These parents may be more likely to seek professional help when responding to mental health concerns in their children, as they may also be more open to integrating new models of understanding with their current belief systems.

4.3.1 Accessing Mental Health Professionals

Some of the participants considered mental health professionals as potential source of help. Participant 4 reflected *"I think that mentally he is not coping. Maybe he needs a psychologist or counselling so that he can talk about the things that happened to him"*, although most did not consider this to be their first resort, Participant 5 shared that she "*would only go to a social worker or psychologist if [her] family failed to intervene"*. Another participant reported that she had accessed psychological services for her daughter as a last resort; after she had tried to get help from family members and church. There seems to be some openness to, but still some reservation around relevance of mental health service input.

4.4 Barriers to seeking mental health care

Parents in this study were also asked to talk about their perceptions of accessing mental health interventions for their children and a number of barriers were perceived to them being able to take up these services.

4.4.1 Perceptions of mental health services

When exploring the perceived roles of mental health services, the participants expressed their understandings that suggested stigmatised views of mental health. There seemed to be a stigma associated to any behaviour that is seem as abnormal. Participants thought that a child who exhibits behaviours such as those described in the vignette would likely be alienated from his peers.

> Participant 5 stated that "*for a child like Sipho who is not cooping at school; other children would laugh at him and parents would also tell their children to stay away from him and not to befriend him because they wouldn't see him as normal*".

Additionally; participant 5 stated that "*people wouldn't treat Sipho well because they will think that he is spoilt*". Participant 4 also stated that "*people would treat children like Sipho as if they are nothing*". It appears that a child being seen as facing mental illnesses are prone to be marginalised and "othered" in their communities; including friends and extended family. Participant 6 also expressed that people would "*gossip about Sipho and his family and that they would warn others that he is mad and dangerous and that they should stay away from them*".

All the participants felt that part of the reason mental illness is difficult to speak openly about within their communities is due to stigma and discrimination that is widespread towards people with mental illness within the African communities: "*Yes there is stigma. There always is.*"

Help-seeking behaviour entails an acknowledgement of difficulty and this may still be met with much discomfort by many of the parents represented by the participants in this study, due to the risk of inviting judgement and discrimination from their community members.

Another dimension of stigma seemed to be attached to seeking help through mental health professionals; such as a psychologist.

> Participant 6 expressed that "*psychology is quite new in my culture; a lot of people don't know about it; and because they don't understand it; they would make fun of me because I take my child to see a psychologist*". Participant 3 expressed similar views that "*even though I am able to know that there are psychologists to work with my children, for other people it's still very new; even unheard of; even anger is new to them and they would not understand psychologists*".

What this participant may have been suggesting was that the language for talking about mental states might feel culturally foreign for her. Participant 6 stated that psychology is understood to be "*Western medicine*". This was further explained by participant 1, the only participant who has accessed psychological services for her child who expressed that psychology wasn't part of her cultural framework and was rather seen as a '*white thing*'. She elaborated that when white people go mad, they wouldn't say that they are mad, but rather go and see a psychologist because they are stressed. The experience of taking your child to seek treatment from a psychologist was reported as being kept private and secretive in fear that family and friends would ridicule the parents for an ill-informed decision. It seems as though the stigma attached to psychology as a modern more Western, white practice serves as a further barrier in accessing the service for their children.

Participants highlighted some of the kinds of discrimination that appears to ensue from such widespread community stigma. It was further told that such widespread stigma in the community also frequently extends to everything that is associated with mental illness. Family members of the mentally ill were perceived by many of the participants to experience stigma themselves. It seems that a myriad of fears are associated with mental illness, which may contribute to the widespread stigmatization of children with mental health disorders as fear translates into negative attitudes and may impact on help seeking behaviour, such as the stigma attached to going to a psychologist is a barrier that parents experience when contemplating seeking professional help for their children. Some participants explained that if they were to allow their children to see psychologists; they would be seen to be "denying" and bringing shame to their culture.

> Participant 1 stated that "*if people knew that my child was seeing a psychologist, they would think that I am pompous, that I think I know better than them; that I feel like I know it all*". This was further expressed by participant 7 who stated that people would say that "*I am acting white, that I feel I am too good for my culture, so for me to avoid being seen as an outsider with my own people, I would just avoid those services entirely*".

The above extracts indicate that seeking help from a psychologist or mental health professional is met with complexities with regards to whether this is culturally acceptable for black South Africans. As a result, participants expressed that they would be reluctant to seek therapy from psychologists in order to avoid being ostracised by their communities.

