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OUTSIDE THE CUCKOO'S NEST: INVESTIGATING THE REASONS BEHIND AFRICAN MALE ENGINEERING STUDENTS' UNDER-UTILIZATION OF MENTAL HEALTH SERVICES

BY

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A thesis submitted in partial fulfilment of the requirements for the degree of

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DECLARATION OF ORIGINALITY

"A research thesis submitted in partial fulfillment of the requirements for the degree of MA Research Psychology in the Faculty of Humanities, University of the Witwatersrand, 30th April 2010".

"I declare that this thesis is my own unaided work. It has not been submitted before for any degree or examination at this or any other university".

……. 30th April 2010

ABSTRACT

It has been found that the under-utilization of mental health services in South Africa is particularly concentrated among young, African males. This population group is also significantly at risk for suicide due to their exposure to stressors said to be related to the development of psychological disorder. Therefore, exploration into their reason(s) for this under-utilization, as well as the identification of their preferred alternate treatments and/or coping mechanisms, is crucial for future efforts to improve mental health care in South Africa. This study thus endeavoured to investigate these issues among a group of young, African males.

The sample comprised eight African males between the ages of 18 to 21 years of age. The participants were first year Engineering students at the University of the Witwatersrand. Individual interviews were conducted with each participant according to a semi-structured interview schedule which was developed and piloted by the researcher. A thematic content analysis was employed to uncover these reasons, alternate treatments and coping mechanisms.

The results illustrate that the alleged barriers to seeking professional psychological treatment in South Africa for young, African males include strong beliefs in an African cultural ideology; beliefs supporting hegemonic male gender roles; the accumulative beliefs of an African male gender role; mental illness stigma; negative indirect contact via stigmatising media representations of mental illness; and the difficulty discerning between normal distress and abnormal psychological disorders. There also emerged discrepancies between the help-seeking pathways the participants would recommend for themselves and those that they would suggest for other people. Furthermore, the participants provided examples of alternate treatments which are used more often and are more preferable as modes of treatment for African males. However, the limited number of alternate treatments and the excessive reliance on negative coping mechanisms highlight the importance of the greater need for appropriate, relevant mental health services for young, African males in this country.

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Mmmm..no, except for just to like tell people to actually take psychological uh, problems very serious. They should take them very serious because uh, it's not just uh, a small thing. It's much bigger than the, the uncurable disease like AIDS. The reason people die of AIDS it's because of psychological problems. They think too much and it like, it actually affects their minds more than the sickness itself. So, psychological problems are much more..**dangerous** than any other thing.

(Thabang)

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CHAPTER ONE
INTRODUCTION

The primary aim of the research was to explore the reasons for the under-utilization of mental health services by many young, African[1] male citizens. It hoped to gain an understanding of why members of a population which is significantly at risk for the development of psychological disorders, often do not voluntarily seek formal psychological treatment. In so doing, this research aimed to highlight an often neglected area of mental health research and draw attention to the psychological plight and treatment of young African male adults in this country. In addition, it aspired to uncover the reason(s) behind this lack of treatment seeking so as to contribute to a greater knowledge base which is aimed at developing and refining "an anti-racist Psychology" and psychological practices within South Africa (Littlewood & Lipsedge, 1997, as cited in Swartz, 1998, p.21). This corresponds with recent demands for the transformation of Psychology to incorporate and utilize cultural beliefs and practices in order to become more relevant to the majority of South African citizens (Kohn, Szabo, Gordon & Allwood, 2004; Leach, Ackhurst & Basson, 2003). Thus, the research endeavoured to contribute to mental health research and mental health policy formation in South Africa so as to increase access to and utility of mental health services.

The ubiquitous nature of mental illness is identifiable throughout history and across a variety of social, economic and geographical contexts. The current climate in South Africa is particularly conducive to the development of mental illness and thus access to and utilization of psychological treatments is essential. Although mental health is attributed limited importance in South Africa (similar to global trends), as reflected in the paucity of mental health professionals in rural areas and the minimal cover by medical aids, the facilities and services available (including those of a gratuitous nature) remain significantly under-utilized (Lund & Flisher, 2006; Oosthuizen, Scholtz, Hugo, Richards & Emsley, 2007). While this

[1]The researcher has chosen to employ the term 'African' in this research study so as to refer to a particular ethnic and cultural group. This is in accordance with the South African government's choice of population names (Statistics South Africa, 2007). She acknowledges the discriminatory and racist connotations that are associated with focusing research upon a single group based on gender, race and affiliated culture, and understands that these connotations are further exacerbated in South African discourse due to the country's political history. However, as many authors have argued, racial categories continue to influence and govern social organisation within many spheres of South African life and cultural, political and economic trajectories continue to exist along racial demographics (Bowman, Seedat, Duncan & Burrows, 2006). Furthermore, investigations into mental health treatment have looked at consumers along racial and gender lines (Kohn et al., 2004; Leach et al., 2003; Trump & Hugo, 2006) and as such this research employed a similar approach. However, this term was flexible to the participants' own expressed sense of identity. For a greater discussion of this choice please see Section 2.2.

under-utilization of mental health services has been observed in almost all international populations (MacKenzie, Knox, Gekowski & Macaulay, 2004), South African studies have found it to be particularly concentrated among young, African males (Kohn et al., 2004; Leach et al., 2003; Trump & Hugo, 2006). Similar trends have been found in international research whereby males, particularly young adult males, utilize mental health services far less than their female counterparts (Good & Wood, 1995; McCarthy & Holliday, 2004). Furthermore, it has also been shown that members of the African racial group are particularly cautious in accessing mental health services (Schnittker, Freese & Powell, 2000).

This knowledge is especially important when contrasted with recent statistics which indicate that young African males have one of the highest suicide rates in South Africa (Burrows, 2005). Significantly, almost half of all completed suicides in South Africa are committed by African males (Meehan & Broom, 2007) within the 15 to 24 year age group (Burrows, 2005). When this is viewed in conjunction with the current overall suicide rate, which reflects almost 8000 deaths a year, this lack of formal treatment seeking presents a worrying concern (Pauw, 2008). Moreover, the paucity of studies into the prevalence of young, African males as mental health consumers or on their perceptions of Psychology and psychological treatment, further emphasises the importance of investigations into this area. Therefore, it was imperative for the mental health status of the country, as African males comprise the second largest population group in South Africa (Statistics South Africa, 2007), to investigate the reason(s) behind this avoidance.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

The terms 'mental illness' and 'psychological disorder' are used interchangeably in this research study and refer to a non-specific psychological problem which has negative and potentially harmful effects upon a person's behaviours, thoughts and emotions (American Psychiatric Association, 2000). The justification for this wide description of mental illness coincided with the study's broad view of psychological treatment. The current research focused on mental health care seeking in relation to medically sanctioned, regulated and legislated health professionals such as psychologists, psychiatrists, counsellors, social workers and general practitioners. In addition, the research investigated voluntary mental health care seeking and thus did not explore aspects related to forced psychological treatment or institutionalisation.

2.2 African Males: Race, Gender, Ethnicity and Culture

As previously explained, the literature on the utilization of mental health services in South Africa has focused on identifying the gender and racial characteristics of mental health consumers (Kohn et al., 2004; Leach et al., 2003; Trump & Hugo, 2006). While the delineation of groups according to their particular racial and gender classifications may seem contrary to the democratic principles entrenched in post-Apartheid laws and practices, it is supported by two different strands of reasoning. The first relates to the continuing self-categorisation with racial identities in South Africa (Grossberg, Struwig & Pillay, 2006). After decades of legally enforced racial classification, it is hardly unexpected that South Africans continue to identify themselves with their racial (and hence physical) characteristics a mere 16 years since the advent of democracy. Race has remained a significant determinant in the formation of South African identities (Grossberg et al., 2006) and has also been found to be particularly important for the majority of members of the African racial group's sense of self (Roefs, 2006). However, it is important to note that South Africans' racial identifications, similar to international findings (Howard-Hamilton & Frazier, 2005), correspond to ethnic and cultural identities and associated ideologies (Grossberg et al., 2006), and these relationships will be discussed further on in this section. In addition, gender has also been found to be one of the central identifying factors for South Africans, with associated socialised

gender roles contributing to the construction of identity, worldviews and resultant beliefs and behaviours (Grossberg et al., 2006). Furthermore, it has been argued that a coterminous relationship exists between gender and race with the identification that both African racial classification and male gender roles contribute to African males' identity and associated ideologies (Morell, 2007). Therefore, the continued identification with race and gender among South Africans provides the impetus for research into how these identities influence beliefs and behaviours including the use of mental health services.

The second rationale for focusing on particular racial and gender groups relates to the fact that while post-Apartheid South Africa is committed to improving the lives of those disadvantaged by the Apartheid regime, the only means to effectively do so is to identify the disadvantaged by the very characteristics for which they were discriminated against – therefore, by their racial group (Zegeye, 2001). Consequently, in order to improve the mental health of those affected by and prevented from receiving adequate mental health care during Apartheid, it is necessary for research into this area to identify the previously prohibited by the racial characteristics which prohibited them. This approach is justifiable when research or policies are aimed at improving or promoting development among the targeted group. As Gibson, Swartz and Sandenberg (2002, p. 83) explain, "recognising the possibility of difference is not the same as using difference as a weapon against people". As such, the transformation of Psychology to include cultural practices can only be achieved by first understanding the use of, and rationale, for such practices (Berg, 2003). Therefore, this foundation for the identification of groups by racial and gender characteristics further provides evidence for the use of such identification and focus in the current study.

As previously described, race, ethnicity and culture intertwine in a complex relationship influencing the construction of identity and resultant beliefs and behaviours. *Race* in South Africa is both a physical and social construct encompassing the physical and biological differences between people, as well as the social differences which developed from separating people into biologically determined categories (Zegeye, 2001). The social differences between racial groups primarily consist of cultural and traditional beliefs and customs, or what can be referred to as a '*cultural ideology'* (Howard-Hamilton & Frazier, 2005). Cultural ideologies (as with all other ideologies) are worldviews which determine a person's beliefs, behaviours and practices (Long & Zietkiewicz, 2002). Moreover, *ethnicity* consists of this cultural ideology (which relates to race) as well as geographic locations and languages, which can also influence and shape cultural ideologies (Howard-Hamilton & Frazier, 2005). Therefore, while this

research identified African males as its focus according to racial categorisations, these racial identities are also hypothesised to include cultural ideologies and to be related to a larger ethnic identity.

2.3 Psychology

Corresponding with the research objective of formal psychological treatment, the general consensus among health authorities is that professional psychological treatments offer the most potential for recovery from mental illness (Lauber, Nordt & Rössler, 2005). This is further evidenced in research findings validating the efficacy of psychological treatment on the reduction of psychological and traumatic distress (Gavrilovic, Schützwahl, Fazel & Priebe, 2005). It is important to note that these validated treatments have a fundamentally westernised and modern basis as they focus on the individual's experience and rely on the individual client's desire for self preservation and protection in order to facilitate change (Bodibe, 1992).

However, despite its popularity and continual development within the psychological community, psychological treatment as well as its foundation, the belief in the very existence of psychological disorders, has been widely criticised and debated. The bases for these critiques are quite varied in nature, of which two are briefly discussed. Kutchins and Kirk (1997, p. 238) suggest that the authors of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or the "psychiatric bible" as they refer to it, are figures of monumental social control and power. These authors argue that the notion of a 'psychological disorder' is an abstract construct that, through its inability to be defined, allows for the pathologising of previously normal, albeit undesirable behavior, as demonstrated through the increasing expansion of the number of diagnosable disorders through each consecutive edition of the DSM (Kirk & Kutchins, 1992; Kutchins & Kirk, 1997). In contrast, Michel Foucault (1967, as cited in Long & Zietkiewicz, 2002) argued that the definition and scope of mental illness is promulgated by the powerful and knowledgeable in society, who sustain this power through their monopolisation of psychological knowledge and discourse. Nevertheless, while the researcher acknowledges the existence of, and arguments supporting, these criticisms, it is hoped that research demonstrating evidence for the value of psychological treatment (Gavrilovic et al., 2005), as well as the open acknowledgement of her standpoint, allows the researcher to position the research within a westernised view of Psychology whereby psychological treatment and actively seeking such treatment personifies good mental health.

2.4 Psychological Disorder in South Africa

South African citizens are faced with a plethora of psychologically distressing problems and, as a result, many people develop mental health problems. Stein et al. (2007) identified that approximately 17 percent of the entire South African population develop psychological disorders. The repercussions of such are manifested in the finding that during the same period, psychological disorder was the third largest contributor to the South African global burden of disease (Stein et al., 2007). Moreover, the most commonly experienced psychological disorders in South Africa have been found to be anxiety, substance abuse and mood disorders (Stein et al., 2008; Trump & Hugo, 2006). As young, African males have one of the highest suicide rates in the country, and are also the social grouping least likely to seek psychological treatment, it was subsequently imperative to identify the various mental health risk factors that young African males face in this country and how these can and do lead to mental health problems requiring professional treatment.

As such, it was important to first look at the general risk factors for psychological disorders and then investigate their prevalence within the socio-cultural milieu in which young, African males living in urban cities locate themselves. Life stressors or events which have been found to be related to the development of psychological disorder in South Africa include role and identity confusion; financial and economic upheavals and losses; exposure to crime, illness or injury; a lack of social support (Myer, Stein, Grimsrud, Seedat & Williams, 2008); and constant academic pressure and related anxieties and feelings of inadequacy (Sennett, Finchilescu, Gibson & Strauss, 2003).

When examining the presence or absence of these risk factors within young African males' lives, it is easy to empathise with the significant stress that is imposed upon them due to their evolving role status within society (Stevens & Lockhat, 1997). The significant changes within the country over the last fifteen years have coincided with an exponential increase in suicide by young African males (Burrows & Laflamme, 2006). These changes have left many African males in their late teens and early twenties finding themselves uncertain of their roles in society, which are now far removed from the political and vigilante roles which their parents most likely played during their own youth (Pattman, 2007; Stevens & Lockhat, 1997). They are also exposed to increasing tensions between the traditional African cultural ways of living adopted by their elders, and their own increasing acculturation into more westernised ideologies (Burrows, 2005). When this is combined with the increase in mental health burdens associated with living in an urban city such as Johannesburg, it appears that young African males are

dangerously exposed to the development of psychological distress or burnout (Burrows & Laflamme, 2006).

Another risk factor is unemployment and because both males and African persons experience the highest rate of unemployment in South Africa, the result is that almost forty percent of African males are without permanent and steady employment (Altman, 2005). As the participants in this study were university students in the lucrative and highly sought after field of Engineering, it may seem easy to assume that they will not personally have to face unemployment. However, the existence of university loans and bursaries with the associated stress of impending financial burden can lead to psychological distress.

Young, African males also fall prey to the third risk factor of crime and violence. The victims of crime in South Africa tend to be young and between the ages of 15 and 45 years (Stevens, Seedat, Swart & van der Walt, 2003). Furthermore, young African males tend to be the targets of violent and serious crimes such as murder (Smith, 2001). Participants in this research study reside in Johannesburg and as a result of the dangerously high crime rate in this city (The South African Police Service, 2008) they are significantly more at risk of being targeted by criminals. Therefore, constant fear about crime, as well as the loss of family members or friends to crime (loss of social support) may be burdensome upon emotional and mental health and thus psychological disorders may develop.

The last risk factor included in this study, and one which is particularly relevant to the context of the study, relates to the stress and constant pressure that is characteristic of university life. Sennett et al. (2003) explain that although all university students experience this stress and study-related anxiety, their research found that students in their first year of study were more likely to be negatively affected by this pressure and to experience greater adjustment problems. Furthermore, their findings indicated that African students experienced these pressures more acutely and that this was often exacerbated by living problems such as transport, housing and distance from university difficulties (Sennett et al., 2003).

2.5 General Barriers to Seeking Psychological Treatment

While the identification and recognition of the risk factors for psychological disorders in young, African males was necessary and important, it was subsequently imperative to investigate some of the reasons which have previously been put forth so as to explain the utilization or under-utilization of mental health

services by South African citizens. This is because while young, African males have been found to be the least likely population group to access mental health services in South Africa, the lack of professional psychological treatment seeking has been observed in all population groups in the country (Trump & Hugo, 2006). Therefore, while the under-utilization by young, African males may be primarily caused by barriers specific to this population, they may similarly be affected by barriers common to the majority of South Africa citizens. Such a finding would confirm the pervasive nature of such barriers and the importance of targeting them to transform and promote the development of Psychology in South Africa.

Significantly, a previous South African study found that within their sample, approximately 80 percent of all persons had delayed seeking professional psychological treatment for a psychological disorder. The primary reasons for this under-utilization have been the fact that mental health services are predominantly located in urban settings, which perpetuates the perception of the inaccessibility of psychological treatment (Kohn et al., 2004), and the overwhelming ignorance of Psychology among the lay public (Swartz & MacGregor, 2002; Trump & Hugo, 2006). For example, many people do not seek professional psychological treatment because they are uncertain as to whether their 'problem' actually constitutes a disorder requiring professional treatment (Trump & Hugo, 2006), or despite acknowledgment of the need for treatment, they do not know where they can access and receive such treatment (Hugo, Boshoff, Traut, Zungu-Dirwayi & Stein, 2003; Leach et al., 2003; Swartz & MacGregor, 2002; Trump & Hugo, 2006). However, a recent study by the researcher also investigating first year Engineering (and Law) students, found that the majority of participants displayed good mental health literacy and that no differences in this literacy were found between racial and gender groups (Samouilhan & Seabi, 2010). Moreover, despite the majority of participants indicating that professional psychological treatments were the best treatments for psychological disorders, they displayed ambivalence towards seeking such treatment themselves thus illustrating a bias in recommended help-seeking pathways (Samouilhan & Seabi, 2010). Therefore, it may be expected that the above general barriers contribute to the current status of young, African males not seeking professional psychological treatment. However, the literature further revealed the existence of barriers exclusive to African males and which demanded an intensive focus in the study.

2.6 Barriers to Seeking Treatment for young, African Males

As explained, it has been found that there are specific barriers to seeking professional psychological treatments which are exclusive to African males. These are presented below.

2.6.1 Elitist nature of mental health care

Mental health care and health care in general, was historically a benefit of those who were advantaged by the Apartheid regime and thus, the African population was prohibited from receiving such help in South Africa (Stevens & Lockhat, 1997). Furthermore, the field of Psychology was seen as a contributor to Apartheid in both its open support, through the development and promotion of psychological testing to validate the Government's claims for separate development, as well as indirectly through its failure to reject Apartheid exclusionary laws (Leach et al., 2003). Therefore, many African persons may choose to reject the system they continue to perceive as racist (Leach et al., 2003). This is aggravated by the fact that the reformation of Psychology has scarcely changed since the termination of Apartheid as very few trained African mental health professionals are available in the country (Pillay & Siyothula, 2008). In addition, Africans are now excluded from the majority of available mental health services through language discrepancies (Pillay & Siyothula, 2008) and the primarily urban locations of such facilities (Kohn et al., 2004). Nevertheless, this barrier did not represent the primary focus of the study as the participants were students at the University of the Witwatersrand, at which there are two mental health service facilities located on campus which offer their services at minimal cost to students. However, questions were posed to participants as to their awareness of these services. Therefore, the primary barriers to treatment for young, African males which were unearthed in the literature and which formed the focus of this investigation were stigma, contact, cultural beliefs and masculinity and these are further discussed below.

2.6.2 Stigma

A common theme within mental health service research relates to the significant influence of stigmatising attitudes towards mental illness and its treatment. Although its power is often dismissed by mental health professionals and the public alike, stigma towards mental illness and people with mental illness continues to increase despite substantial gains in the availability of mental health treatment (Day, Edgren & Eshleman, 2007). Stigma is so pervasive that in 1999 the Surgeon General of the United

States declared that it is one of the most significant barriers to accessing psychological treatment (Couture & Penn, 2003). Furthermore, while stigma is associated with numerous disease conditions, the stigma associated with mental illness is particularly degrading and enduring (Quinn, 2006). In South Africa, a recent study found that almost half of the participants had delayed seeking psychological treatment for more than two years and over thirty percent for more than five years due to the influence of stigma (Trump & Hugo, 2006). This illustrates the enormity of the effect of stigma on the potential utilization of mental health services in South Africa.