There is also the belief that a curse can cause mental illness and within their cultural contexts, one is dealing with a cultural belief that a curse is real. The result can therefore be a state of extreme anxiety on the part of the person cursed. Thus reaction is reinforced by the response of others

who seek mental health services to avoid contact with the cursed people or mock the cursed person. Perhaps there is the underlying fear of the risk of ridicule by people within the same communities. Parents may feel that they will be open to ridicule should the mental illness be seen as a curse and punishment. Such exposure may mean to them that they will become ridiculed. Such statements demonstrate the possible psychological leverage that a group can have over an individual in certain circumstances and the significance of the role assigned to that person.

It can be deduced therefore that mental illness stigma and discrimination is present in South Africa. Discourses of stigma seemed to speak through the participants' talk of mental health. The interviews were saturated with comments that children with mental disorders are stigmatized, feared, marginalized, and negative labels characterised descriptions of mental health difficulties. Thus, children experiencing psychological disturbances are at risk of being victims of some form of discrimination and prejudice, leaving them vulnerable to rejection from either family or friends or from society as a whole. The rejection and isolation that is experienced may result in further harm to mental wellbeing. It was emphasized that such children and their families might experience feelings of shame, being aware of cultural beliefs that may influence community members to believe there has been a defiance of the ancestors. Notions of wrongdoing and punishment may lead to stigmatised views of those who seek intervention for their child's mental health.

It is evident that such stigma would inevitably impact on parents' willingness to seek help from appropriately trained professionals, like psychologists. Through the material obtained, it is possible to deduce that although some parents may be aware of the appropriate places to seek help for mental illnesses, uniformity indicated that they would consider other aspects such as whether or not their extended family members would be accepting of it, other more embraced treatment approaches (such as traditional healers), and the likelihood that their child would be ostracised and rejected by their friends. Those aspects seem to take preference

and appear to be a barrier to seeking psychological help. The lack of family support is a barrier when contemplating seeking psychotherapy and it appears to be a crucial measure in barriers to treatment. Perhaps by gaining familial support, there would be peace of mind as well as reduced chances of being excluded by their family members. In addition, without the family's acceptance, making time for treatment becomes more difficult and priorities may be put into perspective. Furthermore, it was suggested that seeking therapy is associated with serious mental illness. Participants typically reported psychotherapy as unfamiliar and associated with the stigma of mental illness.

4.4.2 Accessibility and affordability

Even though some participants expressed their willingness to seek psychological services for their children, there were anticipated challenges expressed in the reality of accessing such services. *"I would first have to go to town and then find a clinic that would be able to refer me to a psychologist'*. Participant 3 felt that psychologists were inaccessible to her and that there were numerous referrals that she had to obtain before accessing the service. There was a common understanding amongst the participants that Sangomas were more readily available and easier to identify as Participant 2 stated that *"Sangomas are easy for me to find in my area. Maybe I will even find twenty on one street*". She added that Sangoma's are easily identified by the beads they wear on their wrists and ankles. Psychologists on the other hand were perceived to be hidden, a rarity within her community. *"Finding psychologists is hard, you can't just look at someone and see that they are a psychologist*". Additionally some participants held the understanding that approaching a psychologist on their own would result in the psychologist shaming them for accessing their service independently. Additional realities; which spoke to the fact that psychologists are not commonly found in non-Suburban areas were alluded to as Participant 4 expressed: *"I would have to catch many taxi's to faraway places, and if it's raining or too hot, I won't go; I would just rather see a sangoma right on my street*". Contrary to participants 2, 3, 4, 5 and 6; participant 7 didn't feel that

accessing a psychologist would be problematic if he ever desired to make use of such a service as he reported that *"[he] knew where he could find a psychologist privately and didn't feel that [he] needed to be referred to one through social workers.* However; he felt that he would probably never use the service as *"there are too many things attached to children seeing psychologists"*

Only one out of eight participants had previously accessed a psychologist when her child was facing behavioural changes that she understood to be emotional. She stated that finding a psychologist in her suburb area was not challenging; however, if she had been "*back home*" in Limpopo; finding a psychologist would have been very challenging.

> She explained that "*services there are very poor; people find it difficult to access many things. People even find it hard to access an ATM, so how would they access a psychologist? It's heart-breaking because I see what a psychologist was able to do for my child, and it breaks my heart knowing that people in my area don't have access to these services*".

This speaks to the limited mental health resources within certain less developed areas and the feelings that such services are for the privileged others.

Even though seven out of eight participants understood what psychologists and social workers had a valuable service to offer their children, some were not willing to nor did they feel they were adequately empowered to challenge barriers of accessibility.

Another barrier that was identified by participants in accessing mental health services through psychologists was that of financial constraints. All eight participants expressed their concern about the costs of psychotherapy and that even if they did want to access psychological services; they would not be able to afford them. Participant 2 reported that her previous experience made

her aware that psychologists were "*too expensive*". She stated that "*money is a challenge because maybe I will go to a psychologist and maybe they will ask me to pay R1000 and my only income is a social grant. How would I be able to pay that much money*?" there was a common perception that although some mental health services were free or more affordable; there were other challenges such as long waiting periods which then results in preference for consulting more traditional or faith based practices.

The aforementioned alternatives were also reported to be more affordable and that negotiations were possible *"a sangoma can maybe charge R50 for the first meeting and then R200 for the treatment; but if I tell him that I can't afford it he will give me a discount"*. Psychologists on the other hand were perceived to be "*too well trained*" to negotiate payment as Participant 2 expressed that "*I cannot negotiate fees with a psychologist because they are too qualified and I would be scared that they would feel like I am wasting their time."* Moreover, participant 2 stated that psychologists are "*on top*" and that they would refuse lower fees than they state. This speaks to the perceived power dynamics anticipated by the participants between what are seen as "highly educated professionals" and themselves. One participant also questioned the value of psychological services as he expressed that he would "*not be willing to pay for psychological serves as he would rather invest his money in something more beneficial; like education*". The only participant who has accessed psychological services for her child- participant 1 acknowledged that accessing psychotherapy for her child was financially strenuous and has continued to be a challenging part of the process.

4.5 Conclusion

To summarise these results; when exploring the understandings of the causes of mental health problems in their children, participants conveyed the importance of cultural beliefs that influence parenting practices, including their management of child behaviours and potential signs of mental illness. These beliefs seemed to influence help-seeking behaviours, leading to the tendency to seek assistance that is either culturally or spiritually based, as these interventions were experienced as well aligned with cultural meaning systems. Evidence of knowledge drawn from western-based theories of child mental health and illness was presented and there seemed to be willing attempts of parents to consider traditional African as well as western models of understanding, but participants revealed vague and limited understandings of western theory, limiting their opportunities to gauge the relevance of these within their worldviews. The themes that have emerged in this data suggest that there are social and structural barriers to engaging with mental health services, such as stigma, limited accessibility and the lack of availability of mental healthcare services.

Chapter 5: Discussion

5.1 Discussion

The mental health field in South Africa has been largely informed by Western-developed theories, research and best practice (Engel, 1977; Abera *et al.*, 2015). The ideologies supporting mental health care in South Africa are not, at present, reflective of, nor are they effectively responsive to the needs of its culturally diverse residents. The intention of this study was to explore locally-informed attributions and cultural norms to gain a better understanding of the perceptions of mental health and illness and how these manifest in the help-seeking behaviours that people choose or resort to.

The results of this study illuminate some of the tensions between Western and African conceptions of mental health. The discomfort integrating these two meaning systems are not just theoretical, nor are they only manifested externally in the availability and relevance of mental health care services; but many of the participants in this study revealed their internalised discomforts in grappling with these tensions. Frictions with cultural meaning-making was not the only struggle that became apparent. Important aspects of contextual realities were also identified as playing a significant role in perceptions and management of mental health and illness. Furthermore, it seems to be that there is an inextricable link between culture and context, which has been coloured by South Africa's socio-political history.

5.1 Debates and Tensions Between Western and African Conceptions of Health

When making sense of the causes of children's mental health problems, the understandings that were identified by the participants in this study as being aligned with cultural beliefs reveal the tendency to externalise the cause, while much less importance is placed on an individual's mental processes and internal experience. Mental disturbance and dysfunctional

behaviours are traditionally thought to be the result of powerful spiritual forces at work (Sorsdahl et al, 2009). Perhaps the fact that it is not common for mental illnesses to be spoken of and that they are "unseen" or "unheard" of is part of the reason why they are seen to be taboo and are rather accepted as something externalised, in the spiritual realm. These beliefs may insinuate that suffering could be a deserved punishment or ordained by higher, wiser powers, and understandings could perpetuate the stigma associated with mental illness and dismiss empathic understanding.