Stigma is also more often cited as a barrier to seeking mental health treatment for men than it is for women (Björkman, Angelman & Jönson, 2008; Golberstein, Eisenberg & Gollust, 2008). It has also been found to be particularly heightened among African persons (Maphosa, 2003). An illustrated example of this is given (Maphosa, 2003, p. 69) whereby one of the participants in that study stated that, "Blacks (*sic*) don't go to psychologists…you are crazy when you go there". This stigma is aggravated when it is an African male seeking treatment as it is viewed as a weakness and is shameful to the community (Maphosa, 2003). Therefore, stigma alone consists of a barrier to seeking treatment and combined with the experience of being both male and African may present an insurmountable obstacle to seeking mental health treatment.

Stigma as a construct includes a number of dimensions namely concealability, course, disruptiveness, aesthetic qualities, origin and peril (Jones et al., 1984). The concealability of the disorder relates to its visibility to the general public where the level of stigma increases with the disorder's visibility (Quinn, 2006). Psychological disorders range from both concealable to conspicuous and, thus, the level of stigma associated with mental illness differs according to the type of disorder (Quinn, 2006). The course of the disorder consists of the perceptions of the professional efficacy of the agents of psychological treatment as well as whether the disorder is viewed as treatable and recoverable (Day et al., 2007). The third dimension, the disruptiveness of the disorder, relates to whether the disorder is perceived as a hindrance to interpersonal relationships and the communication therein (Jones et al. 1984). The independence of this dimension has previously been questioned as it has more often been found to co-exist with other dimensions than to stand as a solitary mark of stigma (Jones et al., 1984). The dimension of the aesthetic of mental illness relates to how stigma increases according to the unpleasantness of the disorder's aesthetic handicap (Jones et al., 1984). People with psychological disorders are frequently perceived as unhygienic and lazy and, hence, aesthetically unpleasing (Day et al., 2007). The fifth dimension of origin constitutes the etiology or cause of the disorder and as such,

mental disorders thought to be caused by the disordered individual him/herself are exceptionally stigmatised (Jones et al., 1984). The final dimension of peril is one of the most cited and researched dimensions of mental illness stigma. It relates to whether the person with a psychological disorder is perceived as dangerous to either oneself or more specifically, to others (Jones et al., 1984). Despite little evidence to support the perception of peril (Minnebo & Van Acker, 2004) this image of the dangerous psychologically-disordered has gained impetus in recent years due to the unnecessarily negative and violent portrayals of mental illness in the media (Lund et al., 2008).

Therefore, while these dimensions of stigma provide a theoretical understanding, it was essential to also examine the various ways in which stigma can be manifested. These manifestations include limited mental health literacy, such as ignorance towards the causes, treatments and types of mental illness; and negative attitudes and behaviours towards people with mental illness (Tsao, Tummala & Roberts, 2008). Mental health literacy consists of all knowledge of mental illnesses which promote their prevention and treatment such as the ability to identify mental illness, knowledge regarding their etiology, expression and treatment, as well as familiarity with how to access mental health services (Lauber, Nordt, Falcato & Rössler, 2003).

The other most commonly cited expression of stigma is that of negative attitudes towards mental illness and people with mental illness. Psychologically-disordered people are often referred to with derogatory and offensive labels, such as ‘crazy’, ‘mad’, and ‘insane’ (Brown & Bradley, 2002). Furthermore, one of the consequences of mental illness stigma, and also one of the barriers to treatment, is the desire for decreased contact with the disordered individual (Angermeyer & Dietrich, 2006). This is because it affects how people with mental illness are related to and treated, with this disdainful treatment often resulting in the loss of friendships and/or familial support, isolation and marginalisation (World Health Organization, 2003). This invariably leads to a lack of contact (direct or otherwise) with psychological disorders and psychological treatment.

2.6.3 Contact

Following Allport’s (1954) influential contact hypothesis in which he demonstrated how contact with a prejudiced group can reduce one’s own prejudicial and discriminatory beliefs towards members of that group, mental health providers have often used contact in anti-stigma and mental health campaigns (Corrigan, Larson, Sells, Niessen & Watson, 2007; Couture & Penn, 2003). This has given rise to a

number of research studies which have found that people who have had positive prior experience with mental illness and/or people with mental illness are more likely to seek mental health treatment in the future and have less stigmatising attitudes towards mental illness (Vogel, Wade, Wester, Larson & Hackler, 2007).

Moreover, evidence exists that many African persons' decisions to seek or not to seek mental health treatment is similarly affected by such contact. For example, a recent study showed that African persons who had had previous contact with formal psychological treatment, or witnessed mental illness being treated in such a way, were more likely to seek formal treatment for themselves (Maphosa, 2003). However, despite stigma and contact having been identified as important constructs in many African males' decisions regarding seeking formal psychological treatment, it was also important to investigate the social and ideological belief systems which may likely shape and guide their general attitudes, beliefs and behaviours. It thus became important to include African culture, hegemonic male gender roles and African male beliefs in the research study.

2.6.4 An African cultural ideology

Culture can be broadly defined as "the values, beliefs and practices that pertain to a given ethnocultural group" (Betancourt & Lopez, 1993, as cited in Lopez & Guarnaccia, 2000, p. 573). Culture is such a powerful predictor of attitudes and behaviour that its potency has been described by Swartz (1998, p. 5) as such that "no human activity is free from cultural influence". Therefore, culture invariably determines the manifestations of psychological disorders as well as whether certain problems will be perceived as diagnosable disorders in a particular culture (Fernando, 1988). Consequently, treatment seeking for mental health problems and beliefs about this treatment are also influenced by one's cultural beliefs and practices.

It is necessary to note that African culture is not homogeneous in nature. Nevertheless, there remain a significant number of commonalities that tie the different tribal ideologies together such that it is broadly referred to as one overarching culture. Therefore, it was conceptualised as such within the current research study.

Despite South Africa's increasing westernisation and participation in global modernisation, many African people continue to rely on traditional African cultural beliefs in order to make sense of their

worlds (Lebakeng, Sedumedi & Eagle, 2002). The cornerstone of African culture is that God created the universe and that all things in this universe, whether animate or inanimate, human or non-human, are interconnected through mutually influential relationships (Mkhize, 2004). The universe is organised in a hierarchical manner where God is seated at the top and is succeeded by spirits or ancestors who are biological family members and/or respected members of the community who have since passed away and now occupy a protective position over living souls (Mbiti, 1990). Human beings are situated below the spirits and ancestors and they are themselves succeeded by animals and plants with inanimate objects stationed at the bottom of the hierarchy (Mbiti, 1990). Within the human level of the hierarchy are additional rankings insofar as the oldest members of the community receive the greatest respect and reverence, followed by the male members and thereafter by women and children (Loveday, 2001). Men in the African culture are seen as the virile and strong members of the community and, thus, have a greater investment in being seen as healthy and well functioning (Hoosen & Collins, 2004). In an aside, while it is evident that African culture encompasses both religious and spiritual beliefs, its emphasis on the spiritual and supernatural has eclipsed its religious values resulting in religion and African culture no longer being perceived as one overarching ideology (Mbiti, 1990). Therefore, while African culture continues to include religious beliefs, particularly Christianity, religious and African cultural ideologies were not taken as equivalent in this research study (Bourdillon, 1993).

Accordingly, health problems and psychological disorders are viewed within African culture as a sign of witchcraft, a result of the person's inability to form close, meaningful and mutually encouraging relationships with other community members, or the ancestors' removal of their protection over the afflicted person (Loveday, 2001). Hence, culturally-sanctioned treatments are aimed at the above etiological factors. Treatment within the African culture is most often conducted by a traditional or indigenous healer who identifies the etiology of the illness, conducts the treatment procedure and then administers additional help in the form of protection against future related ailments (Bodibe, 1992; Mbiti, 1990; Truter, 2007).

The above description of African culture may explain why many African persons often do not seek formal psychological treatment as perhaps they seek treatment from more traditional or indigenous healers. It could also be that despite having knowledge about formal psychological treatments, their strong beliefs in more traditional healing practices lead to their absence in mental health services. Furthermore, it has been found that many African persons view Psychology as irrelevant to how the African culture treats illness and thus it is perceived as an impractical method of treatment (Leach et al.,

2003). Therefore, cultural beliefs and practices could present as significant barriers to seeking formal mental health treatment. Thus, this important issue of culture was further explored within the interviews with the participants.

2.6.5 Hegemonic Male Gender Role(s)

Numerous research studies have revealed that men seek health treatment consistently less than their female counterparts and that this avoidance is particularly exacerbated in the context of psychological help (Addis & Mahalik, 2009; Levant, Wimer, Williams, Smalley & Noronha, 2009). One of the explanations for this lack of treatment seeking is that the nature of psychological treatment, that of becoming vulnerable and open to expressing one's emotions, is contradictory to the very core of masculinity (McCarthy & Holliday, 2004; Pollack, 1998). Although there are different versions and theories of masculinity, Connell (1995) explains that there exists a dominant form of masculinity called hegemonic masculinity which dictates how 'masculinity' should be performed. Accordingly, being a genuine man consists of prescribed behaviours that men must perform. Furthermore, it is also important to note that while very few men truly and holistically adopt a hegemonic masculinity, all men construct their own masculine identities in relation to it, for example, with beliefs and behaviours that both support and contradict this hegemonic version (Bhana, 2005).

The definition(s) and role(s) of masculinity have been, and continue to be, greatly contested within the literature. Nonetheless, it has been tentatively agreed upon that hegemonic norms for masculinity are universal and exist, in some form or another, in all cultures and locations (Luyt, 2005). The differences between males in various historical and socio-cultural milieus thus emerge in their performed endorsement or rejection of hegemonic masculinity norms (Luyt, 2005). Furthermore, while there are innumerous theories conceptualising the various norms that characterise masculinity, previous research has indicated the relevance of role type theories in the construction of South African masculinities (Davies, 2007; Luyt, 2003). One such role type theory which emerged in a previous Masters degree also utilizing university students (Davies, 2007), as well as loosely formulated in the development of a psychometric test assessing masculinity (Luyt, 2003), was the male gender role theory first described by David and Brannon (1976). Consequently, this theory is used in this study to contextualise and interpret the role of 'masculinity' as a barrier for African men seeking psychological treatment in South Africa.

David and Brannon (1976) differentiated four typologies of male gender role behaviour which are said to be representative of hegemonic masculinity. These four typologies of masculinity include: no sissy stuff, the big wheel, the sturdy oak and give 'em hell (David & Brannon, 1976). A *no sissy stuff* gender role manifests as preventing males from expressing any form of emotion said to be feminine in nature such as sadness or anxiety (Pollack, 1998). This typology represents the rejection of all feminine behaviours and emotions (Solomon, 1982) and is instilled in men from childhood (Pollack, 1998). The second typology, *the big wheel*, is manifested through the power, dominant status and success that men seek to achieve throughout their lives and is typified by the patriarchal promotion of male breadwinners (Solomon, 1982). *The sturdy oak* typology of the male gender role concerns the belief that men should be independent and autonomous and never reveal their weaknesses (Pollack, 1998). As its metaphorical title explains, men should never falter or waver regardless of the problems they may face (Solomon, 1982). The final typology of *give 'em hell* is epitomised through the conviction in male invulnerability, commonly expressed through aggression, violence and risky behaviours (Solomon, 1982). It further symbolises the expression of the 'devil may care' attitude to life.

These typologies of the male gender role have been previously found to present as barriers for males seeking professional psychological treatment. The *no sissy stuff* gender role has been shown to prevent treatment through males' unwillingness to freely express their emotions in a therapeutic environment (Addis & Mahalik, 2009). *The big wheel* gender role has been illustrated in a previous study which found that many men refuse to seek treatment as they fear being judged by others as incompetent and hence, lose their power status (Addis & Mahalik, 2009). Recent research (Phelan & Basow, 2007) found that men are prevented from seeking mental health treatment by their overwhelming desire to remain independent and self reliant according to *the sturdy oak* typology. In addition, the *give 'em hell* typology can be said to prevent treatment seeking through its emphasis on risk taking and associated denial of the necessity of treatment.

Therefore, while masculinity and African culture have been illustrated to independently prevent mental health care seeking, these identities cannot be completely separated and isolated in African males. Therefore, the accumulative barrier of being both male and African required further investigation and inclusion in the study.

2.6.6 An African male identity

The evolution of African masculinity is significant in the context of the country's Apartheid history (Morell, 2001). African men were overwhelmingly excluded from power and independence, which was said to have led to the 'emasculation' of African men (Morell, 2001). Significantly, this emasculation was typified through the widespread practice of referring to African men as 'boys,' thus reinforcing the belief that they had yet to achieve manhood, the denial of which would be legally enforced until the end of Apartheid (Morell, 1998). After the advent of democracy African men were finally allowed to fully embrace and exhibit hegemonic male gender roles (Morell, 2001). This 'new' adoption and over-assertion of strong hegemonic male gender roles could explain why many African men do not seek psychological help as it violates the principles of their new identity. Furthermore, hegemonic male gender roles are emphasised in African culture through its perpetuation of patriarchal traditions and beliefs (Ampofo & Boateng, 2007). Therefore, African masculinity and its associated assumptions potentially prevent professional psychological treatment utilization by young African males in South Africa, and thus its influence was explored in the interviews with the participants.

In summation, it appears that there are a number of potential barriers to seeking treatment for young, African males in South Africa, both generalised and specific to this population group. Taking into consideration these barriers, as well as the potential stressors and risk factors for psychological disorders, this study adopted a multi-theory approach to its investigation into the under-utilization of mental health services by this population. These two theories were: the Theory of Planned Behaviour and Cognitive Dissonance Theory.

2.7 Theoretical Basis

2.7.1 Theory of Planned Behaviour

The Theory of Planned Behaviour has consistently been employed to explain health seeking behaviours within the research literature and has in fact been the dominant theory within health behavioural research (MacKenzie et al., 2004). The theory was developed in 1985 by Azjen and Fishbein (Azjen, 1991) and focuses on predicting human behaviour. The Theory of Planned Behaviour states that health seeking behaviours are the result of intentions to behave, which are in turn informed by the attitude towards the behaviour (such as beliefs about the outcomes of the behaviour), subjective norms (social

pressure or support towards the behaviour) and perceived behavioural control (Azjen, 1991). Thus, if we employ this theory to show why many people voluntarily access psychological services, we could say that seeking psychological help has become more acceptable, and in certain circles more 'fashionable', and this subjective norm could lead to the person seeking help. A positive attitude regarding Psychology and psychological services could also cement the intention to seek help. Finally, anti-stigma campaigns often depict a person who has recovered from mental illness due to formal psychological treatment and this may enhance a person's perceived control over the mental illness and thus, increase their intention to seek recourse from a mental health professional (Corrigan et al., 2007). The Theory of Planned Behaviour has further been shown to be successful in the prediction of smoking cessation, intention to use vitamin supplements, adopting a healthier diet plan and complying with general safety and health regulations (Rutter & Quine, 2002).

The Theory of Planned Behaviour (TPB) can also be applied to the above noted barriers and these barriers can have an impact on treatment seeking both individually and collectively. For example, an African cultural ideology may hold the belief that a person's depression is the result of ancestral discord and, thus, this will result in a behavioural intention to seek traditional or indigenous help rather than formal psychological treatment. In addition, stigma towards mental illness treatment constitutes social pressure to avoid formal treatment and thus this subjective norm influences the intention to seek treatment. Alternatively, an investment in a strong hegemonic masculine identity consists of social pressure to avoid and/or deny the need for psychological treatment. Finally, contact with a person in mental health treatment can increase perceived behavioural control by demonstrating that mental health can be controlled and this also influences intention to seek treatment. However, these factors can also collectively form the intention to seek/or not to seek treatment through their impact on attitude, subjective norms and behavioural control. Thus, the Theory of Planned Behaviour was employed in this study to try to explain the under-utilization of mental health services by young, African males. However, a noteworthy finding relating to treatment seeking is that while a person may acknowledge and even encourage another person to seek treatment, they do not always apply the same principles and beliefs to themselves (Taylor & Brown, 1988). This points to a self/other division in that treatment is perceived to be beneficial to someone else but the person does not recognise or accept that it may be necessary for them as well (Samouilhan & Seabi, 2010). Therefore, the study utilized an additional theory to underscore the exploration of this phenomenon. This theory was the Cognitive Dissonance Theory.

2.7.2 Cognitive Dissonance Theory: Self/Other Dichotomy

The theory of Cognitive Dissonance states that people strive towards inner congruence or a balance within their cognitions (Foster, 2000). When a person contains contrasting beliefs about a self-defining behaviour, he/she will experience cognitive dissonance and so in order to regain an equilibrium he/she will change the weaker belief or the behaviour (Foster, 2000). When we apply this theory to mental health treatment, it is possible that if a person believes that psychological disorders warrant formal treatment and yet they fear stigma with regards to seeking treatment themselves, then they may avoid accessing treatment altogether so as to maintain their self concept as a well-adjusted person. However, if the behaviour relates to someone else seeking treatment, then the person's incongruent beliefs can remain incongruent as he/she does not experience cognitive dissonance due to the fact that he/she does not need to choose between the beliefs. Therefore, this salient aspect of mental health treatment was important for this research study.

Therefore, the Theory of Planned Behaviour and Cognitive Dissonance Theory were collectively employed in the study in order to investigate the reason(s) behind the under-utilization of mental health services by young, African males in South Africa. However, it is important to note that there are a few underlying discrepancies between these two theories. For example, Cognitive Dissonance Theory, as its title denotes, accounts for cognitive, internal processes and how these influence beliefs relating to a particular behaviour (Foster, 2000). Alternatively, the Theory of Planned Behaviour takes into account cognitions as well as emotions and how these support or discourage a particular behaviour (Rutter & Quine, 2002). Furthermore, while behaviours are determined or altered in Cognitive Dissonance Theory according to whether the belief is incompatible with their self-concept (Foster, 2000), behaviours are performed in the Theory of Planned Behaviour according to beliefs about the consequences of the behaviour, the ability to overcome the problem requiring the behaviour, or by societal pressure to perform (Rutter & Quinne, 2002). Additionally, Cognitive Dissonance Theory cannot exclusively fit into the categories of the Theory of Planned Behaviour, such as in attitudes, subjective norms and perceived behavioural control. However, despite these inconsistencies, the Theory of Planned Behaviour was used in this study to explore the participants' perceptions of psychological disorders, treatment and the utilization of mental health services, whereas the Cognitive Dissonance Theory was used to determine if and how these perceptions differ when the participants applied them to their own treatment seeking or when they referred the treatment seeking to another person.

2.8 Research Aims and Questions

In summation, the primary aim of this study was to explore the reason(s) contributing to the under-utilization of mental health services by young, African males. The rationale was based on the identification that African males constitute the minority of mental health consumers both internationally and within South Africa. Specific factors which were identified within the literature, and which were further investigated and elaborated upon in the study included: stigma, contact, African cultural beliefs, hegemonic male gender roles, African male gender roles and the recognition of a self/other dichotomy in perceptions of psychological treatment. Furthermore, the theories employed to guide both the interview schedule and the analytic categories were the Theory of Planned Behaviour as well as the Theory of Cognitive Dissonance. Consequently, the overall research questions for the study were:

1. What are young, African males' perceptions of psychological disorders?
2. What are young, African males' perceptions of psychological treatment?
3. What are the reasons for young, African males' under-utilization of formal psychological treatment?
4. What are the contradictions that emerge when the participants identify seeking psychological treatment with themselves or when they relate it to others?

CHAPTER THREE
RESEARCH METHOD

3.1 Research Design

A research design both guides and is guided by the aims and specific research questions of the study (Durrheim, 1999). The overarching aim of this research was to explore the reason(s) contributing to the under-utilization of mental health services by many young African males. These reasons differ in magnitude and importance between persons and thus are highly subjective in nature. Therefore, a qualitative approach offered the greatest opportunity for a comprehensive investigation into these reasons and allowed the voices of young African males to be more accurately represented. In addition, there is a paucity of literature in this research area and this is significantly so within South Africa. Accordingly, the research aimed to identify previously undiscovered information and therefore the design was exploratory in nature.