The more westernised conceptions of etiology of mental illness that emerged in this research seem to align with the tendency to externalise the cause; for example the lack of adequate stimulation, or the presence of a stressor such as abuse. Internal factors were mostly seen as biologically based; as an organic brain illness was suggested by most to be a logical explanation for mental illness. Little reference was made to the mental states and processes involved in the etiological processes that allow for equifinality and multifinality. The mental processing of experiences seems to be the aspect of child psychopathology that was not articulated, and perhaps the key aspect of mental illness that participants in this research struggled to define. The aspect of mental functioning that was commented on was the notion of choice in the suggestions that symptoms are behavioural difficulties that are facilitated by a child's choice to be naughty or to seek attention. This does not implicate the role of experiences or transactional processes that impact mental functioning, and could risk overlooking the role of parents as being in a unique position to mediate the mental processing of external events. Incomplete information pertaining to child mental illness could be understood as the result of a lack of awareness and opportunities to engage with this knowledge. The lack of emphasis on the individual psyche could also be seen as culturally aligned; as individual identity is defined collectively according to African cosmology (Sue *et al.*, 1999). Harmony and interdependence are valued in traditional African culture and the

facilitation of belonging with a community in which to experience these is by means of collective rituals for good-standing with one's ancestors, and in particular, one's paternal heritage (Nduna, 2014). The notion of the well-being of relational connections with parents and grandparents is not so foreign from the ideas of contemporary western theory on child psychological development and the role of relationships, particularly those with caregivers. Similarly, the notion of relational impact and parenting styles that characterise much of the contemporary theory pertaining risk factors for mental health difficulties for children could be compared to the traditional African concept that illness can be the result of disharmony with the traditional order of things or a rupture with the ancestors (Bornstein, 2013). . Parents play an important facilitative and mediating role in making these connections and legitimizing their children's entry to a cultural group, according to the parents who participated in this study. The actions of parents can also have a significant impact on the well-being of children, according to the culturally-based beliefs that were shared. This phenomenon is linked to the collective identity that is intensified within the family unit and thus a mental illness in a child might be seen as a reflection of the family's alignment with God and the ancestors.

The external, spiritualised attributions of the causes of mental illness also seem to have significance help-seeking activities that emerged in the results of this study. Culturally-based methods of intervention are passed down from parents who are responsible for facilitating the practices which bring about harmony and collective well-being; protecting children from ill-health. Traditions therefore form transgenerational links, and respect for traditional practice is fundamental to the African worldview as it facilitates connection to the ancestors. Children access this through their parents and grandparents, and the father of a baby and paternal family have particularly important roles in the rituals performed. Traditional practices could be seen as facilitating human connections which contribute to the experience of meaningful existence, belonging, and relational fulfilment. They are not random activities, but significant

practices for internalising the relational representations that are supportive of good mental health. Rituals are organised around milestones and significant life events, as was seen in the results of this study, and the structure of these practices may provide a means for mentally organising life experiences; also supporting mental health. The cultural meaning that forms part of the human psyche entails each individual's internalised meanings of connecting with tradition and practicing rituals. To understand and explore culturally-based beliefs and practices seems to be an important consideration in supporting the developmental and mental health needs of South African children.

The results of this research suggest some tension between religious and African belief systems. However, the utilization of religious help was commonly accepted, which may suggest some areas of resonance between these meaning systems. One observation is the external, concretised means of intervention, such as religious guidance or prayer. Religious communities, too, operationalize much of their relational functioning by means of externalized gestures and structured action. This overlap is confirmed in the parenting interventions that emerged in the results of this research; such as following advice given, carrying out disciplinary actions, or providing nurturing in a concrete manner. Culturally-informed traditional African practices are potentially supportive to parenting, and the absence of these seems to be a great source of anxiety for the group of parents in this study. Perhaps the themes which emerged with regards to help-seeking behaviours in this study can illuminate learnings about what is deemed to be important for mental well-being according to traditional African ideologies. One reflection is that it seems to be important that if mental health interventions are to find resonance with those invested in these cultural values, they need to be collaborative with and supportive of traditional practices and the ways in which these are carried out; as it is the culturally familiar way of doing things that makes traditional practice meaningful. Furthermore, if fathers and the paternal heritage holds such importance within African culture, then inclusion of and collaboration with fathers in mental health

interventions for children seems paramount in legitimising mental health interventions according to cultural perceptions.

The findings of this research revealed that while African conceptions of health were elevated, there was not an absence of psychologically or psychiatrically informed understandings. Although some responses reflecting this were vague and undeveloped, some of the thought processes reflected in the narratives presented, suggested meaningful engagement and appreciation of developmental experiences and their emotional impact, and the role of psychosocial stressors in their understandings of child mental health. This presence of discourses influenced by a biopsychosocial model of etiology may suggest some exposure to possible modes and aspects of psychoeducation that are accessible to and possibly even valued by those who are also invested in African meaning frameworks. This study was not able to achieve the exploration of the sources that informed these perspectives on child mental health, and this is a potentially valuable area of enquiry for future research.