3.2 Participants

The participants included in the study were eight African males currently registered at the University of the Witwatersrand. The participants' ages ranged from 18 to 21 years of age. A non-probability purposive sampling approach was employed to select the participants (Durrheim, 1999). The number of participants was chosen so as to allow for a deep investigation into each participant's beliefs and perceptions. All eight participants were registered first-year students in the Engineering faculty of the University of the Witwatersrand, specifically within the Electrical and Metallurgical fields. It was predicted from the review of the literature that first year students experience greater stress and mental health strain and so the researcher chose to include only those students. Additionally, research has shown that Engineering students are the least likely to access psychological treatment and thus represented the specific targets of the research (Flisher, De Beer & Bronkhorst, 2002). Therefore, these participants were carefully chosen on the basis that they are considered the most likely to experience stressors known to contribute to the development of psychological disorders, as well as the least likely to seek and utilize professional psychological treatment. Consequently, it was assumed that they would provide the greatest insight into the under-utilization of mental health services by young, African males.

3.3 Measures

A semi-structured interview schedule (please refer to Appendix A) was developed by the researcher in accordance with the theoretical principles of the Theory of Planned Behaviour and Cognitive Dissonance Theory. In addition, interview questions were adapted from existing quantitative scales, specifically Day's Mental Illness Stigma Scale (Day et al., 2007), MacKenzie et al.'s (2004) Inventory of Attitudes Toward Seeking Mental Health Services as well as a mental illness contact scale (Tsang, Tam, Chan & Cheung, 2006). The researcher chose to use the term 'psychological disorders' in her interview questions so as to avoid potential biases which may have arisen from the more negatively associated expression of 'mental illness'. The interview schedule was piloted during June 2009. The volunteer participant included in the pilot study was a Psychology Honours student at the University of the Witwatersrand. Subsequent to the piloting of the schedule, minor alterations to the question content were made. Ultimately, the interview schedule consisted of eleven interview questions with associated prompting questions and these are further described below.

The *first* interview question was designed to elicit information regarding the participants' self descriptions. It was important that the participants had the opportunity to describe and explain how they defined themselves in terms of their ethnicity (as indication of racial group certification as well as an African cultural ideology) and what factors were integral to the construction of their identity (Howard-Hamilton & Frazier, 2005). It was also necessary to obtain demographic characteristics such as their age and home language so as to gain a broad understanding of the participants. The *second* interview question sought to encapsulate the participants' views on life in order to further ascertain their chosen ideologies (Long & Zietkiewicz, 2002). In terms of the theoretical basis for this study (and in particular the Theory of Planned Behaviour), the participants' ideologies and views on life would help illuminate both their potential attitudes towards psychological disorders and treatment, as well as the subjective norms that would impact upon their intention(s) to seek psychological treatment.

The *third* interview question inquired into the participants' previous and/or current stressors and challenges which may have impeded upon their mental health, as well the help and support structures that they receive(d) during these difficulties (Myer et al., 2008). While this question enabled an understanding and investigation of the participants' mental health and potential need for mental health services, it also provided insight into the formation of their perceived behavioural control regarding mental illness – an important component of the intention to seek treatment, as outlined by the TPB. The

fourth interview question investigated the participants' mental health knowledge and their cultural beliefs surrounding psychological disorders (MacKenzie et al., 2004). It further questioned who, in their opinion, determines who is psychologically-disordered and the source of such powers of diagnosis. This question was valuable as it allowed for the interpretation of the participants' cultural view of disorders (Loveday, 2001) as well as their conviction in mental illness stigma (Jones et al., 1984). In addition, socially determined attitudes and responses such as stigma and cultural ideologies constitute subjective norms to seeking treatment in accordance with the TPB.

Similarly, the *fifth* question also investigated subjective norms as the participants were asked to explain how psychological disorders are treated and their perceptions of professional psychological treatments (Day et al., 2007). It examined their African cultural beliefs regarding psychological treatments as well as investigated whether cultural differences and urban-rural divisions play a preventative role in psychological treatment (Pillay, Kometsi & Siyothula, 2009). The *sixth* question was included to determine if and where participants have previously encountered psychological disorders and was used to interpret mental illness stigma as well as contact with mental illness in order to uncover subjective norms and perceived behavioural control (Tsang et al., 2006).

The *seventh* question related to the participants' hypothesised experiences if someone they knew were to develop a psychological disorder. It was included to observe the participants' mental illness stigma (and as such their subjective norms) as well as their recommended treatments for the disordered person (perceived behavioural control and attitudes towards behaviour) (Foster, 2000; Loveday, 2001). This was later compared to the treatments that they indicated they would make use of for themselves. Therefore, this interview question aided in the analysis for the fourth research question investigating whether any contradictions emerged when participants identified treatment seeking with themselves or when they identified it with another person and as such, was further guided by the Cognitive Dissonance Theory. The *eighth* interview question investigated the help-seeking pathway(s) that the participants would choose if they were to develop mental health problems (MacKenzie et al., 2004). The associated prompting questions also sought to determine where participants would receive their chosen treatment as well as the people in whom they would confide that they were experiencing psychological problems or receiving treatment (Phelan & Basow, 2007).

The *ninth* interview question inquired into the reason(s) why many men do not seek professional psychological treatment and was created from the review of the literature (Addis & Mahalik, 2009;

Levant et al., 2009) as well as from the aims of the study. The *tenth* questioned why many African persons do not seek treatment (Bodibe, 1992; Mbiti, 1990) and the *final* question investigated the accumulative impact of being both African and male on seeking treatment (Morell, 2001). Therefore, while the previous questions were designed to elicit answers relating to these final three questions, they were nevertheless included for summative and comprehensive purposes.

3.4 Procedure and Ethics

The researcher first obtained permission from the University of the Witwatersrand's Ethics Committee to conduct the study and proceeded with the research only once this had been procured. This permission for the research was granted under the protocol number MPSYC/09/009 IH (please see Appendix B for the ethics clearance certificate). The researcher then received consent from the course co-ordinators and lecturers of the first year courses in the Engineering faculty. An example of the information and consent forms provided to these authorities are included in Appendix C.

Once the researcher had obtained the above permission, she proceeded to approach her potential participants. On the 23rd and 29th July 2009 the researcher introduced the study to the first year Engineering students in their lecture venues and invited them to participate. An information sheet (available in Appendix D) was provided to all those who were interested and detailed the nature and aims of the study as well as what would be requested of them should they choose to participate. This participant information sheet explained that all participation would be voluntary, that participants would be able to withdraw from the research at any point and that they would also have the right to refuse to answer questions. Due to the nature of the research study, they were also notified that the research would in no way constitute a therapeutic session, nor would the researcher employ any therapeutic methods during the interview. This was to ensure that potential participants understood that the interview itself should not be seen as a substitute for psychological treatment. The researcher also included a variety of ways in which potential participants could express their willingness to participate, by providing her cell phone number, email and private office room number on this information sheet. In addition, the researcher distributed contact detail consent forms (see Appendix E) to all those who indicated their intent to participate. Potential participants were able to indicate on the form that they wished to participate and furthermore provide the researcher with their contact details should they have wished for her to contact them instead. These measures were included to ensure that all interested individuals would have had the opportunity to contact the researcher in the approach in which they felt

most comfortable. Furthermore, it compensated for any lack of funds which may have prevented or excluded willing persons from participating. Thereafter, during the period of 31st July to 19th August 2009 individual interviews were conducted with the students who expressed their indication to participate. An example of the participants' consent forms to be interviewed as well as recording consent forms can be found in Appendix F1 and F2. Each interview was conducted in the researcher's private office at the University of the Witwatersrand and lasted no longer than one hour.

The post-participatory welfare of the participants was protected through the participant debriefing sheet which was provided to participants once their interview was completed. This participant debriefing sheet (see Appendix G) included the contact details of mental health services in Johannesburg. The mental health organisations who granted permission for their contact details to be included on this sheet were the CCDU, the Emthonjeni Centre and the South African Depression and Anxiety Group. The CCDU and the Emthonjeni Centre further offered to provide services to the participants free of charge while the South African Depression and Anxiety Group donated literature in the form of pamphlets on mental illnesses which were included with the debriefing sheet in a debriefing pack. However, the researcher also accommodated for those persons who did not want to participate in the study but still wished to have the contact details of these mental health services. The researcher obtained permission from the University of the Witwatersrand's Student Representatives Council (SRC) to place information sheets (see Appendix H) on notice boards throughout the university. These sheets also contained the details of the above mental health organisations and helped ensure the anonymity of all persons who wished to access the information.

Although the nature of qualitative research does not allow for confidentiality to be guaranteed, the researcher attempted to protect the participants' confidentiality to the best of her ability. All participants were represented by pseudonyms in the transcripts as well as in this research report and only general, non-specific descriptions of each participant are provided where these descriptions were fundamental to the interpretation of the data. This ensured that both the participants' identities and their responses to interview questions remained anonymous. Furthermore, participants were required to arrange appointments with the researcher for their interviews and these were scheduled at sufficiently different time intervals so that participants did not accidentally encounter one another at the interview venue. Participants were also informed that all audio tapes and transcripts were kept at the researcher's home and only the researcher, her supervisor and the external examiner would have access to these interview

materials. In addition, all interview materials will subsequently be destroyed following the report's final examination.

A final, specific ethical concern related to the researcher's own gender, race and identity as a White woman, as participants may have felt uncomfortable disclosing private beliefs and perceptions to the researcher. While the researcher did not feel that this concern arose during any of the interviews, she continued to maintain objectivity and respectability at all times and recorded her thoughts, feelings and anxieties of the process in her personal research journal. This personal research journal was used to maintain self-reflexivity throughout the process and further discussion of the journal's use is included in Section 3.5.3.

3.5 Data Analysis

3.5.1. Introduction

Once all eight interviews had been conducted, they were transcribed in preparation for the analysis. The method of analysis chosen for the study was a thematic content analysis in order to identify the recurring themes relating to the under-utilization of mental health services. Braun and Clark (2006) postulate that one of the primary benefits of thematic content analysis relates to its flexibility as there are a plethora of themes which can be identified and expounded upon. Consequently, there are two specific paths to identifying themes, specifically an inductive and a deductive approach (Braun & Clarke, 2006). Inductive analysis involves categorising themes which were not classified at the outset but which emerge from a thorough analysis of the data (Patton, 1980). A deductive analysis is one in which the analytic themes were noted at the outset from the review of the literature and relevant theory (Braun & Clarke, 2006). The researcher adopted both a deductive approach to the data, and once the primary themes had been extracted and analysed, she conducted an inductive analysis so as to determine additional and/or unforeseen themes which emerged during the interviews. This joint bottom-up and top-down analytic process allowed for the greatest opportunity to elicit the richest, most detailed answers to the research questions posed (Braun & Clarke, 2006).

3.5.2 Steps in the analysis

Coinciding with Braun and Clarke's (2006) approach to the process of thematic content analysis, the following steps were undertaken in the analysis:

1) Once all the interviews had been conducted, the researcher transcribed each interview, collating the verbal information from each interview with additional information, such as nonverbal cues and subjective experiences of the interviews and participants, as noted in her research journal. For example, for each transcription she initially documented how comprehensively expressive or impassive each participant was during his interview.
2) The researcher then read each transcript carefully, noting any ideas or questions in the margins of each transcript. Once such example was the initial observation of stigmatising labels such as 'crazy' and 'mad'. Thereafter the researcher reread the transcripts and coded the data into categories (such as negative perceptions of psychological disorders) which related to each research question.
3) The researcher then identified and classified the deductive themes which were noted before the analysis of the data. These themes included positive and negative attitudes towards mental illness (Day et al., 2007); positive and negative attitudes towards people with mental illness (Day et al., 2007); positive and negative attitudes towards psychological treatment (Tsao et al., 2008); direct and indirect contact with mental illness (Vogel et al., 2007); African cultural beliefs about mental illness (Loveday, 2001); African cultural beliefs about seeking psychological treatment (Loveday, 2001); stereotypical male role beliefs regarding seeking psychological treatment (Pollack, 1998); beliefs regarding seeking treatment that contradict hegemonic male gender roles (Luyt, 2005); and the use of negative labels to describe mental illness (Braun & Bradley, 2002).
4) Thereafter, the researcher noted the inductive themes as they emerged. An example of an inductive theme which emerged during the analysis was that related to culturally-based psychological problems.
5) Once all the data had been coded, the researcher further differentiated the themes and interpreted, according to the literature, how they answered the research questions. For example, the broader theme of perceptions of the agents of psychological treatment was differentiated into themes such as the trustworthiness of mental health professionals and their objectivity. These themes related to the second research question examining the participants' perceptions of psychological treatment.

6) It is important to note that the analysis continued throughout the process of the writing of the report thus ensuring continual re-interpretation. As such, themes were constantly being re-examined and further categorised.

3.5.3 Trustworthiness

Lincoln and Guba (1985) describe the four fundamental criteria on which a qualitative research study should be judged. These include credibility or the degree to which the researcher's interpretations reflect those intended by the participants; the transferability or applicability of the research in other contexts; dependability or stability of the results; and the confirmability or reflexivity of the research. The researcher undertook numerous precautions in order to adhere to these four criteria. To begin, she tried to ensure credibility by comparing her data and interpretations with the relevant literature as well as through frequent clarifications from participants during the interview process itself. This helped to ensure that the researcher's interpretations were consistent with the participants' intentions. Thick descriptions of the development of the interview schedule, selection of participants, analyses procedures and of the participants themselves have been provided in order to ensure the transferability of the data. The researcher's prolonged engagement with the data and its analysis helped maintain the dependability of the data. Finally, the neutrality of the research was ensured through the researcher's self-reflexivity. The researcher kept a journal throughout the research process in which she documented all the steps of her analysis as well as her thoughts, feelings and ideas throughout the research study. During the process of data analysis she reconciled her journal with the transcripts in order to ensure that her own thoughts and feelings had not filtered into and biased her interpretation of the participants' ideas and explanations. For example, during Makhaya's (one of the participants) interview, the researcher felt uncomfortable and concerned by this participant's very personal descriptions and disclosures of prior challenges and stressors, as well as his attempts at familiarity and contact with the researcher (through his initiation and insistence of a hug at the conclusion of the interview). This led the researcher to question Makhaya's motives for participation in the study. However, after careful analysis of both Makhaya's transcript and her notes on his interview, the researcher concluded that her own concerns about his motives had clouded the overall assessment of the value of Makhaya's contribution. Furthermore, it was realised that Makhaya's interview was one of the most informative and detailed, and thus by removing her own judgment, the researcher was able to appreciate Makhaya's significant contribution to the research findings.

CHAPTER FOUR
RESULTS AND DISCUSSION

The results and discussion for the study are presented concurrently according to the overarching themes and sub-themes that emerged. In order to protect their anonymity, each participant was assigned a pseudonym and is only described using general representations. As such, the participants are herewith referred to as: Wezile, Calvin, Ayanda, Makhaya, Vukile, Thabang, Frank and Sandile. In addition, the following referencing convention for the participants' quotations is used: each quotation is followed by the first letter of the participant's pseudonym as well as the line number for the quotation in the participant's transcript. All quotations by the researcher/interviewer are identified by the letter 'I' followed by the quotation's associated line number in the transcript.

As outlined in Section 2.4 of the literature review, young African males have been found to be exposed to a plethora of stressors known to contribute to psychological distress and increase vulnerability to developing a psychological disorder. Therefore, investigations into the participants' experience(s) of stressors causing psychological disorders, and subsequent assumed probable need for psychological treatment, would help to contextualise these young, African males' perceptions of psychological disorders, treatment, and their willingness or reluctance to access such treatment. This is because if they have not been exposed to such stressors and the impact of these stressors upon their mental health, then the subsequent 'foreign' nature of psychological disorders and treatment for these participants would prevent meaningful interpretations to be explored. Nevertheless, as was predicted, the previously identified stressors (see Section 2.4) were acutely experienced among these participants.

4.1 Stressors

It emerged that while all of the participants had experienced stressors found to be related to psychological vulnerability in South Africa, half of the participants acknowledged that these stressors actually led to their development of a psychological disorder. While the occurrence of these disorders could not be professionally verified, and these participants may have exaggerated their past psychological distress due to the nature of this research, the fact that they spontaneously admitted to a previous psychological disorder was interpreted that they subjectively felt that their distress was severe enough to be a disorder. Psychological disorders in South Africa commonly take the form of mood

disorders, most often manifested as depression (Stein et al., 2008). The nature of these participants' previous psychological disorders is congruent with these findings with three out of the four previous disorders appearing to constitute depression, all seeming to result from family difficulties (Wezile, Thabang and Sandile). Thabang's description of his depression provides an explanation for how his guilt and grief over the death of his mother lead to his developing a disorder.

> *Not that I can't talk, I can talk. But I, I, I, I was just quiet, not talking. Okay, I can answer questions in class but just socialising with people, I couldn't do that. Well, not because I, I, I couldn't, but I just didn't want to. Because I had this thing eating me inside* (T85).

In contrast to the more commonly experienced psychological disorders in South Africa (Trump & Hugo, 2006), Makhaya's disorder was quite severe in that it caused him to feel physically sick despite medical examinations failing to determine a physical etiology. This led to his seeking psychological treatment from the CCDU. The only other participant to acknowledge previous psychological treatment was Thabang, although this only consisted of a single counselling session. Therefore, the finding that half of the participants believe that they have experienced a psychological disorder illustrates that African males might be more at risk for developing psychological disorders than the general population. While these participants' familiarity with psychological disorders cannot be said to be indicative of all young, African males in South Africa, it can be interpreted as quite significant that 50 percent of these participants have had a disorder, compared to 17 percent of the entire South African population (Stein et al., 2007). Furthermore, only two of these participants sought psychological treatment for their disorder, with only one participant (Makhaya) sustaining this treatment for longer than the introductory session, thus considerably contributing to the rationale of the study – of the under-utilization of mental health services by young, African males in South Africa. Therefore, these participants appear to reproduce the phenomenon behind the rationale for the study, thereby strengthening the importance of their participation in this study.

Comparable to the experience of an actual disorder, all the participants divulged that they have previously experienced stressors (more than one year ago) which have been found to significantly impair psychological health (Myer et al., 2008). Of these stressors, only family and poverty/financial difficulties emerged for these participants. These family difficulties primarily centred on absent parents (Makhaya), particularly absent or neglectful fathers (Sandile, Vukile and Calvin). Due to the fundamental role that a father plays in the male child's socialisation (Mkhize, 2006), an absent father

figure has been shown to have a significant negative influence on a male child's emotional growth and stability (Stevens & Lockhat, 1997), as well as stimulate the over-development and exaggeration of hegemonic male gender roles (Mkhize, 2006). This is important given that hegemonic male gender roles influence the utilization of mental health services, of which will be discussed in Section 4.4. Consequently, these participants' experience of their absent fathers may present as a double-edged sword for their mental health, simultaneously increasing vulnerability to disorders but preventing seeking professional psychological treatment through their exaggeration of stereotypical male gender role beliefs and behaviours. Given that a significant majority of African adolescents have grown up without male parents (Mkhize, 2006) this stressor may be having a considerable impact both on young, African males' development of psychological disorders and their corresponding avoidance of professional psychological treatment.

The second previous stressor to emerge, financial difficulties, is significant in that despite post-Apartheid South Africa's attempts to redress the socio-economic injustices of the past, the majority of African South Africans still hold the highest rate of unemployment in the country (Mayekiso & Tshemese, 2007). Therefore, Calvin and Vukile's past experience of financial stressors is unsurprising. However, while Calvin's financial difficulties were due to general, external economic causes, Vukile's were caused by his estranged father's unwillingness to financially support him and his mother. Significantly, Vukile was aware of his father's avoidance of financial responsibilities. For example,

> *But what he'll tell me is he doesn't have money and the last time he got a job he didn't contact us. I called him, I said I need this, he said no, I don't work. Whereas I knew he was working so…* (V47).

This stressor, similar to that of an absent father, also presents a paradoxical problem in that while relative poverty may contribute to the development of a psychological disorder, it can also prevent treatment seeking as the person may not have the funds to pay for psychological services. Therefore, the fact that two of the participants experienced this stressor is considerable and may contribute to the current status of African males developing disorders but not receiving professional psychological treatment for these disorders.

It is noteworthy that despite their previously accessing psychological treatment, neither Makhaya nor Thabang highlighted any previous stressors or challenges over which they had to overcome.

Furthermore, in contrast, despite Calvin and Vukile experiencing both of the previous stressors which emerged in the analysis, neither admitted a previous disorder or treatment. It thus seems that encountering these stressors does not always result in the development of a disorder, and that there are may be other stressors or problems leading to psychological disorders other than those commonly referred to in the literature. Therefore, it was similarly important to explore the participants' current mental health status and stressors to which they are exposed as these would contribute to their future use or avoidance of mental health treatment.

The participants seemed overly enthusiastic in affirming their healthy mental health status. In fact, only three participants (Sandile, Vukile and Thabang) indicated that they were currently experiencing great psychological distress, but these participants further emphasised that they perceived this distress as temporary. An example of this positivity was expressed by Sandile,

> *Uh..I can't say I'm coping..but I'm going there* (S22).

However, when viewed in conjunction with the fact that half of the participants have previously experienced a psychological disorder, this finding points to a significant bias that young, African males may be more vulnerable to psychological disorders in South Africa than other groups. In addition, it further illustrates the importance of this exploration into their under-utilization of mental health services.

Interestingly, a point of contention emerged whereby despite Makhaya's inclusion as one of the participants who said that they were currently psychologically healthy, it appears that he remains afflicted by psychological distress as he expressed an overpowering propensity for self-induced solitude.

> *I'm super happy.* (M27).
> *Just being alone. Believe me, when I'm alone there's no disappointment. You know, I, I don't think a lot. You know, when I'm alone it's..* (M84).

While the purpose of this research was not to diagnose participants with particular psychological problems, Makhaya's self induced isolation can be viewed as unhealthy and abnormal behaviour (Johnson, 1991). Thus, there exists a contradiction in Makhaya's assertion that he is currently very happy and his actual behaviour which is suggestive of a psychological problem. A possible explanation for his apparent denial of psychological distress could be that he is trying to over-assert his healthy

mental state in order to reduce or destroy his previously obtained (through the process of requiring psychological treatment) label of someone who is 'mentally ill'. The assertion and charade of happiness could be Makhaya's attempt at escaping this highly stigmatising label. This finding is also significant in that it reflects a general trend of denial of mental health problems in order to escape the stigma and the label of being 'mentally ill' (Trump & Hugo, 2006). This self concealment can lead to severe consequences for the person, such as the worsening of the disorder, as well as contribute to an avoidance of mental health treatment (Quinn, 2006).

Similar to the exploration of the participants' past stressors, they were also questioned as to the current challenges with which they are faced. The participants were recent entrants to tertiary education and thus would have experienced significant turmoil and changes within the past year. Therefore, it was expected that the primary stressor which they currently face would be related to this academic transition. Furthermore, scholastic and academic difficulties are the chief psychological problems experienced by South African adolescents under the age of eighteen (Petersen, 2004). Therefore, while these participants were all older than eighteen, the significant changes associated with entering a university education, as well as the psychological distress thus associated, were expected to have negatively impacted upon their mental health. Furthermore, findings from a previous South African study showed that African students experience the greatest strain in adjusting to the greater competitive level in tertiary institutions (Sennet et al., 2003). This stressor was exacerbated by the loss of the 'above average intelligence' reputation that often occurs when moving into a class with the high achievers from schools all around the country. The influence of this stressor upon the participants' self esteem is succinctly summarised by Wezile,

> *Like..this is my first year at varsity so then, and then at high school you're this top student and then you come here and start to failing some tests oh* (W16).

The impact of the stressor was further worsened by the drastic change in the style and method of teaching between secondary and tertiary education (Bitzer, 2005). It was found that this significant difference in teaching modalities increases the strain of constant work and pressure (Vukile and Thabang) as well as forces students to become independent and self critical. Thabang explained how this forced independence is initiated,

> *Like uh..it's uh..it's like uh, having to..move from knowing everything and backwards to starting afresh and not knowing anything and having to start things by yourself this time. I mean like, at high school they used to give us everything.. But here you have to..develop your own solving problem, problem solving skills* (T42).

Forced independence was also associated with the sudden loss of support systems, such as family and friends. It is valuable to note that while this transition emerged as the primary stressor in these participants' lives and may be harmful to their mental health, transitory problems are common for almost all first year tertiary education students and perhaps are just heightened among these participants due to their isolation from their family and familiar communities (Sennett et al., 2003). Nevertheless, it was clear that this acute stressor was causing them great psychological distress and so their psychological health appears to be at risk. A noteworthy finding was that Makhaya offered a dissenting view to the above participants in that he found university life a refreshing and desired change from high school.

The other most common stressor to emerge was that of course work and course load strain. It appeared that these participants were struggling to cope with the cognitive demands of tertiary education. Their inability to cope was also expressed by the Dean of Engineering who had, after the end of the first semester, issued the first year Engineering students an ultimatum determining the continuation of their studies. A description of how course load strain poses a risk to mental health was provided by Sandile,

> *Okay, okay it was challenging because like..it pushed me to a limit where like I have to like sweat you know like a-like I was exhausted ever-first semester was the most exhausting. I was like sleeping in lectures..I was sleeping the whole day, didn't attend, you know was always tired* (S62).

Thus, the presence of this stressor confirms findings from a previous South African study which found that constant study-related stress and anxiety significantly impairs the mental health of first year students (Sennet et al., 2003), with this stressor also having been found as a contributor to the development of psychological disorders within South Africa (Myer et al., 2008). Thus, these two primary stressors, the difficulties associated with the high school to university transition, and the associated increase in course work load, places these participants' mental health in a precarious position, thus emphasising the

importance of their perceptions of psychological disorders, treatment, and their perceived willingness or reluctance to access such treatment.

Other key stressors to emerge were financial difficulties (similar to the past stressors), and immigration/xenophobia. The stressor of current financial difficulties was illustrated in the finding that many participants had to finance their studies through bursaries and loans. Financial difficulties were both a previous and current stressor for Calvin who was forced to apply for a bursary from the Zimbabwean government. He explained how his anxiety over his inability to pay his fees started interfering with his work,

> *I wasn't doing that badly but I couldn't concentrate. I wasn't doing my best* (C65).

Makhaya also had to apply for a bursary in order to fund his studies while Thabang had to apply for financing for a university residence after his exorbitant travelling expenses prevented him from being able to attend all of his lectures. Therefore, these three participants are currently experiencing financial stressors which have been found to contribute to the development of psychological disorder in the South African context (Myer et al., 2008). Furthermore, it also confirms that poverty and financial difficulties, as risk factors for psychological disorders, are pertinent among young, African males in South Africa (Mayekiso & Tshemese, 2007). It is also significant how financial difficulties exacerbate the transitory stressor explained above, thus mutually negatively impacting upon the participants' mental health.

A stressor specific to those participants who had recently immigrated to South Africa was the stress and anxiety associated with such a drastic relocation (Calvin, Ayanda and Frank). Frank found the move particularly painful as he was forced to give up his dreams and fantasies about his future in Zimbabwe.

> *I thought that was just like gonna be my life like just being in Zimbabwe. And now you know suddenly you're just like just have to change you know? And I had to adapt to that and it wasn't easy. You know cause I left everything I thought that I was gonna grow up with…But like..that wasn't the case.* (F56).

Coinciding with the stressor of immigration was the associated xenophobic attitudes to which these participants were subjected. While the level of xenophobia that they experienced was not as severe as what has previously been experienced by foreigners in South Africa (Nyamnjoh, 2006), they were

nevertheless negatively affected by it. Finally, the remaining stressors experienced by the participants were difficulties with their roommates, such as personality clashes leading to arguments (Wezile) or abuse and destruction of each other's property (Sandile); crime which was targeted at family members (Thabang); family problems (Sandile); burdensome family responsibilities (Thabang); and direct experience with HIV/Aids (Sandile). These stressors have been found to contribute to the development of psychological disorder in South Africa (Myer et al., 2008) and so indicate the risk for psychological disorders among these participants.

In conclusion, these participants have been or are currently exposed to stressors which have been found to contribute to the high levels of psychological disorder in South Africa (Myer et al., 2008) and thus appear to be at risk for developing psychological disorders. While they believe that they are currently psychologically healthy, the presence of stressors such as financial difficulties, tertiary education difficulties as well as those stressors relating to crime and HIV/Aids may be causing them psychological distress. If the participants do not attempt to overcome and confront these challenges then their distress may develop into psychological disorders. While Makhaya and Thabang have previously received professional psychological treatment, their current perceptions of psychological disorders, psychological treatment and their preferred help seeking pathway(s), as well of those of the remaining participants, will provide insight into whether they would utilize mental health treatment in the future, and may contribute to an understanding of why other young, African males do not access such services.

These perceptions and beliefs will thus be presented according to the overarching themes which emerged in the study namely: identity; African culture; masculinity; stigma; contact; and normal versus abnormal behaviour and the implications therein. The importance of the participants' constructions of their identities relates to their choice(s) for explanatory models of human behaviour which, inevitably, shape their perceptions and understanding of psychological disorders and their treatment. Therefore, a brief overview of the participants as well as a discussion of their self-descriptions of their identities is first presented, thereafter followed by an exploration of their ideological frameworks.

4.2 Identity

As previously explained, the eight participants in this research study were all students registered in the Engineering faculty at the University of the Witwatersrand. Six of the participants were from the field of Electrical Engineering with the remaining two in the Metallurgical Engineering field.

4.2.1 Participants Overview

Wezile

Twenty year old Wezile's home language is Venda and he currently stays with his roommate in a flat off the university campus. Wezile explained that he is first and foremost a student in the field of Engineering. He appeared to be a very friendly person and he expressed his extroverted personality by explaining that he is very outgoing and loves meeting new people. Wezile's sole focus at the moment is on his education, as he explains that,

> *without education then there…then there is no hope for the future* (W14).

Calvin

Calvin is nineteen years old and is fluent in both Shona and English. He defines himself as an African male and also strongly aligns himself with a student Engineer identity. Calvin characterises himself as a quiet person and this also emerged during the interview process itself. Calvin values his family and cultural heritage, which includes the importance of family cohesion and support. Although he is originally from Zimbabwe, Calvin now resides with fellow Zimbabweans outside of the university campus.

Ayanda

Nineteen year old Shona-speaking Ayanda describes his ethnicity as being that of a "Black" (A2) male. He associates his identity with that of his career choice and in terms of his position within his immediate family. Ayanda is the eldest of three children and he currently lives at home with these siblings and his parents. Similar to Calvin, Ayanda is also Zimbabwean and only moved to South Africa last year. Ayanda appeared quite happy, albeit a little shy, during the interview process.

Makhaya

The oldest participant, twenty-one year old Makhaya, speaks a variety of languages including SiSwati, Zulu and English. He described himself as a quiet African male. He is suspicious of other people and prefers not to converse often with others. His education is currently his first priority but he also values his own life as well as enjoys economically-driven commodities, such as his laptop. He currently stays with a roommate and his relationship with his girlfriend had recently ended. Makhaya was very open during the interview although it seemed that he wanted to talk about his own psychological problems,

rather than answer the questions which were posed and this raised concerns about whether he perceived the interview as constituting a therapeutic session. Nevertheless Makhaya provided very informative and insightful contributions and thus remained as a participant in the research study.

Vukile

Vukile is currently nineteen years old and has a younger sister who is in Grade Eleven. He speaks Sotho and he defined his ethnicity as being that of an African male. He described himself as a hard worker who, despite excelling in school, is currently struggling with the cognitive demands required for a tertiary education. He believes that he is a nice, albeit shy, person and this was reflected during his interview where he appeared quite nervous and avoided eye contact with the interviewer. Originally from a rural town in Limpopo, Vukile prioritises his career above everything else in his life although he provides for entertainment and relaxation thus contributing to a more balanced lifestyle. Vukile lives with his roommate in one of the university residences but goes home during the holidays to visit his family. He is in a committed relationship and says that he values his girlfriend almost as much as he does his career.

Thabang

Xhosa speaking Thabang is nineteen years old and, while he sees his ethnicity as South African, he believes that it is more strongly that of an African ethnicity. He explains that a South African would always also be an African due to the country's position within the continent.

> *Oh, okay well I define myself as both South African and African male because it's basically the same thing. When you're a South African you're still an African. Okay, you cannot consider yourself as an outsider whereas you were born in Africa, a part of Africa.* (T5).

He also strongly identified himself with being an Engineering student. Thabang's primary caregivers have been his grandparents and he acknowledges the important role that they have played in helping him to become the person that he is today. Like Makhaya, he too values his own life, primarily because of his responsibility for his younger siblings. In addition, Thabang recently moved into one of the university's residences and currently lives there with his roommate.

Frank

Frank is nineteen years old and like Vukile, his home language is Sotho. He is the youngest of five children and describes his ethnicity as African. Frank, originally from Zimbabwe (similar to Calvin and Ayanda), currently lives off campus in an affluent suburb with his parents. Comparable to the other participants, he initially described himself as a student but he also included the identity descriptor of a rugby player. His inclusion of this traditionally male activity illustrates his identification with strength and masculinity. Furthermore, his family and friends are the most important people in his life and he also admits to enjoying female attention.

Sandile

The youngest participant, eighteen year old Sandile, speaks South Sesotho and defined himself as a South African male. He explained that although he tends to be reserved around people he does not know, he enjoys making new friends. Originally from Sebokeng, Sandile described himself as a Casanova who enjoys material commodities. He is focused on his future success and appreciates the importance of his family in his life. Sandile currently lives with his roommate in one of the university's residences.

Therefore, this brief overview of the participants was important in order to contextualise their participation in the study as well as obtain a brief understanding how they choose to identify themselves. However, further examination of their self-identifying descriptions and characteristics was important in order to understand their chosen ideological frameworks.

4.2.2 Self-identifying characteristics

Investigations into the participants' self descriptions illustrated their inexperience with this type of self reflection. They expressed a great difficulty with self identification, as explained by Frank,

> *Eish..well…as an individual? That's, that's a difficult question. I mean…* (F3).

Makhaya for example, was confused as to whether the question related to physical characteristics as his height or weight. However, this confusion and difficulty in self definition may be expected given their youth and recent entry into tertiary education. In terms of Erik Erikson's theory of personality development, as outlined in his psychosocial stages of development, the participants would still be in the

stage of testing and refining their identities (Meyer & Viljoen, 2002). This stage, commonly referred to as "identity versus role confusion" is characterised by exploring the various facets of oneself and finding an identity that encompasses these various facets (Meyer & Viljoen, 2002, p. 201). Therefore, these participants may still be evaluating different types of identities and thus a question in which they would have to state their primary identity would likely present as an impossible challenge.

However, it is also important to note that this identity confusion may alternatively have resulted from the evolving role status of African males from their subordinate position during the Apartheid era to their current escalated social and economic elevation in South Africa. African males are simultaneously faced with the competing demands of being forced to adopt capitalistic beliefs in order to improve their economic position in post-apartheid South Africa whilst having to retain a racialised perspective in order to honour their ancestors' struggles for democracy (Stevens & Lockhat, 1997). Thus young, African males may be uncertain of the roles and identities which they are now freely able to adopt and this could explain their confusion and hesitation over declaring their identity (Stevens & Lockhat, 1997). Furthermore, it is important to note that this identity and role confusion has been said to be a contributing factor of psychological disorders within the South African context (Myer et al., 2008) and, hence, highlights the psychologically treacherous position in which these young African men find themselves and further demonstrates the importance of investigations, such as this study, into their utilization or avoidance of mental health services.

Nevertheless, despite their initial difficulty with the concept, the participants overwhelmingly identified themselves as students and/or Engineering students. As these participants have only recently been inducted into adopting a university student identity, their enthusiastic over-identification with this identity may best be explained by the novelty and excitement of the student identity. Alternatively, it may be that these participants are close to the resolution of Erikson's identity versus role confusion stage, which is said to be concluded through occupational choice (Hook, 2002). This perspective may offer a greater rationalisation for the identification with an Engineer student identity.

The remaining identifying characteristics which emerged were: introverted or extroverted personality traits, where participants described themselves as shy, quiet or outgoing; their position within their immediate family, for example, identifying with being an older sibling; and identity in relation to place of origin such as identifying with Limpopo or Zimbabwe. While this discussion of the participants' identifying characteristics was important for an overall understanding of the participants, one identifying

characteristic was reserved for an exclusive discussion owing to its integral position in this research study. This characteristic was the participants' ethnicity and how it relates to their ideological frameworks influencing their perceptions of mental illness.

4.2.3 Ethnicity

As previously explained in Chapter One, the participants were invited to identify and explain their ethnicity. Thus, as specified in the footnote to the study, the definition of the participants as 'African' males was subject to their own interpretation so as to allow for greater representation of the participants' own voices in the study. However, while the use of ethnicity as a more politically correct method for classification of population groups has been widely popularised within democratic South African discourse (Bowman et al., 2006), an emphasis on a cultural and/or ethnic identity and the rejection of racial categorisation did not emerge as an important contributor to the participants' sense of self. Significantly, only Calvin and Ayanda understood the term 'ethnicity' while other participants, specifically Wezile, experienced immense difficulty in describing their ethnicity. This lack of knowledge regarding ethnicity and its importance for identification, has implications for how young South Africans view themselves and how they judge their similarities and differences with other people living in South Africa. It also appears to replicate other studies whereby it was found that racial categorisation endures as the primary measure for population division within democratic South Africa (Duncan, Bowman, Stevens & Mdikana, 2007). Therefore, the participants' dearth of ethnic understanding may imply that the assertion of an ethnic identity may not be as important to young South Africans as it may have been to the older generation who witnessed the dire consequences and discrimination which resulted from previously racialised identities (Zegeye, 2001).

Nevertheless, following clarification, all but one of the participants defined themselves as African in ethnicity. This association with 'Africanness' superseded those of national ethnicities. The identification with an African ethnicity has consistently been found among members of the African racial group in other studies conducted in post-Apartheid South Africa (Goldschmidt, 2003). The only participant to propose a dissenting ethnicity, Sandile, felt that he could identify more with a South African ethnicity. Although this ethnicity is seldom demonstrated by members of the African racial group, it has been found to correspond to attempts to re-establish a cohesive and united national identity after many years of legally sanctioned division (Goldschmidt, 2003). In summation, as the overwhelming majority of participants identified with an African national ethnicity, thus correlating with the study's original

categorisation according to the South African government's choice of racial population divisions (Statistics South Africa, 2007), this 'African' classification will symbolise both their racial classification as well as their chosen ethnicity in the study.

The understanding of the participants' chosen ethnicities served an additional purpose whereby, as previously explained in Section 2.2, ethnicity implies a distinct ideological outlook of a particular ethnic group (Hutchinson & Smith, 1996). This ideological framework or worldview shapes how they view all phenomena, including psychological disorders and treatment (Long & Zietkiewicz, 2002) and emerged as a prominent theme in the analysis.

4.2.4 Ideological frameworks

The exploration of ideologies demonstrated that these participants, similar to other South Africans (Long & Zietkiewicz, 2002) draw from a number of worldviews in order to make sense of their worlds and the experiences within them. This is particularly important when one takes into consideration that many participants moved from more rural areas to the urban hub of Johannesburg, thus encountering more westernised and diverse explanatory frameworks. Consequently they are faced with a plethora of possible belief systems and are often forced to choose whether to reject these new ideologies, reject traditional African culture or try to assimilate these new beliefs and ideas into their old ideologies (Lopez & Guarnaccia, 2000).

Calvin, Makhaya and Thabang argued that despite their previous self categorisation as African in ethnicity, they dissociated ethnicity from cultural identity. They explained that they had become skeptical of the supernatural beliefs and customs inherent in an African cultural system (Agara, Makanjuola & Morakinyo, 2008) and had chosen to reject their traditional beliefs. Calvin explained that,

> *So..if anyone tells me that there is some witchcraft in it I don't..I don't believe in it* (C115).

Thabang clarified that a belief in culture automatically implies a belief in witchcraft with magnificent, almost God-like powers being attributed to the agents of these supernatural forces.

> *People can be able to make their own lightnings, people can be able to make you uh..mentally disabled. People can be able to make you do that by this and that and that* (T60).