5.2 Considering Culture in Context

Interestingly, the extent to which participants in this study subscribed to psychologically informed ideas did not always align with their willingness or levels of comfort in accessing mental health services as part of their help-seeking behaviour and parenting repertoires. These results could be understood by considering the barriers when seeking mental health care that were put forward by the participants. Swartz and Foster (1982) warn against the false assumptions about African culture that surface when one tries to understand cultural meaning by separating the analysis of a group from society as a whole. Thus, it would not be sufficiently illuminating to consider the impact of culturally-informed perspectives on mental health and illness, and help-seeking behaviours for managing mental illness, without proper consideration of the macro-system. Reflections on culture in South Africa often become embroiled with context. This makes sense, taking into account the political history of the segregation of cultural groups. Assumptions about cultural norms are perhaps, at times,

distorted by the socio-political experiences shared by cultural groups because of their shared environmental realities and the nature of the dynamics that have come to characterise the relationship between Western and African ideologies. During the apartheid era; the health care provided for white residents aspired to the standards set by research and practice in the developing western world, while the majority of people were deprived of access to adequate health care services (Stuckler et al, 2011).

This was operationalized through spatial segregation; thus systematizing the unequal access to health care. While efforts have been made toward equality, the lack of affordability and accessibility of these resources continues to exist for many of South Africa's black residents; perpetuating the limitations in developing services to be relevant and building a level of trust between communities and health care professionals. These experiences are captured in the themes of the unaffordability and inaccessibility of mental health services that emerged in the data. In the past, healthcare models drawn from western practices were withheld from people because of their cultural belonging. The progress in broadening access and facilitating affordability has not addressed these gaps. This may contribute to an experience of members of African cultural groups feeling excluded from health care services in a harmful way. This could promote the tendency to stigmatize mental health services and raise suspicion or judgement of those who are able to, and choose to make use of these services. The theme of stigma related to mental health and those who access professional services may be exacerbated by mistrust and discomfort with Western meaning systems that have been used in an exploitive manner in the past. Suspicion and mistrust perpetuate a segregation of the two meaning systems, and may contribute to the perception that they are less compatible than they actually are. The hesitation to integrate understandings gained from Western knowledge and those derived from African culture is also indicative of the ruptures that exist in the social fabric of South Africa. The healthcare system continues to fail a large portion of the

South African population; as the inaccessibility and unaffordability of mental healthcare services exclude many who may seek out professional help.

The concern for the amount of money that psychologists charge was identified by most participants in this study. Stein (2012) argued that the current social and economic realities in South Africa and unaffordability of psychological services exacerbates the treatment gap. Additionally, participants in this study expressed their belief that even though they felt as though they could negotiate payments with traditional healers; they would not be in a position to do the same with a psychologist. There has been a call for psychology to be more relevant and meaningful within the current social and political context of South Africa (Macleod & Howell, 2013). Perhaps due to views such as those held by the participants, psychology is still seen to be something that is only accessible by the "rich white man". Some participants felt that the service is not for them and they somehow felt unworthy.

Cross cultural competence is not emphasised within the South African health care system, and there is a lack of encouragement to value the diverse multiculturalism that characterises the South African population (Nemutandani et al, 2016). This has the potential to alienate and steer large groups of the South African population away from mental healthcare in the absence of a service that is available and relevant to them. Those who value traditional beliefs drawn from African culture may feel that the knowledge systems that they find supportive are misunderstood, dismissed, and sometimes undermined. Parents who are invested in their cultural identity may also feel disempowered in their role of understanding and supporting their children. Nemutandani's (2016) report of the vilifying of African traditional culture and health systems by the Apartheid regime may continue due to the lack of collaboration between traditional and western health care providers. The reluctance to engage with mental healthcare professionals in the South African context may be understood as a communication of the lack of an experience of personal relevance, ownership of, and human right to mental healthcare.

Religiously-based help-seeking behaviours seemed to be found more relevant for the participants in this study. While religious meaning systems are also informed by western culture, opportunities for religious help-seeking practices were not as inaccessible in the past, and the results of this study suggested that this kind of help would be readily available to them, should they seek it; parents had an internalised understanding and ownership of the religious meaning system that they made reference to, and it equipped parents with tools to help their children themselves.