The participants further described how witches have the power to bewitch and bring misfortune upon the victim of their power. This belief, particularly relating to the ability to conjure lightning, is what led these participants to question their cultural beliefs. Therefore, there existed a tension within these participants' ideological beliefs as they struggled to align themselves with a cultural identity with which they no longer agree. As African culture is becoming more diluted in urban areas and infused with westernised beliefs, many African persons have begun to leave their cultural ideology behind in favour of beliefs more 'acceptable' by their western counterparts (Naidoo & Mahabeer, 2006). The recent induction of these participants into a tertiary education, which commonly promotes the amalgamation of ideological beliefs (Naidoo & Mahabeer, 2006), may be contributing to this large dissension from African culture, as evidenced by three out of the eight participants. However, an absolute denunciation of a primary ideology without acceptance of a substitute may leave these participants vulnerable as they might be without recourse to an ideology which will help them understand psychological disorders and their treatment.

Coinciding with the theme of a rejection of traditional African beliefs was the intensified belief in religious belief systems such as Christianity. As previously explicated (see Section 2.6.4), African cultural beliefs and religion are no longer perceived to be synonymous. Where participants were disillusioned by the supernatural beliefs inherent in African cultural systems, they found solace in God and religion. However, this rejection of African culture and increased investment in religion appears paradoxical when one examines the 'supernatural' ideas governing Christianity, many of which would be impossible to examine scientifically. It must be assumed that these Christian and religious beliefs are more believable by participants because they are more acceptable in modern, western culture. Nevertheless, Makhaya admitted that he invests wholeheartedly in a Christian ideology.

> *So, I felt like no, I just have to have faith in everything I do. That's the only thing that will take me there* (M124).

He explained that his faith in God informs his entire belief system, including his perceptions of psychological disorders and their treatment. Nevertheless, while Makhaya adopted Christianity as his sole ideology, others such as Ayanda, Vukile, Frank and Thabang chose to combine Christianity with their African cultural ideology. Ayanda explained that his joint belief system is a consequence of the integration of many of the Shona cultural principles (his specific cultural affiliation – see Section 4.2.1.) into certain churches and religious teachings. This fusion allows him to have faith in both systems

without competition or tension. The idea of a joint African and Christian ideological framework has gained popularity in recent South African history with the development of the Zionist churches (Lebakeng et al., 2002). In addition, this is a reflection of the widespread movement of the induction of traditional African principles into westernised belief systems (Truter, 2007).

However, in contradiction, Ayanda admitted that this harmonious relationship is threatened by psychological problems. He agreed with Makhaya that where Psychology, and hence psychological disorders, is concerned, he rejects traditional African culture and relies solely on his Christian belief system. His justification for this rejection was that when faced with a disorder he could simply believe that God would help him, whereas African cultural beliefs would instruct him to perform certain customary practices in order to recover. This fundamental incongruity is what leads him to automatically align himself with a Christian ideology in his understanding of psychological disorders and their treatment.

> *Well, from my point as I said before, for seeking treatment as a Christian..okay this culture thing gets out. Okay, it's eliminated. I do not believe in that stuff okay…You know your hope is still in God that a, He's gonna bring you through the situation, it will be okay. And you know, you can get healed, it's more of faith in God and trust in God to make it better. But then if you go into culture and stuff that's kind of a contradiction of trusting in God because you know we don't as a Christian you're not believing in these culture things are God so that's why you definitely cancel the culture things out as a Christian* (A132).

Ayanda's argument for the rejection of African cultural beliefs, that they will require him to conduct customary healing rituals, and his subsequent reliance on a Christian ideology, that God will help him to overcome the problem, may be an indication of a an eagerness to relinquish agency, and consequently, responsibility for the illness and its treatment. Coinciding with the Theory of Planned Behaviour (Azjen, 1991), if an illness and its treatment is attributed to an outside influence, then the responsibility for overcoming the illness relies on this outside source, leaving the afflicted person free from having to do anything to resolve the problem. Therefore, if Ayanda perceives recovery from mental illness as being instituted by God, then he might not actively do anything to help with his convalescence. This would, through its influence on avoiding actively helping himself, present as a barrier to his seeking formal psychological treatment as offered by psychologists, psychiatrists and other mental health professionals. Furthermore, this evasion could be aggravated by the fact that formal psychological treatment is often

viewed as contradictory to the underlying principles of religion and God and is thus avoided (Mayers, Leavey, Vallianatou & Barker, 2007). However, Ayanda's conviction in the efficacy of religion in treating psychological disorders has been found in international studies to be more commonly endorsed than the help of mental health professionals and many people have been successfully treated using religious means (Farrell & Goebert, 2008). Therefore, while Ayanda's use of this alternative treatment prevents him from seeking professional psychological treatment, it should not be seen as an impediment to his mental health but rather as an equal, alternative form of treatment.

While Frank, Vukile and Thabang admitted that they usually adhered to a joint Christian and African cultural ideology, they similarly disclosed that this belief system is threatened by psychological disorders and their treatments. They believed that both ideologies are inadequate for the explanation for psychological disorders and so they embrace a third ideology – a western biomedical framework. This is because psychological disorders, as representative of and defined by western medicine, cannot be integrated into African cultural systems due to the fact that the fundamental principles on which African culture is based, specifically that disease or illness results from supernatural forces such as bewitchment or possession, contradict the etiological and treatment beliefs governing traditional Psychology and psychotherapy (Truter, 2007). As African culture emerged as an overarching theme in the analysis, perceptions of psychological disorders and treatment as influenced by this ideology, as well as its role as a barrier to seeking professional psychological treatment, will be further explored in Section 4.3.

As a result, when faced with Psychology and psychological problems, these participants are forced to adopt a western biomedical framework, as propagated by the scientific and psychological profession. Vukile and Frank felt that they would utilize both western biomedical and Christian ideologies in order to understand and approach psychological disorders. Vukile explained that he would first rely on his religious belief system whereas Frank preferred to adopt the western, biomedical framework in his initial approach to Psychology. However, Frank later contradicted himself by explaining that if he had a child one day and this child started experiencing psychological problems, then he would first investigate African cultural etiologies and only seek biomedical or religious help if this proved unsuccessful.

> *But usually I'll be suspecting like maybe..you know a family member or someone you know just tried to put a jinx on him or something like that. You know, that's the first thing that comes into mind cause if he was normal and just started doing funny stuff now, you know it gets you wondering* (F145).

Therefore, it appears that investing in alternate ideologies which have opposing ideas about the nature of psychological disorders creates tension for participants and may further add to their suffering if they themselves were to develop a psychological disorder. Furthermore, confusion over the nature of psychological disorders may impede their recovery as they would be unable to decide on the appropriate mode of treatment and hence may not receive treatment at all (Long & Zietkiewicz, 2002). Nevertheless, it was shown that ideological frameworks influence perceptions of psychological disorders and their treatment. While the influence of a religious ideology has been discussed, the theme of an African cultural ideology emerged as an overarching theme in the analysis and will consequently be explored in greater detail below.

4.3 African Culture

An notable finding emerged that while the study focused on African culture holistically (see Section 2.6.4), the understanding of the expression and etiology of mental illness within African culture differed according to the participants' tribal groups under the umbrella of 'African culture'. In addition, this was further differentiated into perceptions from the Shona culture (Calvin, Ayanda and Frank), those from the Venda culture (Wezile) and then perceptions from non-specific African cultures (where the specific tribal group was not referenced).

It was explained that within the Shona culture, psychological disorders are quite uncommon, and on the rare occasions that they do occur, the disordered person is isolated in order to protect the community from harm.

> *You know, it's something that is a bit rare and strange cause if it does happen usually isolation occurs and you are just this person has gone mad and yeah, coming from where I come from definitely isolation occurs, no-one really wants to talk to you anymore and you're kinda by yourself* (A56).

As such, the presence of a psychologically-disturbed person is believed to result in bad luck and/or tragedy for the Shona community (Patel, Mutambirwa & Nkhiwatiwa, 1995). Consequently, a powerful conviction in a Shona ideology may prevent the utilization of professional psychological treatment as the disorder may have to be concealed to protect against such stigmatising prejudices. The idea of

concealment was further strengthened by proclamations that the secret of a psychological disorder in the Shona culture can only entrusted to one's closest family members.

> *It's more like..most Africans when, when they're brought up you know, they just brought up in a, in a like uh…if you got a problem it's more like you tell, you tell your parents, you tell your brothers, your sister. It's someone close* (F242).

It thus seems that the fear and mystery surrounding psychological disorders may present as a barrier to seeking formal psychological treatment for Shona African persons. This understanding appears to be similarly prevalent in non-specific African cultures, as Makhaya explained that psychological problems are often perceived as disobedience, and so a psychologically-disordered person would be subject to criticism and punishment for his/her lack of discipline and manners. It is clear that such a belief may prevent the acknowledgment of a psychological disorder and subsequent utilization of professional psychological treatment and as such, principles within African cultural ideologies may be contributing to the under-utilization of mental health services by African persons.

However, these perceptions of mental illness can be contrasted by those within the Venda culture. Wezile, the representative of Venda culture within this study, explained that the open expression of psychological disorders is encouraged and preferred within the Venda culture.

> *I think…should just express it as you get it..Yeah, just have to show your expressions and…um, yeah* (W65).

Accordingly, it may be that conviction in a Venda cultural ideology would increase the likelihood of utilizing formal mental health services, as compared to the Shona culture and the African culture referred to by Makhaya. In addition, this finding provides evidence that while African cultural beliefs may contribute to the under-utilization of mental health services, this is not true for all African cultures and perhaps further research into the various tribal groups and their perceptions of Psychology may yield greater insight into this finding.

The theme of African cultural ideologies as a barrier to seeking professional psychological treatment continued with the role of etiological bases and their influence on choice of treatment. Similarly, tribal groups differed according to their beliefs regarding the etiology and development of psychological

disorders. Within the Shona culture, the supernatural etiologies of bewitchment and possession (usually by a demon) emerged as the most likely causes of psychological disorders. Bewitchment and possession are the trusted etiologies of illness, both physical and mental, within the Shona culture and thus have implications for the treatment thereof (Bourdillon, 1993; Patel et al., 1995). This treatment thus constitutes methods employed to liberate the disordered person from the curse or supernatural being possessing him/her and is commonly conducted by traditional healers, who are the most knowledgeable of such treatment modalities (Patel et al., 1995). Thus, a belief in this type of etiology, with its associated trust in the traditional healer as the health professional, contributes to the under-utilization of mental health treatment, as provided by a psychologist, psychiatrist, social worker or general practitioner. However, an additional etiology in the Shona culture was proposed by Calvin, who felt that when supernatural origins are excluded, the other etiology that is investigated is genetic heritability. This is not supported in the literature on traditional Shona cultural practices (Patel et al., 1995; Presler, 1999) and may perhaps indicate the westernisation of African culture, including the Shona tribe, to include more biomedical explanations for disease. Therefore, acculturation of African cultures, including the Shona, may increase the likelihood of seeking professional psychological treatment.

Etiologies prevalent in non-specific African cultures were expressed by Thabang and Vukile. Comparable to the bewitchment etiology in Shona culture, they agreed that other African cultures similarly rely on such causal beliefs.

> *If ever you were fine and you started uh..feeling bad and like you having headaches and stress and everything, it simply means that someone is against you, someone is doing this and that and that to you.* (T58).

This coincides with the literature on African culture that the most common etiology for illness is believed to be bewitchment (Loveday, 2001). Therefore, these participants similarly attribute the etiology of all illness (physical and mental) to spiritual causes. Accordingly, the treatment for illnesses of such origins is conducted by those proficient in supernatural life and healing such as traditional healers (Truter, 2007) and not mental health professionals. This would contribute to the under-utilization of mental health services in favour of traditional treatment. However, corresponding to Calvin's novel rationalisation of genetic etiologies in the Shona culture, this etiology also emerged in non-specific African cultures.

> *So, most of the people, they're not educated to that extent that they can think more, this the fault of chromosomes and stuff like DNA so…yeah* (V71).

This finding is particularly important as it relates to the participants' rejection of African cultural ideologies in favour of western, biomedical explanations for Psychology as explained in Section 4.2.4. This argument, that people acculturated into westernised belief systems are more open to, and accepting of, biomedical ideological frameworks to understand disease, subsequently influences perceptions of psychological treatment. It was apparent in the participants' explanations that the African cultural belief system has evolved to encompass beliefs formerly exclusive to a more westernised ideology. Sandile, for example, felt that African culture promotes formal psychological treatment and further referenced a family member, his uncle, who had previously accessed such treatment.

> *No, no my culture no, we not that much into traditions and stuff. But yeah I'm sure they'll do like, I'm sure cause now we westernised people..I'm sure there's, they think of going to a psychologist or something like that* (S123).

African culture is no longer pure and unsaturated by western cultures and often blends western concepts with traditional African beliefs (Naidoo & Mahabeer, 2006). Therefore, it is unsurprising that certain African cultures now embrace biomedical explanations for disease and as a consequence, promote professional psychological treatments for mental illness.

A corresponding belief relating to some of the participants' arguments that Psychology cannot be integrated into an African cultural ideology (see Section 4.2.4), is that the field of Psychology is unbiased towards cultural affiliations and thus is culture-free. Four out of the eight participants felt that due to Psychology's position within the medical field, the treatment of psychological disorders is unaffected by cultural traditions and beliefs. It is the impartiality of mental health professionals which enables them to effectively treat their patients, regardless of either person's ideological beliefs. Thabang explained the role of Psychology's impartiality,

> *They take uh, a psychological problem as something general, for everyone. So, they kind of help you in the same way as they help someone who's from another culture* (T81).

Sandile added that psychologists are able to treat and help people from contrasting cultures as the processes of modernisation and acculturation have reduced the differences between African and western cultures. As shown above, this acculturation has also increased the likelihood of African persons seeking professional psychological treatment. It thus seems that acculturation of African cultures both contributes to African persons' likelihood of accessing mental health services, as well no longer presents as a barrier to benefitting from such treatment.

However, as can be deduced, the remaining participants disagreed with this outlook and believed that Psychology, as in all other fields of social influence, is shaped by culture and so mental health professionals are unable to treat people from cultures alternative to their own. This argument ranged from the belief that a psychologist would still be able to treat someone from a different culture though not as effectively as someone from the same culture (Wezile), to absolute denials of the culture-free allegation.

> *To understand the person better you have to know where he came from, you have to know where he was raised at, you have to know his beliefs and whatnot* (A85).

Similarly, as explained by Ayanda, there are certain cultural traditions that must be adhered to in the course of one's life, and a mental health professional from an alternate culture would not be acquainted with such practices, and thus would be unable to understand the patient's problem in its entirety. Therefore, a mental health professional, whose guidance challenges the underlying beliefs of his/her patient's ideology, would be ineffective in helping that patient overcome his/her psychological disorder. Such beliefs would no doubt present as barriers to seeking treatment for many African persons as the majority of mental health professionals in South Africa are White (Leach et al., 2003; Rock & Hamber, 1994) and thus, unlikely to be affiliated with African cultures. Significantly, many mental health professionals have acknowledged this shortfall which they also believe to prevent many African persons from seeking treatment, and have advocated for greater training in cultural ideologies so as to transform Psychology to be more relevant and thus provide more effective services to the majority of South African citizens (Kohn et al., 2004). While much has been done to include African cultures in Psychology curriculums, the training that occurs is superficial at most and thus Psychology continues to be perceived as ignorant of the majority of South Africans' ideologies and ways of living (Kohn et al., 2004).

A corresponding theme to emerge was that many participants expressed a differentiation between disorders that are rooted in culture and thus cannot be treated by a mental health professional of a different cultural affiliation, and generalised disorders which are culture-free. The preferred treatment of psychological disorders is thus also affected by how its development and etiology is influenced by culture.

> *Yeah, if my problem is not culture related then you can go to them. But if it's culture related I think it's best if I go to another..person from my culture* (C160).

Examples of culture-related problems, as described by Calvin, Wezile and Sandile, are marriage or family difficulties, as there are prescribed ways of relating to and dealing with conflict with different family members in African culture. These culture-specific problems would then require the help of a mental health professional familiar to and part of that peculiar culture. Significantly, this theme echoes the propositions made by the psychological community relating to the inclusion of culture-bound syndromes in the DSM (Lopez & Guarnaccia, 2000) and thus highlights the universality of the belief in the influence of culture on the expression and definition of psychological disorders. However, one disorder which was said to be similar to all cultures, and thus not requiring culturally-specific treatment, was depression. Calvin explained that a person suffering from depression simply needs to speak to a professional and the ideological beliefs or cultural affiliations of the professional are rendered irrelevant. As depression is one of the principal psychological disorders in South Africa (Stein et al., 2008), this finding reveals that the majority of disorders can actually be treated by mental health professionals regardless of their cultural affiliation.

The culture-bound versus culture-free debate continued in the participants' answers to questions regarding whether urban or rural spatial locations, and the cultural and community implications thus associated, are significant for psychological disorders and their treatment. These perceptions were important because of the disparaging truth that the majority of mental health professionals and services are located in urban settings (Pillay et al., 2009). As a result, mental health facilities are easily accessible to only a small proportion of the country's population, potentially alienating millions of people. Furthermore, urban habitation inevitably increases exposure to westernised and modernised belief systems and thus it is possible that fundamentally irreconcilable ideological differences exist between urban and rural dwellers. The participants' responses seem to validate this assumption as only two participants felt that an urban psychologist would be able to successfully treat a person from a rural area.

Makhaya explained that an urban psychologist would not experience any difficulties in treating the rural living person because of the generalised nature of psychological disorders. Wezile consented with Makhaya but added that this rule is only applicable to 'general, universal' problems such as the trauma associated with being a victim of rape.

> *Yeah, it's the same experience whether you are in town and you get raped. It's something that's happened inside you* (W98).

Rape is primarily conducted against women (Abrahams et al., 2008) and perhaps Wezile's reference to 'rape' indicates a belief that only women are vulnerable to psychological disorders. This idea, of the feminine nature of psychological disorders and male invincibility, is fully explored in Section 4.4. However, the remaining six participants disputed the claim that urban-rural differences were immaterial in Psychology. This argument ranged from the belief that urban mental health professionals are able to treat rural living people if they have some understanding and knowledge about life in the rural areas, to the outright denial of being able to help rural persons. One claim to support this argument was that people living in rural and urban areas have irreconcilable value systems predominantly because the diverse mix of cultures in urban areas creates one large African culture very different from the specificity found in rural areas.

> *Because in urban areas there is a mixture of cultures so..we try to fit in to almost every culture like here there are the Zulus, Sothos and everything. Yeah, but we are living in the same communities, we have, most of the stuff we have the same values* (C170).

Thus, this greater saturation of African cultures in rural areas is what prevents urban mental health professionals from being able to effectively treat rural living persons (Ayanda and Thabang). In addition, African persons living in rural areas were said to believe more strongly in African cultural ideologies which endorse more traditional etiologies such as bewitchment (Vukile) and associated treatment using herbal methods (Frank). This provides evidence that it would be unlikely for African persons living in rural areas to access formal mental health services which are contrary to their ideological beliefs. Thus, this may contribute to an explanation for their under-utilization of professional mental health services as they may alternatively utilize treatments which correspond to their ideology, such as treatment by traditional and indigenous healers.

The final themes relating to African cultural perceptions of Psychology include that the discipline is seen as a traditionally 'White' approach to treatment, the mystery of Psychology, and the expense of treatment. Wezile explained that formal psychological treatment is commonly regarded as a 'White' experience and that people of the African racial group should not access such treatment unless they wish to be perceived as wanting to be White. This apprehension has been found to be a barrier to psychological treatment for many African persons in South Africa (Ross & Deverell, 2004) and thus should be the focus of future efforts to transform and promote Psychology in the country. It is momentous considering the Psychological field's exclusion of African persons during Apartheid and the subsequent creation of a seemingly 'White' discipline (Pillay & Siyothula, 2008). Furthermore, in post-Apartheid South Africa, less than twenty percent of all clinical psychologists are African (Pillay & Siyothula, 2008) further perpetuating the image of a White elitist health sector. Therefore, it seems inevitable that African persons continue to feel under-represented in Psychology, which may contribute to explanations of their under-utilization of mental health services.

This finding correlates with another barrier that emerged, that many African persons are unaware of Psychology and psychological treatment. Thabang explained that this is a particular problem for people residing in the rural areas who are relatively unexposed to mental health services.