The tension between Western understandings of mental health and meaning-making derived from African culture undoubtedly impacts and complicates how many South Africans manage their own mental health care and their relationship to mental health care services. However, the results of this study have revealed that not only do culturally-informed perceptions, attributions and norms play a role here; but factors pertaining to context also emerged. In particular, the profound impact socio-political history of South Africa seems to play an important role in a cultural divide that has not allowed for the effective adaptation of mental health practices in the South African context to be responsive to the people who live in it.

Chapter 6: Conclusion and Recommendations

6.1 Conclusion

This study acknowledges that in understanding mental illness in children, one cannot separate it from their cultural values and norms. This study proposes that is critical to understand how people may perceive mental illness, how it may be defined, its etiology as well as treatment. This cannot be accomplished without the considerations of cultural beliefs, values and traditional norms and practices and well as religious affiliations and rituals.

The results revealed that culturally based beliefs are used by parents to make sense of potential mental health difficulties. The participants in this study reported on the cultural norms to externalise the cause of mental disturbance and behavioural difficulties, often attributing these to a curse. Cultural factors include the belief in witchcraft and how detrimental that can be for the mental health of a child, the lack of the paternal protection, regardless of presence or absence of the father and what an impact neglecting to execute rituals may have on a child's mental health and development. This excludes the opportunity to identify other mental illnesses such as depression and adjustment disorders. However, participants in this study also offered evidence of understanding based on western theory. Although these two meaning systems were both held in mind, there was a lack of evidence of integrating these understandings.

Culturally and religiously sanctioned help-seeking behaviours emerged as a dominant theme in the results. There was also acknowledgment of family responsibility and the role parents play in their child's development. While help-seeking from mental health professionals emerged as a theme, there was also evidence of barriers to using these. Stigma presented as one possible barrier, as well as the affordability and accessibility of mental health care services. The lack of integration between African and western concepts of health could be seen as a reason for parents vague understandings of their internal mental processes involved

in child development and psychological functioning, as well as their role as parents in facilitating the emotional environments that will optimise their development. By integrating western and African meaning systems; there seems to be an opportunity to support development and protect mental health.

The findings further indicate that the willingness for people to seek mental health services may be largely impacted by widespread stigma and discrimination that was reported to be extensive in South African communities. Due to the fact that mental illnesses are associated to marginalisation, vulnerability; these have been identified as significant contributors to mental health help seeking disparities. Further challenges are associated to economic and lack of awareness that are common within South Africa. Furthermore, literature proposes that irrespective of health policies and the advocacy of mental health, all of these factors require comprehensive approaches, including increased awareness in order to decrease the morbidity and life disruption that can result from mental illnesses throughout South Africa.

6.2 Strengths of the Study

The fact that the study focused on mental health of children within a South African context suggests that this study is highly relevant due to the high prevalence of children diagnosed with mental illness in South Africa. Furthermore, the findings of this study provide insights on the caregivers' contributions to mental illness (in particular, depression and conduct related disorders)

Because this study primarily focused on the parent's perspective with regards to understanding mental illness and the effects it has on help seeking, it adds to a growing body of literature on mental illness in children within a cultural context. It provides a unique perspective on the understanding of mental illness culturally and how help seeking is influenced by it. Such insight is useful in identifying the role of the parent in supporting and caring for such children. This study, along with the resultant recommendations, may be used

to advocate for further research and resources with regards to the inter-relationship between the cultural understanding of mental illness and the preferred method of help seeking.

This study also identified a gap in literature with regards to the inter-relationship between the understanding of mental illness in children and the effects this has on help seeking behaviours. The research findings can be beneficial in motivating for further research in the field of childhood disorders, especially against the backdrop of cultural and religious perceptions facing many South African families.

6.3 Limitations

The limitations of the study are important to consider in evaluating the results of the current research. In South Africa, there are a diverse range of cultures, and although they may have very similar beliefs and practices; this study grouped them all under one culture, which may be seen as a limitation.

The most notable limitation of the study is the small sample size. Although a rich amount of data emerged, only eight participants were interviewed. Therefore, in terms of diversity, the results of this study cannot be taken as representative of all South African cultures as the participants did not represent all variations in that aspect. Furthermore, the sample point to a potential bias in favour of women. Consequently, much of the views of this research were reflective of a female cohort and it is therefore unclear the extent to which gender differences exist. This limited the responses received from the male members and it is unclear if gender differences exist. It is therefore proposed that this should be considered in further studies and

that the gender difference be addressed. Additionally, a comparison between the different South African cultures would prove to be beneficial.

Results obtained from the interviews of the participants are limited and cannot necessarily be generalised to the general population of parents of children with mental illness in South Africa. Furthermore, participants were subjected to a single interview and therefore this may not have been entirely representative of the complete range of views they held.

Additionally, the use of a vignette could have led to limitations in terms of the perception and understanding of the mental illness relayed in the vignettes; therefore limiting the participants' responses. It is important to note that although some of the participants were able to communicate sufficiently in English, the use of language and the role that played in the dynamics between the participants and the researcher were present. This may have caused the participants to feel intimidated by the interview process.

6.4 Recommendations

It is recommended that all caregivers be given some theoretical understanding of mental health and disorders; their etiology and treatment options. This may be achieved through mental health campaigns and awareness programmes carried out at; but not exclusive to; primary health care clinics. Due to limited research on childhood mental disorders, it may be beneficial to extend such research in this field.

It is further recommended that increased support be offered to caregivers with children suffering from mental disorders. It is also recommended that future research could focus on the various cultures in South Africa and how each of these cultures perceive mental health in

children. Based on the findings of the study, it is recommended that there is a need for a holistic approach to treating mental illnesses. There is a need to incorporate traditional practices with medical models, in order to make mental health services accessible on a broader scale. Additionally, training of mental health practitioners is primarily based on western principles and medical models. Although these may be beneficial, there needs to be an African approach that caters for the African population and takes into consideration the cultural elements associated to mental illness.

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Appendix A: Participant Information Sheet

School of Human and Community Development

Private Bag 3, Wits 2050,
Johannesburg,
SouthAfrica,

Tel: (011) 717-4500

Fax: (011) 717-4559

Good day,

My name is Esther Chunga. I am currently pursuing a Master's Degree in Community based Counselling Psychology at the University of the Witwatersrand Johannesburg. As part of my degree, I am required to complete a research project.

I am interested in understanding how mental illness in children is understood from a cultural perspective. How parents or caregivers seek help for their children; the difficulties they may experience in seeking help, the different resources which parents can obtain help from.

I invite you to participate in this research study, which will involve taking part in an interview that will last approximately 60 minutes. There are no risks anticipated if you choose to take part in this study; nor are there any direct benefits for your participation in this part of the study; however, you will be assisting me to understand mental health issues from a cultural context. This is useful for health professionals, especially in providing relevant services. Although you will be required to sign a consent form with your details such as your name, none of you responses will be linked to you personally and your identities will remain confidential. With your permission the interview will be digitally recorded in order to ensure accuracy. Please note that your participation in this study is voluntary, you will not be rewarded or penalized in any way. You have the right to withdraw from the research at any point. You may also refuse to answer any questions that make you uncomfortable. All data collected in the focus group discussion (including digital recordings, notes, or transcripts) will be kept strictly confidential, all material will only be seen, heard, and processed by myself and my supervisor. All the data collected will be kept in a safe location with restricted

access. A feedback sheet in the form of a one to two page summary of the study and its findings will be provided to you upon request. You may email or phone my supervisor or myself if you would like to receive this. Our contact details appear in the signature below. The feedback will be available approximately six months after the collection of the data. Results may be presented at a conference or written up in the form of a research publication.

If you feel vulnerable on completion of the interview, the following organisation may be contacted. This organisation provides free support and counselling.

- Lifeline (011 728 1347).

If you feel you have any concerns regarding the study, or if you require any additional information, please feel free to contact me telephonically or via email.

Kind regards,

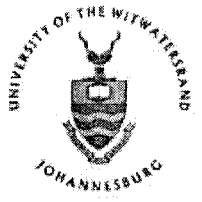
Esther Chunga

0765454138
estherhchunga@yahoo.co.uk

Dr. Vinitha Jithoo (Supervisor)

011 717 4523
vinitha.jithoo@wits.ac.za

Appendix B: Informed Consent Form



School of Human and Community Development

Private Bag 3, Wits 2050,
Johannesburg,
SouthAfrica,

Tel: (011) 717-4500

Title: An investigation into cultural factors associated to mental illnesses and the influence they have on help seeking behaviour.

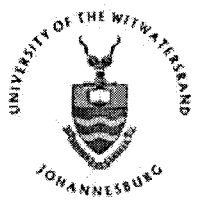
Should you wish to participate in this research; it is necessary that you give your informed consent. By signing this informed consent form, you are indicating that you understand the nature of this research study and you role in this research.