> *It's because from their own growth they didn't know anything about psychological uh, professionals* (T122).

This is a common fear of mental health treatment and is particularly pertinent in South Africa among members of the African racial group due to their history of exclusion from the practice (Petersen, 2004). Furthermore, due to the urban locations of the majority of mental health professionals, knowledge of Psychology is often nonexistent in the rural areas of South Africa (Leach et al., 2003). This lack of exposure, and thus lack of knowledge, that formal psychological treatments exist, confirms previous research which noted that African persons are more unfamiliar and unsure of the process of therapy than other racial and cultural group (Petersen, 2004). It should be unsurprising then, that many African persons do not utilize such treatment, as one cannot make use of a service if one is unaware that it even exists. Therefore, it appears that if Psychology in South Africa is to achieve its aims of developing anti-racist psychological practices (Littlewood & Lipsedge, 1997, as cited in Swartz, 1998) by becoming more relevant to the majority of citizens (Kohn et al., 2004), then greater education and promotion of psychological services in rural, and previously disregarded, areas of the country is required.

The final theme relating to African cultural perceptions of Psychology was the suspected or known expense of treatment and the resultant belief in its luxurious and hence unnecessary nature (Calvin and Vukile). Wezile further contributed that many people within the African culture prefer to only spend their money on necessary items or services.

> *Maybe a luxury yeah. Uh, and a waste. Cause if you pay for it and..you know pe- African men they think of lots of payments to do with their money so. Especially saving* (W167).

Given the high rates of unemployment and poverty among African persons (Altman, 2005) compared to the exorbitant, and often unaffordable, rates of psychological services (Department of Health, 2008), it is inevitable that psychological treatment be perceived as a luxury and something which should be avoided if possible. This finding consequently highlights the need for professional psychological treatments to be made more affordable for the general public, as well as greater advertisement of free or minimal cost mental health services, such as those offered by non-governmental organisations.

Therefore, it has been shown that certain African cultural beliefs indirectly influence the perception of psychological disorders and their treatment, as well as prevents the use of formal, mental health treatments. Consequently, there emerged specific, culturally-determined treatments that replace formal mental health treatment for many African persons. These practices consist of the alternate treatments offered by indigenous healers, elders or close family and friends. The preferred alternate treatment was said to be that by indigenous healers, particularly where the etiology was believed to be bewitchment. Traditional healers often use a variety of methods to heal disorders and Thabang illustrated the process of 'bone throwing' as a therapeutic technique.

> *And then the traditional healer will take those bones and then have to blow on them and then he throws them down and then he'll start talking ah, you see this bone, what it actually says is that uh, you, you, you have this invisible beast that's sitting on top of your shoulders* (T76).

The types of treatment techniques used by traditional healers were also differentiated according to the different tribal groups in African culture. For example, those participants from the Shona culture further described how traditional healers often employ cleansing rituals (Calvin), prayer (Frank) or seek to re-establish connections between the disordered person and their ancestors (Ayanda). Treatment by traditional healers is utilized by approximately eighty percent of people in Africa (Berg, 2003; Loveday,

2001; Truter, 2007). Traditional healers are also more fairly dispersed among the people in South Africa than psychologists and psychiatrists, thus increasing access to treatment for millions of people who would not otherwise be able to receive such help (Truter, 2007). Furthermore, this treatment is obviously seen as superior to formal mental health services by people who ascribe to an African ideology, as traditional healers are experienced in dealing with such cultural distress as well as innately understand their patients' experiences (Bourdillon, 1993). The problems thus associated with professional psychological treatment as shown above, such as culture-bound problems, and an inability to truly understand the patients' experiences, do not emerge in traditional healing. Nevertheless, despite constant calls for the inclusion and training of traditional healers in the field of Psychology, little has been done to address this concern (Kohn et al., 2004) which could be used to transform Psychology to be more relevant to African citizens. As such, despite traditional healing practices preventing many African persons from seeking formal psychological treatment, they are nonetheless receiving help for their disorder(s) and this 'barrier' should instead be viewed with positivity.

Informal counselling from one's elders was also frequently mentioned by participants as a conventional form of treatment for African persons. Ayanda and Sandile both indicated that elders help provide practical advice, due to their age and reputation, as well as a sympathetic ear to the disordered individual. Furthermore, they represent the 'psychologists' within African culture despite their lack of professional credentials.

> *They can help you decide what to do and yeah. So, in our culture we have psychologists but they are not professionals. It's just someone you can trust and go to talk to* (C147).

Support from the elders has been found in the literature to be a regular substitute for professional psychological treatment in the African culture and is often chosen because it is free of charge, readily available and conferred by people whom the disordered person respects (Mbiti, 1990; Ross & Deverell, 2004).

Additional substitute treatments said to be utilized by African persons were religion and confiding in close friends. Calvin described how the Shona culture incorporates religion into traditional healing practices to treat psychological disorders. In addition, Wezile explained that many African persons confide in their close friends and family members who provide informal counselling and prevent them

from becoming even more disordered. Vukile explained how the practical advice bestowed by close friends and family members helps in the recovery,

> *Maybe a lot of them say no, the other one maybe might say no, I know this person had a problem like this. What you need is this and this and this. So they would really..give good advice* (V169).

Therefore, these alternate forms of treatment appear to improve psychological health (as they promote mental health and are not harmful) and are subsequently beneficial for the treatment of millions of African South Africans. Importantly, confiding in close family and friends is the first mode of psychological treatment for the majority of South Africans (Hugo et al., 2003) as well as for international populations in more westernised, developed countries (Goldney, Fisher, Wilson & Cheok, 2002). It thus seems that the alternate treatment of confiding in friends and family members is a universal phenomenon and perhaps highlights the need for greater education for the public on how to help and counsel loved ones, thus capitalising on this form of psychological help for less severe disorders. Furthermore, while it seems that a belief in an African cultural ideology may prevent the utilization of formal mental health services through its alternate etiologies and negative perceptions of professional psychological treatment, it nevertheless provides its own culturally-sanctioned methods of treatment. Therefore, it is a barrier that protects and sustains mental health and thus should be optimistically viewed. Furthermore, while an African cultural ideology was shown to be a primary barrier, masculinity and hegemonic gender role behaviour, also emerged as an overarching theme in this study and accordingly will be further explored below.

4.4 Masculinity

As previously described (see Section 2.6.5) characteristics supporting hegemonic male gender roles have frequently emerged as contributing to the lack of treatment or help seeking by males (Addis & Mahalik, 2009). Furthermore, it was also shown that while different theories of masculinity exist, this study focused on the four typologies of the male gender role first categorised by David and Brannon (1976) which included: *no sissy stuff*, *the big wheel*, *the sturdy oak*, and finally *give em' hell*. As shown in previous studies, males construct their own beliefs regarding masculinity as either supporting or rejecting these hegemonic versions of masculinity (Davies, 2007; Walker, 2005). Similarly, the participants' beliefs which emerged in the analysis relating to perceptions of psychological disorders and

their treatment, also supported and/or rejected these hegemonic male gender roles and thus will be presented as such.

In relation to the first typology, *no sissy stuff*, the first belief to emerge rejecting this male gender role was that talking and expressing feelings is actually beneficial for males. For example, Sandile was adamant that the silence and secrecy surrounding psychological disorders only serve to exacerbate the problem and inevitably, the man's suffering.

> *That's why keeping it inside is very bad, you must talk, talk, talk, talk* (S183).

The *no sissy stuff* gender role prescribes that men should not adopt behaviours which are characteristically feminine in nature (Pollack, 1998). The disclosure of the feminine emotions of sadness, fear or anxiety, such as those proposed in this view, would be perceived as contravening this male gender role and thus not upholding masculinity (Oransky & Maracek, 2009). This rejection of the *no sissy stuff* role was further emphasised by the expression (particularly from Wezile) that it has become 'acceptable' for men to elicit the help of professionals such as psychologists for their problems. There is an increasing desire for men to be vulnerable and open; to become what is often referred to as a 'metrosexual male' (Pollock, 1998; Walker, 2005). However, this contemporary desire has been found to create greater distress for males who wish to adapt to the changing ideas of masculinity. This is because while men are requested to be more open with their feelings, they must also maintain the fine balance between being open and being **too** open, which results in their being seen as weak and less than a man (Pollock, 1998). Nevertheless, this finding thus provides evidence that these young, males are actively contesting hegemonic male gender role prescriptions that prevent men from utilizing mental health services.

However, these disputing beliefs can be contrasted with those endorsing the typology and its associated behaviour(s). Many of the participants perceived psychological disorders to represent the antithesis of masculinity. By their very definition mental illnesses are presented as feminine disorders with their symptomatology characteristic of traditionally female qualities (Maddaux, 2004). Consequently, stereotypical hegemonic masculinity is upheld as the epitome of mental health and wellbeing by both mental health professionals and the lay public (Renzetti & Curran, 1999). For example, when asked for examples of different types of psychological disorders, Wezile automatically referred to anorexia nervosa. Despite the recent increased prevalence of this disorder among men and African cultures

(Fernández-Aranda et al., 2004; Wassenaar, le Grange, Winship & Lachenicht, 2000), anorexia nervosa continues to be perceived as a characteristically White, upper-class feminine disorder (McVittie, Carvers & Hepworth, 2005). Therefore, it could be assumed that Wezile was referring to this disorder as indicative of who develops psychological disorders, thus perpetuating the image that men are invulnerable to psychological disorders. In addition, Calvin and Thabang both felt that psychological disorders symbolise women's weakness in being unable to deal with the challenges and difficulties in life. Therefore it is evident that gender bias in the definition of mental illness remains significant and influential in shaping perceptions of mental illness. This may hinder these participants should they ever develop a disorder as they may not recognise a problem as symptomatic of a psychological disorder as they see themselves as invulnerable due to their gender (Renzetti & Curran, 1999). As such, a rejection of the existence of a psychological disorder will inevitably prevent recovery through the evasion of treatment.

In addition, gender bias also emerged in the perceptions of psychological treatment, as this too was found to represent the epitome of feminine behaviour. For example, Makhaya explained that if a man utilizes psychological treatment and thus openly expresses his feelings, he will be seen as acting like a woman and will be subsequently judged as less than a man, or a 'sissy'. This is because psychological treatment involves openness and vulnerability, which are perceived as characteristically feminine qualities, and as such, have been found to contribute to the avoidance of mental health treatment by males (Addis & Mahalik, 2009; Pasick, Gordon & Meth, 1990). However, these 'feminine qualities' are essential for the therapeutic relationship to develop and for change to occur (Good & Wood, 1995) and thus may not only prevent men from first accessing treatment, but may also hinder their healing process and subsequent recovery. Therefore, these participants' explanations for the under-utilization of mental health services by men support the male gender typology of *no sissy stuff*, and thus both confirms the typology's presence and role in African culture, similar to previous research (Ampofo & Boateng, 2007), as well as its continued preventative influence on male help-seeking behaviours.

The second typology, *the big wheel*, which states that men are the powerful and dominant sex and should not give up this power through their admission of weakness (Solomon, 1982), was also surrounded by both contradictory and supportive beliefs. The beliefs contradicting this gender role were that men should not let their ego prevent them from seeking psychological treatment (Makhaya) and that the majority of male perceptions have evolved to the extent where it is now acceptable to access such help (Sandile). However, these contradictory views were eclipsed by the expressed beliefs supporting

the big wheel typology. It emerged that males are generally skeptical and distrusting of anyone outside their close circle of family and friends, which prevents them from even considering the possibility of psychological treatment.

> *Okay, but you can't tell like a therapist?* (I128).
> *Nah, you can't. That's that not a do-that's not even on the list when you are trying to get help (laughs)* (F128).

The second supporting belief relating to *the big wheel* typology was of the immediate distrust and refusal to be treated by a female psychologist. Significantly, half of all the participants stated that they would never accept treatment from a female mental health professional as admitting weakness to a female is directly paradoxical to the typology's emphasis on power and dominance over women. Thus, the very act of seeking treatment from a female mental health professional, would immediately disempower men as they would no longer see themselves as masculine (Addis & Mahalik, 2009). Furthermore, there was the belief that women cannot and should not be trusted as they enjoy 'gossiping' about men (Vukile). This fear and support of this hegemonic male gender role would certainly present as a barrier for males in South Africa due to the fact that females dominate the mental health profession in this country (Leach et al., 2003). It is further evident that the professional nature of mental health professionals cannot surpass such deeply entrenched gender role beliefs which evidently present as barriers to male treatment seeking behaviours. Therefore, it is evident that because mental health treatment from a female would destroy men's status of power and dominance, they would prefer to avoid being in such situations. This can also be related to the final belief supporting *the big wheel* typology, that the mere admission of the presence of a psychological disorder is enough to cost a man his power and authority. This is because they fear that they will lose others' respect once they are no longer perceived as strong, in control and all powerful.

> *Once you are the head or you are the boss and then they hear about it (laughs) and they, the way they express themselves to you might turn to be a bit different* (A125).

This fear is exaggerated when the man in question is in a greater position of authority, such as the head of the family or a high ranking official (Sandile). Therefore, these perceptions that support the male gender typology of *the big wheel* confirms the typology's presence and role in African culture, as well as

its continued preventative influence on male utilization of mental health services and thus consists of a significant barrier to treatment for African men in South Africa.

The participants also provided evidence for both contradictory and supportive beliefs regarding the third typology, *the sturdy oak*, which holds that men should be able to overcome any problems with which they are faced (Pollack, 1998). Similarly, the beliefs supporting this hegemonic version of masculinity far outweigh those contradicting it, thus highlighting the continued omnipresence of hegemonic masculinity in these African males' lives. Nevertheless, the presence of contradictory ideas also contributes to the understanding that men are constantly challenging and interrogating the concept of masculinity and how it permits and restricts behaviour. The belief contradicting this typology was that while men are supposed to be strong and able to face all problems, they are not strong enough to independently handle their psychological problems. Thabang provides an example exemplifying this contradictory belief,

> *A psychological problem seeks a professional whether you are a man or a woman. Yes* (T115).

However, the supporting beliefs to emerge were that men are unable to admit that they have a problem, that men are supposed to be strong, and that men are socialised into being self sufficient and independent and that they struggle to admit when that is no longer true.

> *Because men tend to think that you should be the one who never has problems yet your problems need to be solved by someone else and then, you don't want that and yeah (laughs)* (W153).

Consequently, men prefer to suffer the consequences of internalising their feelings (Pollack, 1998) rather than admit that they are not as strong as they seem, or are supposed to be (Frank). Furthermore, this obstinacy prevents many men from seeking and receiving treatment as an admission of an inability to cope is emasculating to men.

> *So you think no I'm the man..if I go ask for help I'm not the man anymore…It shows weakness* (M228).

This is further supported by the belief that seeking treatment signifies weakness, as expressed by six out of the eight participants. The importance for men to be seen as strong and in control was emphasised as

well as the perception that receiving professional psychological treatment immediately implies weakness in the inability to help the self. Therefore, they would avoid seeking treatment, or any other form of mental health help, even in the face of a worsening condition or suicidal thoughts. Examples of these supporting beliefs are provided below,

> *Most of the people have the thingy like no, men don't cry…So, they think like if you go talk to somebody they will judge you or you're not a man enough* (M202).
> *Yeah or maybe it's the way we brought up..yeah just like if you're a boy you know you shouldn't cry and stuff like that* (F208).

These beliefs may be particularly strong barriers, not only to seeking mental health treatment, but to all forms of male mental health promotion, as the inhibition of emotional expression and disclosure of distress is detrimental to mental health (Kauffman, 1995). The final belief supporting *the sturdy oak* typology was that men trust that they are able to help themselves and so do not need professional help. As a result, men prefer to confront their problems silently without outside interference (Frank). Accordingly, a belief in the influence of this male gender role typology would similarly prevent treatment through its emphasis on self-initiated recovery.

Nevertheless, contrary to what these typologies proposed, a number of alternate treatments for men emerged. These consisted of confiding in close male friends and negative coping mechanisms, such as alcohol abuse and aggression. It emerged that the primary alternate treatment for men is confiding in their close male friends. This was because it is easier for a man to speak to his close male friends than it would be to a mental health professional (Calvin). Furthermore, the informal counselling which occurs between males are not simply confessions of distress but reciprocal processes whereby men help each other resolve their problems and difficulties through practical advice and mentoring (Sandile). Additionally, this informal therapy often occurs spontaneously where one person might introduce the subject as something that recently occurred to them and the others will offer advice on how they would overcome the problem in a language and manner which is realistic and understandable to the person with the problem.

> *Yeah, they talk. Like uh, you just see them sitting together and then it will start as a simple topic, ay you know yesterday this is what happened to me and it made me feel like that. And…if he's talking to a friend, a friend will just have a way of, of kind of advising him on what to do* (T119).

While this male with other males disclosure has been found in a previous study of male support systems for psychological distress (Goldfried & Friedman, 1982), more recent studies have revealed that the majority of men do not confess their personal and emotional problems with other men (Oransky & Maracek, 2009; Shepard, 2005). It thus seems that these participants are more critical of hegemonic masculinity prescriptions (particularly *the big wheel* typology) and are establishing new masculinity norms that confiding in other males is acceptable male gender role behaviour. However, due to the paucity of research into South African males' constructions of male gender role behaviour, it cannot be determined whether this finding occurs more commonly among young, African men. Moreover, owing to the semi-structured nature of the interview schedule as well as the focus of the study, further exploration of the depth to which the participants believe that men reveal emotions and problems to one another could not be explored and as such this indicates the need for further research into this area. However, this finding can also be juxtaposed by the participants' insistence that while confiding in other men is a primary alternate treatment, such help from female acquaintances would not be similarly acceptable.

> *Well, you'd be submitting to women and like you are opening up to women. Some of the stuff you are not supposed to open up to women. You just have to keep them to ourselves, as men…* (C255).

This finding coincides with the above beliefs supporting hegemonic male gender roles of men not wanting to lose power and authority by allowing women to see their weakness. Furthermore, while the finding that men confide in each other is encouraging, as despite their not accessing professional psychological treatments they may still be receiving alternate help in ways that are preferable to them, it also emerged that many men rely on negative coping mechanisms to help them through their distress. The two central negative coping mechanisms to emerge were aggression/physical abuse and alcohol abuse. The reliance on such coping mechanisms that disregard health promotion and which inevitably cause greater harm to the individual, support the risk taking behaviours and bravado which typify the *give 'em hell* typology of hegemonic male gender role behaviour (Renzetti & Curran, 1999). Disturbingly, half of the participants felt that the expression of anger provides an outlet for men's feelings, often manifesting in the form of spousal and child abuse (Wezile, Calvin, Sandile and Makhaya). Violence has become one of the foremost ways in which men assert and represent themselves (Renzetti & Curran, 1999) and thus it is unsurprising that many men channel their psychological suffering into aggression. Furthermore, violence has become the most commonly used means to resolve

disputes or overcome difficulties in South Africa (Harris, 2001). This 'culture of violence' can be traced back to the Apartheid era whereby the current government used violence and resistance to overcome Apartheid practices and laws (Swart, 2007). Thus, it may be expected that many men in South Africa use violence as a way to express their emotions and overcome their psychological distress. In addition, Shepard (2005) proposed that because anger is the only truly 'acceptable' emotion for men, it is used to express all other emotions, such as sadness or fear. This may further account for the role of aggression and violence in male coping mechanisms. Nevertheless, it is clear that this is psychologically harmful and may lead to greater impairment for men, as well as reproduce psychological disorders in the people that they abuse.

The abuse of alcohol to suppress negative emotions is also congruent with the *give 'em hell* typology through its emphasis on quick fixes for problems and the indifference to receiving help for the actual source of the problem (Calvin and Vukile). Furthermore, alcohol and physical abuse are often used simultaneously as coping mechanisms (Makhaya and Ayanda).

> *Yeah, that's the main alternative. Most men, they take, they just go out when they have problems and just drink until they are drunk* (C274).