Please consider the following points before signing:

- I understand that I am participating in psychological research.
- Participation in this study is voluntary.
- I may refrain from answering any questions.
- I may withdraw my participation and/or my responses from the study at any time.
- There are no risks or benefits associated with this study.
- I understand that the interviews will be audio recorded.
- I understand that my identity will not be linked with my data, and that all information I provide will remain confidential;
- None of my identifiable information will be included in the research report.
- If I am quoted in the research report, a pseudonym (Participant X, Participant Y etc.) will be used.
- I am aware that results of this study will be reported in the form of a research report and that it may be presented at a conference and published in a journal and/or book.

Signed: _____ Date: _____

Appendix C: Audio Recording Consent Forms



School of Humanand Community Development

Private Bag 3, Wits 2050, Johannesburg,SouthAfrica,

Tel: (011) 717-4500 Fax: (011) 717-4559

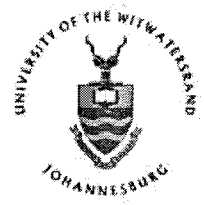
I, _____hereby voluntarily consent to participate in an interview with Esther Chunga for her study, on cultural factors associated to mental illnesses and the influence they have on help seeking behaviour.

- The digital recordings and transcripts will not be seen or heard by any person at any time, except the researcher and the researcher's supervisor
- All digital recordings will be destroyed after the research has been examined.
- No identifying information will be included in the interview transcripts or the research report or subsequent research publications or conference presentations.

Signed: _____

Date: _____

Appendix D: Information sheet for organizational leaders



School of Humanand Community Development

Private Bag 3, Wits 2050,

Johannesburg, SouthAfrica,

Tel: (011) 717-4500 Fax: (011) 717-4559

Good day

My name is Esther Chunga. I am currently pursuing a Master's Degree in Community based Counselling Psychology at the University of the Witwatersrand Johannesburg. As part of my degree, I am required to complete a research project.

I am interested in understanding how mental illness in children is understood from a cultural perspective. How parents or caregivers seek help for their children; the difficulties they may experience in seeking help and the different resources which parents can obtain help from. I am interested in using participants from your organisation in order to obtain my data. Participants will be requested to take part in a semi structured interview that will last approximately 90 minutes in which I will ask them about their understanding of culture and why they use the mental health services that you do. There are no direct benefits for their participation in this study nor is there any foreseen harm should they decide to participate.

Although they will be required to sign a consent form with their details such as their name, none of their responses will be linked to them personally. If you feel you have any concerns regarding the study, or if you require any additional information, please feel free to contact myself or my supervisor telephonically or via email.

Kind regards,

Esther Chunga

0765454138

estherhchunga@yahoo.co.uk

Dr. Vinitha Jithoo (Supervisor)

011 717 4523

vinitha.jithoo@wits.ac.za

Appendix E: Interview Schedule

A. Establish rapport by introducing myself.

B. Inform participants of the purpose of the study as well as go through the information and consent from with the participant.

C. Inform participant of the anticipated length of the interview.

Obtain biographical information

- Age of child
- Ages of parents
- Family composition
- Linguistic group
- Cultural affiliations

D. Present vignette

Questions:

1. What did you understand from what I read to you?
2. What do you understand about mental health and mental illness?
3. If that was your child, how would you understand your child's mental health needs?
4. What do you think would cause these problems?
5. How would you cope with these problems?
6. How do you understand these problems within your cultural beliefs?
7. What types of treatment would you seek?
8. What are some of the difficulties you think you would experience if you had to seek help for your children's problems?
9. How do you think your family and friends would treat you if your child was diagnosed with such a problem?

Appendix F: Vignette

School of Human and Community Development

Private Bag 3, Wits 2050,
Johannesburg,
SouthAfrica,

Tel: (011) 717-4500

Sipho is a ten year old boy who is in grade 4. For the past few months he has been very sad and unhappy, often feeling as though he can do nothing right. Sipho used to be a playful, fun loving boy who loved to spend time with his friends playing football in the fields. Lately however, Sipho prefers to spend his time alone, walking straight home from school and spending all his time locked up in the one room. Sipho's mother reported that she often hears him crying at night. Sipho also doesn't seem to have much energy and is always tired but still finds it hard to sleep, often lying awake for hours and then struggling to get out of bed in the morning. Sipho used to enjoy his food, but now either refuses to eat or eats very little when forced to. Lately Sipho's teacher has reported that he has been struggling to concentrate in class and has been having difficulty coping with his school work, often not completing his homework. He has not been helping with the chores at home. His school teachers are concerned as they are struggling to make sense of why he is failing, and his parents are also struggling to understand these changes in him.