The use of alcohol as a coping mechanism has been found to be particularly pervasive among men and indicates poor psychological functioning (Goldfried & Friedman, 1982; Solomon, 1982) which often leads to the co-morbidity of both depression and substance abuse in men (Stein et al., 2008). Therefore, these two negative coping mechanisms, aggression and alcohol abuse, are psychologically unhealthy and may impair males' functioning rather than help them to cope with their psychological disorder. It thus seems that while many men reject formal psychological treatment they do not have sufficient alternate coping mechanisms or modes of informal treatment and are suffering as a result. Alternatively, they rely on such negative coping mechanisms which mask or even exacerbate the disorder. It is thus evident that there exists an underlying discrepancy between an African cultural ideology as a barrier and the influence of hegemonic male gender role beliefs as barriers to the utilization of mental health treatment. While perceptions of Psychology within an African cultural ideology often prevent the utilization of such professional services, it does not prevent their seeking other forms of treatment, such as that by indigenous healers. However, the beliefs expressed by participants supporting hegemonic male gender roles appear to prevent seeking help in any form, not only professional psychological treatments, but even the informal counselling from family members and colleagues. Therefore, it appears that while

African culture may prevent professional treatment seeking, hegemonic male beliefs inhibit and impair mental health in its entirety and consequently should be the focal point of future research into this area.

An associated consideration, and one which was highlighted in the literature review, was that if a person is both African and male, then they will be influenced by the accumulative effect(s) of being an African male and the beliefs thus associated. Therefore, while not a dominant and overarching theme, it became important to explore this accumulative influence. These findings provide some insight into the reason(s) behind the lack of formal psychological treatment seeking by this particular population group. A critical belief to emerge was that African men are portrayed as the strong, authority figures and as such, their seeking psychological treatment would be seen as an admission of weakness. Therefore, forms of treatment like professional psychological treatments are not considered as options for many African men (Frank and Thabang). This belief was eloquently explained by Thabang,

> *Well..this is straightforward and simple. It's because uh, according to culture men is, men are supposed to be strong. Every problem that he come across with, it shouldn't hurt them. It shouldn't uh, it shouldn't disturb them. Men are, were made to be strong. If ever you have a problem you can't cry. You just stand up as a man and you'll solve it* (T114).

The importance of maintaining these hegemonic masculine traits in the African culture was further accentuated by the finding that African men will not seek psychological treatment as that would imply that they have to ask another person for help and thus surrender their power and autonomy (Makhaya and Calvin).

> *So..someone can't just go down there and ask someone for help, it's a sign of weakness I said* (C283).

It further emerged that the extent to which these beliefs influence African men depends on various factors such as their investment in an African cultural ideology and their location in rural or urban settings (Wezile). Therefore, this fear of being perceived as weak and no longer in power and authority appears to typify the hegemonic male gender role of *the big* wheel, which holds that men should strive to maintain their power and status (Solomon, 1982). Furthermore, combined with traditional African patriarchal beliefs of the power and authority of men (Mbiti, 1990), this belief provides evidence for

how this accumulative barrier of patriarchal, African cultural beliefs and hegemonic male gender roles can lead to the under-utilization of professional psychological treatment.

The second critical belief was that African males have a resolute confidence that they will be able to overcome the disorder by themselves. Half of the participants believed that this barrier prevents many African men from receiving professional psychological treatment (Thabang, Makhaya, Ayanda and Vukile).

> *It's my problem, not our problem, my problem, so..just wanna let it go. So, just live with the problem* (V179).

This particular belief can be said to be typical of *the sturdy oak* typology of masculinity which maintains that men should be able to overcome any challenge with which they are faced (Pollack, 1998). Furthermore when this is combined with traditional African patriarchal beliefs, it could result in the accumulative barrier of not seeking professional psychological treatment because they believe that they will be able to 'treat' the disorder by themselves without professional assistance and thus, provides further evidence of the accumulative barrier of African cultural beliefs and traditional male gender roles.

Another belief which may be a potential barrier for African males seeking psychological treatment is that Psychology and psychological treatment are perceived to be irrelevant in an African cultural worldview. It emerged that many African men who live in rural areas do not trust an outside person to tell them that they have a disorder and/or to treat them for that disorder. Thus, rural African men are suspicious of people who do not understand and accept their cultural beliefs and thus would be particularly skeptical of Psychology and psychological treatment which is biomedical and western in origin.

> *It's, if you are really, uh you were born in a rural place..you just don't think it's necessary* (V165).

Furthermore, African men follow the traditions of their forefathers, such as confiding in elders and being treated by indigenous healers, and thus do not see mental health professionals as appropriate avenues for treatment (Thabang). This emphasis on male customary practices within the African culture may illustrate why many young, African men do not seek formal psychological treatment as they would

prefer to access treatment from indigenous healers whose help aligns with their own worldview or ideology.

The final barriers specific to the accumulative impact of masculinity and African culture are the fear of being stigmatised and the view that psychological treatment is the exclusive realm of females. Sandile and Wezile believed that many young, African men avoid treatment as they are afraid of being ridiculed or associated with the stigmatising labels of 'crazy' or 'insane'.

> *Uh..I think it's this thing of becoming embarrassed. Yeah they become embarrassed about no, people will laugh at me. They will say it's not cool, they know that you're going to someone, people will laugh at you.* (S191).

The final barrier of psychological treatment being perceived as only being helpful to women was expressed by Frank. He disclosed that only women need to access psychological treatment due to their innumerous and enduring problems. This fear of receiving a form of treatment normally reserved for females represents the *no sissy stuff* male gender role, which prohibits any behaviour said to be feminine in nature (Pollack, 1998) and thus seems to be particularly evident within the African culture.

Therefore, it has been shown that African male beliefs influence the perception of psychological disorders and their treatment and also present as indirect barriers to seeking professional psychological treatment. However, there also emerged African male practices that offer preferred alternatives to psychological treatment. These practices consist of the alternate treatments of confiding in close male friends, elders and/or girlfriends, as well as negative coping mechanisms, such as alcohol abuse and aggression. The first alternative treatment for African males, similar to that expressed for all males, was that many young, African men confide in their close male friends and act as informal counsellors for one another (Calvin and Frank). African men were said to be able to trust their male friends with their secrets as many of these friends are childhood acquaintances (Wezile). It was further explained that these informal counselling sessions occur in relaxed, humorous atmospheres so as to encourage the illusion of non-treatment seeking. However, a downfall to this alternate treatment, is that African men sometimes give incorrect or dangerous advice which may further harm the disordered individual (Makhaya and Vukile). An additional recourse for psychological help was that African males often turn to their elders for advice and informal treatment (Thabang). Moreover, contrary to the alternate treatments for males without the influence of African culture, Wezile explained that African males often

confide in their girlfriends or wives. Nevertheless, while these alternate treatments are encouraging in that despite many African men not utilizing professional treatments they are still receiving help in other forms, it also emerged that many African men rely on negative coping mechanisms as a form of treatment. Similar to those for males without an African cultural influence, alcohol abuse and physical abuse emerged as the two primary coping mechanisms for African males and that these two coping mechanisms often coincide (Sandile and Makhaya).

> *Mm..I think ah..they some, some, some, yeah the African man they drink beer like they, they, they, so maybe they can fight* (S188).

Regarding aggression and physical abuse, it was felt that the insidious nature of psychological disorders forces many African men to manifest their emotions as violence, typically against their wives and children (Makhaya and Sandile). A particularly remarkable finding, and one which may be useful in understanding the high rates of sexual crimes in South Africa (Abrahams et al., 2008), was that violent crimes such as rape are often committed in order to cope with a psychological disorder (Sandile).

> *The problem is inside of themselves so that's why they turning it out yeah* (S189).

The remaining negative coping mechanisms for African males were said to be the pretense of wellbeing (Vukile) and the final, devastating outcome of committing suicide (Wezile). Therefore, it seems that while young, African males do have alternate treatments to cope with their psychological problems, their use of negative coping mechanisms may significantly impair their mental health. Therefore, they remain a vulnerable population in which greater efforts should be made in order to maintain and protect their psychological health.

In summation, it was found that an absolute belief in a religious ideology, an African cultural ideology, supportive hegemonic male gender role beliefs and the accumulative influence of African male beliefs, all influence perceptions of psychological disorders and their treatment, as well as contribute to an understanding of the under-utilization of mental health services in South Africa. Nevertheless, additional, overarching themes emerged specifically relating to psychological disorders and their treatment. The first theme of stigma however, constituted a deductive theme as it was one of the primary barriers to emerge in the review of the literature (see Section 2.5.2) and so was expected to dominate the participants' perceptions.

4.5 Stigma

4.5.1. Dimensions of Stigma

As aforementioned in the literature review, stigma has been shown to be one of the major contributors to the avoidance of psychological treatment (Trump & Hugo, 2006). This is primarily because the ubiquitous nature of mental illness stigma means that almost all people hold or at least have heard of stigmatising beliefs about psychological disorders and people who are so afflicted. This omnipresence of stigma also emerged in these participants' beliefs about psychological disorders and treatment. As previously explicated (see Section 2.6.2) there are six universal dimensions of stigma namely: concealability, the level of disruptiveness of the disorder; aesthetic qualities; the origin or etiology; peril; and the course or progression of the disorder (Jones et al., 1984).

The first dimension, which is the *conceability* of the disorder, emerged as a primary theme in the analysis and dominated the participants' views of psychological disorders. A significant number of participants felt that psychological disorders are easily visible, and therefore, difficult to conceal (Vukile, Frank, Sandile, Ayanda and Calvin). Mental illnesses were said to be conspicuous to people of all ages because the psychologically-disordered person behaves differently to everyone else (the normal majority), thus making it difficult and sometimes even impossible to conceal. It further emerged that disordered and normal behaviour acts within a situation of sine qua non as it is only possible to identify abnormal behaviour if there is normal behaviour with which to compare it to. A noteworthy idea was that abnormality is contextual as it depends entirely upon the situation and others in the environment. Therefore, while it is the majority of people who are considered normal, if you are surrounded by people who are typically regarded as 'abnormal' then they would see you, as the outsider, as abnormal.

> *So, if you go into a room full of psychos they might think you are the psycho so it depends on who you are with* (C120).

Thus, it appears that these participants believe that psychological disorders are extremely conspicuous, even to non-professionals, and this illustrates that they are accompanied by a great deal of stigmatising attitudes and beliefs. However, a dissenting voice emerged from Thabang who expressed that psychological disorders are not conspicuous as they are isolated within the individual and thus can in fact be concealed from others.

If ever you don't talk about it no one will know. Even a psychologist cannot just come and point at you and says you have a psychological disorder (T88).

This view challenges the stereotypes contributing to the stigma of mental illness and may stem from Thabang's previous experience with psychological treatment. It also coincides with the view expressed by half of the participants who felt that a diagnosis and final decision on whether a person is psychologically-disordered ultimately rests with a mental health professional. It was felt that only someone educated in Psychology can confirm or refute the manifestation of a psychological disorder necessitating treatment (Wezile and Makhaya). In addition, one particular justification for the necessity of a professional opinion was that a final judgment of abnormality requires professional evidence for doing so.

But I think the proper definition needs someone more experienced or who knows how to deal with such things cause I wouldn't really like to judge someone from what he's been going through you know? (A67).

The second dimension of stigma is the level of the *disruptiveness* of the disorder. However, no data emerged in the analysis for the independence of this dimension, but as explained in the literature review, it often corresponds with another dimension. With regards to this study, it was found to coincide with the dimension of peril, of which will be examined further in this discussion. The third dimension, the unpleasant *aesthetic qualities* of psychological disorders, surfaced as a concern for one of the participants. Calvin was particularly offended about the negative aesthetic qualities which he perceived to be associated with psychological disorders. He felt that homelessness was pathological and thus not caused by any socio-economic or political reasons.

Yeah..there's some really crazy people who just go around eating stuff from bins (C173).

Furthermore, he explained that psychologically-disordered people are unhygienic and unclean. This pathologising of poverty has severe consequences for this participant's stigmatising attitudes about mental illness and people with mental illness as well as for his views on poverty and inequality in South Africa. Although research has indicated a reciprocal relationship between poverty and psychological disorders (Gibson et al., 2002), poverty in South Africa is primarily attributed to the overpowering socioeconomic inequalities suffered by the vast majority of citizens (Mayekiso & Tshemese, 2007). This

finding has implications for aspects external to the current research as Calvin may not understand and appreciate the variety of factors which contribute to poverty, which is also one of the primary problems facing South Africa today, and so may be unwilling to contribute to the reduction of the problem. Furthermore, Calvin's belief that psychologically-disordered people are unhygienic and thus aesthetically unpleasant illustrates his highly stigmatising beliefs about psychological disorders and also show the types of aesthetic stigma surrounding mental illness that may prevent him and other people from admitting to having a psychological disorder.

The participants were very open in expressing their answers to questions regarding the *origin* of psychological disorders. The primary etiology to emerge was that internalising one's problem(s) can lead to the development of psychological disorders (Wezile and Sandile). Psychological disorders were said to arise when people are unable to talk about their problems with other people, either due to their own inability and/or reluctance to be open to vulnerability, or because they do not have trusted people to confide in. The person then assumes a mask of happiness in order to preserve this illusion of being psychologically happy and healthy, and this effort further hinders the person's chances for recovery.

> *And you can also show that you have a problem, but some people they keep it inside and they put a smile on their face but they feel inside its hurting them, yeah* (W59).

This suppression of feelings of sadness and the subsequent exacerbation of the disorder has been found to be particularly prevalent among adolescent boys and young adult men due to the influence of hegemonic male gender roles (Pollack, 1998). In addition, this etiology has been identified by both experts in the Psychological field as well as the general public as leading to the development of psychological disorders, specifically depression (Wang et al., 2007). The other most common etiology was that of constantly ruminating on one's problems. Therefore, psychological disorders emerge if the person is so transfixed upon his/her problem that it occupies all of his/her concentration and attention thereby preventing the person from living a normal, active life (Makhaya and Ayanda).

> *Even when someone wants to talk to you, you kind of, you know, you're not quite listening to them anyway you're thinking of that* (A53).

Many of the participants also emphasised the role of trauma in the development of psychological disorders. One such example of trauma was that brain trauma, such as those caused by a head injury or

disease, can lead to psychological disorders (Frank). The etiology of brain trauma was similarly endorsed in a previous study conducted in Nigeria (Adewuya & Oguntade, 2007). However, this type of trauma would indicate mental retardation and/or neurological damage and while these symptoms may mimic the symptoms of psychological disorders, their classification, diagnosis and subsequent treatment would be very different from those related to psychological disorders (Patel et al., 2007). Other types of trauma which participants felt contribute to psychological disorders are sudden deaths and losses within the immediate family (Ayanda) and/or continual physical, emotional or sexual abuse (Calvin). As previously indicated, the above etiologies have been found to be conducive to the development of psychological disorder within South Africa (Myer et al., 2008) and thus it is particularly significant that these participants agreed that they can lead to disorders.

Additional etiologies or causes to emerge were family difficulties such as discord or hatred between family members (Calvin) and over-studying to the point of exhaustion (Vukile). A final point of interest is that one participant believed that psychological disorders are the fault of the sufferer who must have done something wrong in order to be punished in such a way. Frank explained that if you have a psychological disorder then you must receive treatment for it because you deserve to be subjected to treatment if you developed a psychological disorder.

> *…Well if, if, if you deserve it I mean..yeah you might as well just have to go.* (F14).

This finding may indicate Frank's high level of mental illness stigma as the belief that a person's mental illness was self-caused has been shown to increase stigmatising beliefs and attitudes (Jones et al., 1984). Many of the participants also expressed their fear of persons with psychological disorders as being violent and dangerous to both themselves and to others. This corresponds with the fifth dimension of *peril*. The unpredictability of a person with a psychological disorder perpetuates the stigmatising belief that they might be violent and scary, even towards their own family and friends (Calvin, Ayanda and Sandile). The fear of the unpredictable nature of psychologically-disordered people has been frequently found in previous international research (Angermeyer & Dietrich, 2006; Björkman et al., 2008) and thus the fact that it also emerged within this group of young, African males is indicative of the universalness of this fear. Furthermore, this widely publicised belief has gained impetus with the media depictions of mentally ill people as murderous and violent (Botha, Koen & Niehaus, 2006) and inevitably has severe consequences for the openness towards interacting with people with psychological disorders (Björkman et al., 2008). In addition, it further indicates the existence of the dimension of *disruptiveness* as

participants fear that the disordered person's unpredictability will disrupt and prevent normal interactions.

The sixth and final dimension is that of the *course* or progression of the disorder. As explained in Section 2.6.2, this dimension consists of perceptions of the professional efficacy of mental health professionals, the treatability of the disorder, and potential for recovery from the disorder. The findings will be presented according to the perceptions relating to the role of the agent of psychological treatment, as well as the nature and purpose of psychological treatment.

4.5.1.1 Role of the agent of psychological treatment

A primary theme to emerge in the participants' perceptions was that psychologists are seen to be in a position of great power over their patients in that they are able to decide when a person can be classified as disordered. Furthermore, they have acquired this power through their knowledge and study of Psychology as well as by proxy of the position in which they are in. It was felt that psychologists are doctors and because they have studied Psychology they have the power to determine if someone has a psychological disorder (Wezile and Thabang).

> *Well it's because they studied for it and they know..so you can't really..uh argue with someone who knows, yeah* (T68).

This relationship between knowledge and power has been widely acknowledged in the literature on Psychology and the therapeutic relationship (Long & Zietkiewicz, 2002). Abnormal behaviour is established by the Diagnostic and Statistical Manual of Mental disorders or DSM. The DSM and its authors determine which behaviours are socially undesirable and hence should be classified as abnormal (Kutchins & Kirk, 1997). The ability to use the DSM (as obtained through the study and qualification as a psychologist) automatically assigns one the power to determine who is abnormal and will receive the stigmatising label of mental illness. Furthermore the power assigned to a psychologist includes the power to commit a patient and this fear of institutionalisation increases the fear and power of psychologists (Szasz, 1987). When this is viewed in conjunction with the contextual history of South Africa where members of the African racial group were disempowered and deprived of even basic human rights, the power that psychologists wield and the fear of regression to Apartheid status may prevent these participants from seeking and accessing mental health treatment.

However, an alternate view was voiced by Ayanda, who felt that psychologists have power because of the position of the profession that they are in. He felt that their respect and trust is automatically implied by their status in society as medical professionals.

> *Um..I guess just the fact that they're the person that's his profession and you know, um it's an element of trust where you think well what he says, says in that job or whatever, if he says this it's correct it's correct, if he says it's wrong it's a disorder then it's a disorder* (A70).

This finding is important as the very nature of the psychologist and patient relationship is imbued with a significant power imbalance where the psychologist holds all the knowledge and the patient has none (McLeod, 2003). However, this argument met opposition of the denial of the psychologists' power.

> *They don't have to have power, it's just that when you..they, they have to tell you when you're malfunctioning (laughs)* (M26).

The final theme in the perceptions of the agents of psychological treatment was related to their trustworthiness. Many participants felt that it would be difficult to open up to a psychologist and accordingly receive psychological treatment due to the absence of prior, established trust in the psychologist-patient relationship (Wezile, Frank and Thabang). As a result, these participants feared that the detachment expressed by psychologists may interfere with the process of recovery as they would not be able to truly understand their patient's experience in order to effectively help him/her.

> *Yeah basically, well I really believe if I have a problem I mean ag how will, how can someone else help me? I mean if he's not like close to me or something like that yeah* (F209).

This barrier surrounding the trustworthiness and discretion of mental health professionals has been previously illustrated in a South African study investigating a student counselling service (Flisher et al., 2002). Furthermore, it results in the preference for psychological 'treatment' from people with whom this trust has already been established, rather than with someone who is paid to care about their problems and sees patients simply as a means to earn a living. Previous research has also found that the public rate talking to family and friends as more effective than that with professionals primarily due to the trust and history implicit in those relationships (Goldney et al., 2002).

4.5.1.2 Nature and purpose of Psychological Treatment

Significantly, seven out of the eight participants (with Thabang dissenting) expressed positive attitudes regarding psychological treatment. This positivity is aptly demonstrated in the following quotation,

> *we all need psychology* (W127).

The effectiveness of psychological treatment was said to be produced by the healing conversation(s) that occur in counselling and therapeutic environments (Calvin and Makhaya) as well as by helping the psychologically-disordered person to revisit their childhood in order to resolve the issue.

> *Treated? Um..by, according to a psychologist? Talking about your, your, your problems maybe talking about your past, your past. Maybe there, maybe what's happening now has something to do with your past. Psycholo-Psychologists can handle those things, you know, helping you* (S109).

This type of treatment is representative of traditional psychoanalysis or psychodynamic treatment and is the theoretical treatment which has been most represented in media and cultural representations of Psychology (Ivey, D'Andrea, Ivey & Simek-Morgan, 2002). While many people have thus been exposed to this idea of psychological treatment, Sandile was the only participant to speak freely about it and to appear to honestly believe in this mode of treatment. Thus, he may be more willing to access this particular mode of therapy than the other participants.

Finally, one participant, Vukile, proposed an interesting and anti-pathologising view of psychological treatment. He explained that while he believed in the efficacy and importance of professional psychological treatment of psychological disorders, he maintained that this treatment should only be provided to those who choose it for themselves, as mandatory and forced treatment is harmful to people. He explained that when people are forced into treatment they are closed to the effects of this treatment and will terminate the treatment once they are allowed to make their own decisions.

> *I, let those who wanna..wanna like really be treated..yeah be so, so as the rest who, who just wanna give up on their lives..just let them..do what they wanna do. Cause you can't force someone to do something that they don't wanna do* (V87).

In summation, while positive perceptions about psychological treatment were common among this group of young, African males, these perceptions were superficially limited to it being viewed as helpful in treating disorders. The participants did not explain how this treatment helped or why it was superior to other methods of treatment (such as self help interventions or informal counselling by family and/or friends). From this finding it might be assumed that these participants see professional psychological treatment as most helpful for the treatment of psychological disorders and be hypothesised that if these participants were to develop a disorder then they would thus seek and access these services. However, there emerged an alarming number of negative and stigmatising perceptions of psychological treatment and these will be further discussed below.

A prominent theme which emerged in relation to negative perceptions of psychological treatment was that professional help (from a psychologist, psychiatrist or other mental health professional) was unnecessary as talking with friends or family members offered the same benefits and effectiveness (Wezile, Thabang and Sandile). This is because it is easier to open up to such confidantes owing to the relationship's previously established trust and strength. This finding is significant as help and counselling from friends and family members has been shown to be just as effective as those offered by mental health professionals (Jacobson, 1995). In addition, it correlates with the above findings (see Sections 4.3 and 4.4) that Africans and African males rely on this informal counselling as an alternative to professional psychological treatment. Similarly, it was emphasised that anyone has the ability to help a person with a psychological disorder.

> *Anyone I mean you don't really have to have a degree to, to know how someone's feeling.* (F20).

In addition, the importance of community support and not being helped by only one professional was indicated by Ayanda.

> *Yeah, it's okay but I think if they kinda let the person talk to more people or different, at different times, it might help. That's what I think as well* (A76).

A second theme for negative perceptions of psychological treatment was that the 'talking cure' or conversational aspect of therapy was not perceived as being helpful for the serious and practical problems that many of the participants had or were experiencing. For example, issues such as poverty or university transitory difficulties are two of the most common stressors facing these participants (see

Section 4.1) and seem to require more practical interventions than Psychology can offer, in order to be overcome. Thus, simply talking through one's problems may not seem particularly helpful in the light of such severe problems.

> *A therapist? Ag why I mean, I, I, I don't know…but it's more like..it's just talking to someone and..pffft I can do that with anyone* (F195).

This desire for 'practical' solutions has been found to be acutely intense among men (Pasick et al., 1990). An addition criticism stemmed from whether the effects of talking with a professional last outside of the therapeutic session and environment.

> *Sometimes happens that uh, people see uh psychologists as uh, useless people because you talk now and then just when you leave..once you start thinking about that thing again it comes and eats back. So they just think it's waste of time and money because you will talk and talk and talk and then when you leave the problem comes back* (T119).

This criticism has been well observed in many research studies and subsequent demands to make Psychology more accountable owing to the fact that proof of the enduring efficacy of professional psychological treatment has yet to be found (Jacobson, 1995). Therefore, it is unsurprising that mental health services are under-utilized as people are unlikely to seek treatment of which they doubt the efficacy and value thereof. Finally, Calvin felt that when a person was so disordered that they no can longer participate in a conversation then the talking cure would be ineffectual with them. Thus, professional treatments involving the 'talking cure' are seen as quick fixes and unable to help with the practical problems that these participants may be facing. This finding perhaps highlights the importance of educating the public about the various types of psychological treatment, with some offering more practical interventions than others (McLeod, 2003), and thus not the exclusive realm of the talking cure.

The remaining themes relating to the negative perceptions of psychological treatment are the expense or cost of treatment, the mystery surrounding the process, and the role of medication. Only one participant felt that he would not seek professional treatment due to its perceived expense.

> *You know sometimes you see people go there, especially rich people go to psychiatrists and therapists for advice so then you don't know how much they are paying* (W124).

As shown in Section 4.3, this view was found to be evident within African cultural perceptions of psychological treatment and is, in fact, a correct assumption of the high cost of psychological treatment in South Africa (Department of Health, 2008). Wezile held particularly negative perceptions towards psychological treatment as he was also the only participant to express that the unknown nature of psychological treatments makes it seem foreign and overwhelmingly intimidating. He explained that he is uncertain of the processes involved in psychological treatment and thus would not have the courage to even make an appointment to see a professional. This perception also emerged in relation to African culture (see Section 4.3) and thus appears to be a substantial barrier for the under-utilization of mental health services.

An interesting theme to emerge was the criticism of medication as a treatment for psychological disorders. It was felt that medication has a numbing effect which merely masks the disordered person's symptoms (Calvin) and is generally not at all helpful (Thabang). These criticisms mirror international studies whereby the findings showed that many people are suspicious and fearful of medication as they believe it is actually harmful to the person (Jorm et al., 1997). Nevertheless, it was acknowledged that medication can be useful for severe disorders, such as psychotic disorders or schizophrenia (Calvin). However, the fearfulness and distrust surrounding the use of medication as a treatment for psychological disorders may prevent these participants from accessing treatment for fear that medication may be forced upon them.

In summation, the participants demonstrated the stigmatisation of mental illness on all six dimensions of stigma. These participants' expressions of mental illness stigma confirm its universal presence in South Africa and particularly within African males. This consequently poses a significant threat to their acknowledgment of a psychological disorder and subsequent willingness to seek any treatment (not just professional psychological treatment). However, it is also important to examine whether any of the participants expressed previous or present manifestations of these stigmatising beliefs. These will be explored in terms of the primary manifestations outlined in the literature review namely, ignorance towards mental illness (insufficient or incorrect mental health knowledge) and negative attitudes and behaviours towards people with mental illness (Tsao et al., 2008).

4.5.2 Manifestations of Stigma

It emerged that many of the participants had insufficient and incorrect knowledge and understanding surrounding western conceptions of mental illness. This was primarily indicated through the inability to define psychological disorders (Thabang, Ayanda, Sandile, Makhaya and Frank).

> *(laughs) well, I'd, I think I will kinda need a definition as well (laughs). Uh…psychological..mmm* (A42).

Nevertheless, two of the participants exhibited a greater range of knowledge through their use of the psychological vernacular. For example, Wezile referred to the mood variations that coincide with psychological disorders, such as those categorised under mood disorders in the (DSM) (American Psychiatric Association, 2000). In Calvin's explanation of psychological disorders he explained that they sometimes occur in the form of phobias and provided the example of claustrophobia to illustrate his explanation. Claustrophobia is a psychological disorder recognised by the DSM (American Psychiatric Association, 2000) and Calvin's knowledge of this disorder affirms his familiarity with psychological discourse and understanding. Calvin further demonstrated his awareness of psychological disorders through his acknowledgment of depression as a mental illness and explained that the abnormal thinking which symbolises psychological disorders is also evident in depression.

> *Cause, okay when you are in depression you, your brain won't be functioning well, you'll be depressional right? So, I think it's a disorder yeah* (C93).

As sufficient mental health knowledge or literacy is conducive to openness towards seeking psychological treatment (Lauber et al., 2005), it could be assumed that Calvin and Ayanda may be more likely to access formal treatment than the remaining participants. However, mental health literacy also consists of knowledge regarding psychological treatment, which was of particular importance in this study, and thus an investigation into the participants' mental health treatment knowledge was necessary.

It emerged that many of the participants had an absence of mental health knowledge regarding psychological treatment. This was first evident in the participants' queries for clarification from the interviewer as to the variety of psychological treatment.

Mmm…well..I would really have to know more about psychological, professional psychological treatment, what it, what is it? Am I allowed to…? Just know what it kind of involves as well so that I can, I can…(A75).

This finding of a lack of familiarity with formal psychological treatment may prevent these participants' access to and utilization of such treatment as they cannot access and utilize a service of which they are unaware. Additionally, there surfaced an automatic referral to non-professional modes of treatment, such as those not conducted by psychologists, psychiatrists or other mental health workers (Ayanda). This participant explained that the optimal treatment for a disordered person is to talk to them, show them that they are cared for and finally, to create a stable environment so that the person can learn more 'normal' ways of behaving. This finding is significant in that it is indicative of the preference for self-help treatments which has been found in international studies investigating the mental health literacy of the lay public (Goldney et al., 2002). A discussion of the efficacy of such self-help treatments is included in Section 4.5.1.2 above. Although Ayanda's instinctual preference for non-professional treatments may simply be his own personal choice, it may also be symptomatic of the African population's history of exclusion from health services. During the Apartheid era, the field of Psychology (and other health services) was historically reserved for the White minority with African people rarely, if ever allowed access to these services (Pillay & Siyothula, 2008). The majority of psychologists and psychiatrists were White males who primarily treated White females (Pillay & Siyothula, 2008). These demographic characteristics have scarcely changed in democratic South Africa and despite African people's new capacity to access these services, many remain excluded through language differences and geographic isolation from mental health services (Yen & Wilbraham, 2003). Therefore, many African people in South Africa may not view professional psychological treatment(s) as an available option due to their historical exclusion from such practices and this may contribute to an understanding of the under-utilization of mental health services by this population.

Nevertheless, a contrasting finding was that psychological disorders are primarily treated through traditional psychotherapy, or the 'talking cure' (Wezile and Thabang). Below is an example of how the participants described the process of the 'talking cure'.

I, they kind of treat them in the way of talking to you, they just talk to you, ask you your problems because I think the reason they talk it's simply that they know uh, for a person to be relieved it's

when he or she talks to someone. That's what helps a person to be relieved. So, the reason they talk to you it's one way of you letting out what's stressing you (T70).

All counselling and psychotherapeutic modalities involve allowing the patient to talk to the mental health practitioner, and it is through this conversation that recovery occurs, regardless of the theory underlining the specific type of therapy (McLeod, 2003). This finding thus indicates these participants' mental health literacy which may improve their likelihood of seeking psychological treatment. Another example of a good mental health knowledge base (as demonstrated by Vukile) was the description of how different psychological disorders, with their differing etiologies, require different and specialised treatments. Therefore, if a psychological disorder was caused by bewitchment then the treatment professional should be an indigenous healer, whereas if it was due to genetics, a biomedical doctor would be required. This discernment between treatments for different types of disorders has been found in international studies as representative of superior mental health knowledge (Schnittker et al., 2000). Consequently, it may be assumed that low mental health literacy regarding the types of available psychological treatments would not constitute a barrier to seeking this treatment for these participants.

As previously explained, mental health literacy includes knowledge about how and where to find mental health treatment. Owing to the context of the study, conducted at the University of the Witwatersrand with university students as participants, this aspect of mental health literacy was investigated through questions exploring the participants' knowledge of the campus mental health facilities. The University of the Witwatersrand has two mental health facilities, the Career and Counselling Development Unit (CCDU) (University of the Witwatersrand, 2009a) and the Emthonjeni Community Centre (University of the Witwatersrand, 2009b). While none of the participants acknowledged familiarity with the Emthonjeni Community Centre, more than half stated that they were aware of the existence of the CCDU (Makhaya, Thabang, Wezile, Calvin and Vukile). Some participants' knowledge of the CCDU was a result of their direct contact with the service.

Yeah, uh, I've heard about the CCDU. Okay, well sometimes they will come to-I stay at res so most of the time they tend to come there so..I've been attending..yeah (V28).

However, the remaining participants' ignorance of the CCDU as well as all the participants' unawareness of the Emthonjeni Centre may prevent many from accessing psychological help and thus contribute to the under-utilization of available mental health services. As indicated above, the other

manifestation of mental illness stigma which was investigated in this study was that of prejudice, namely negative attitudes and behaviours towards people with mental illnesses. Prejudice appeared to be a recurrent subject within the participants' descriptions and comprehension of psychological disorders and people so afflicted. One such example of this prejudice was that half of the participants automatically thought of, and referred to, the extremities of psychological disorders. For example,

> *Psychological disorders…that thing sometimes people think-imagine things that don't exist* (M103).

Other extremities were that a psychologically-disordered person is someone who fights with inanimate objects, possibly in response to a hallucination (Vukile), says things that do not make sense to 'normal' people (Ayanda) or bizarrely comatose behaviour (Frank).

> *Just look at the sky..or just always uh something, I mean something stupid I must say. I don't know..yeah* (F70).

These symptoms are primarily associated with more severe disorders, such as schizophrenia, psychosis and bipolar disorder (American Psychiatric Association, 2000) and do not represent the more commonly experienced psychological disorders. However, the fact that these participants felt that psychologically-disordered people typically display such extreme behaviour illustrates their incorrect and stigmatising beliefs about people with mental illness. Furthermore, this relates to another theme associated with prejudice, that of the excessive use of negative labels with which participants used to describe people with mental illness. The participants referred to people with mental illness as 'crazy' (Ayanda, Calvin, Vukile, Makhaya and Sandile), 'psycho's (Calvin), 'mad' and 'insane' (Frank). Furthermore, the poor and homeless were felt to be preferable to people with mental illness,

> *A hobo is too much better* (V124).

Sadly, these derogatory labels are commonly used in both informal and professional discourse (Brown & Bradley, 2002) and perpetuate the negative images and beliefs about people with psychological disorders. Nevertheless, one participant expressed a positive attitude towards people with psychological disorders. Despite referring to people with mental illness as *crazy* and focusing almost exclusively on extreme psychological disorders as representative of disorders in general, Makhaya revealed that

mentally ill people should be perceived as humans deserving of love and acceptance. Nevertheless, it appears that holistically, the participants have shown evidence of great mental illness stigma. The implications of these stigmatising attitudes for these participants are severe. One consequence may be that if these participants have internalised the stigma, then if they were to develop a psychological disorder themselves, they would be confronted by the belief that they will also begin to hallucinate or do such conspicuously strange things. Consequently, it was important to investigate the participants' levels of internalised stigma.

4.5.3. Internalised Stigma

The fear of being stigmatised is often experienced as threatening to the person's sense of self (Crocker & Garcia, 2006) and this may prevent these participants' acknowledgment of problems and disorders and subsequent avoidance of treatment for that disorder. Moreover, previous research on mental illness stigma (Angermeyer & Matschinger, 2003) has found that the majority of psychological patients believe that the best way to avoid being stigmatised for the disorder is to reduce social contact with other people and maintain the concealment of the disorder. Therefore, it was important to ascertain whether the participants have internalised this stigma and this was explored according to whether they would, hypothetically, be willing to disclose that they had a psychological disorder, and/or were receiving psychological treatment, and the persons to whom they would be willing to disclose. A reluctance to disclose either is indicative of internalised self stigma, which would in turn present as a severe barrier to seeking treatment (Phelan & Basow, 2007).

4.5.3.1 Disclosure for psychological disorders

While all eight participants acknowledged that they would disclose that they had a psychological disorder, they further divulged that they would limit this disclosure to appropriate confidantes. Of the people to whom they were willing to disclose, the primary confidante, as noted by seven of the participants (excluding Makhaya) would be a close male friend. The reason(s) for their willingness to confide in male friends were that male friends would be more understanding of their position and problem and would also be more likely to appreciate the seriousness of the disorder and thus would not force the person to adopt the pretense that everything is normal. The solid bonds between men would further encourage the sharing of problems and distress,

> *Yeah it, tell, telling the other guys yeah. Cause as, as guys I mean we might just..we actually you know, just strengthen each other like* (F213).

This finding seems more credible when viewed in conjunction with the above findings (see Section 4.4) that a primary alternate treatment for men is confiding in other close male friends. The participants also acknowledged that they would disclose the existence of a psychological disorder to their immediate family (Thabang, Calvin, Ayanda, Vukile, Frank and Sandile). An unusual finding to emerge was that some participants particularly mentioned that this familial disclosure would be to their mother as they believed that she would be best equipped to support and help them through the disorder (Sandile and Wezile). The remaining confidantes included girlfriends and roommates (Vukile) or, as declared by Makhaya, anyone who expresses an interest in his mental health.

As previously explained, the participants also identified the people to whom they would never disclose the presence of a disorder. While Ayanda admitted that he would confide in his family, he further explained that the family members in whom he would confide would only be those who believed in a Christian ideology rather than the Shona culture due to the highly stigmatised nature of mental illness in the Shona culture (see Section 4.3). Frank felt that, contrary to other participants, he would not disclose to his mother as he would not want to cause her anxiety or fear. However, Frank and Sandile agreed in their refusal to disclose to a female friend or girlfriend as this admission of a psychological disorder to a woman violates hegemonic male gender roles and makes men feel inferior and powerless.

> *Yeah cause you used to them like coming up with all this problems and you giving advice. It's kinda, you know it's not just normal just being the other way around. Yeah, it's kinda unusual.* (F225).

Their refusal to disclose to women can be said to be an expression of *the big wheel* typology of the hegemonic male gender role (see Section 4.4) as this refusal is driven by the desire to remain in the position of power and authority. Therefore, it appears that overall, the participants have not internalised the stigma relating to psychological disorders and would be willing to disclose the existence thereof. This may aid them should they develop psychological disorders as it would improve their likelihood of receiving alternate treatments such as the informal counselling from friends. However, as this study explored the reasons for the under-utilization of mental health services, the participants' willingness to

disclose information regarding their treatment will provide a final answer as to whether stigma is a contributory barrier.

4.5.3.2 Disclosure for psychological treatment

A divergent pattern emerged in the interpretation of the participants' willingness to disclose their utilization of psychological treatment. Compared to all eight participants for the disclosure of a disorder, only five participants indicated a willingness to disclose treatment. This discrepancy was explained by the belief that receiving treatment for a disorder is associated with greater stigmatisation because the disordered person is perceived to be unable to help him/herself.

> *(laughs) Umm (laughs)…uh (laughs) alright, now treatment is another story cause you know at times you're afraid about the judgment of other people or what they might think at times* (A119).

Nevertheless, of those who would be willing to disclose treatment, the choice of confidantes was similar to those for the disclosure of a disorder. For example, male friends also emerged as the primary confidantes for disclosure of receiving treatment (Sandile and Thabang). However, it was also found that the number of male friends and family members would be limited when it comes to disclosure for psychological treatment. Similarly, mothers were particularly chosen as the appropriate family members to disclosure treatment to (Calvin and Sandile). Finally, as with his willingness to disclose a disorder, Makhaya explained that he would disclose his use of treatment to any person who he felt would benefit from such information.

> *A lot of people who normally ask me why I'm always alone, why I'm quiet, they know my story. And they know about CCDU (M198).*
> *So..if something happens to me and somebody help me in a good way I share the, the knowledge (M199).*

In contrast, those participants who rejected the possibility of disclosure for psychological treatment could not provide reasons for this declination (Wezile, Vukile and Frank). For example,

> *Okay, and would you tell anybody if you were getting treatment for a psychological problem?* (I226).

(laughs) No (laughs) (F226).

Hence, this indicates that these participants have internalised the mental illness stigma of receiving treatment and thus may choose not to seek and utilize treatment for fear of being stigmatised. Furthermore, it further solidifies the significant influence that mental illness stigma has as a barrier to mental health treatment seeking. In summation, the theme of stigma appears to fundamentally influence perceptions of psychological disorders, psychological treatment, and prevent the utilization of mental health services. Further efforts need to be employed in order to reduce the influence of stigma in South Africa so as to promote the use of mental health services by all those who wish to do so. Mental illness stigma has also been shown to be reciprocally related to contact with disordered people (Vogel et al., 2007). Similarly, the influence of contact emerged as an overarching theme in the analysis and thus will be further explored below.

4.6 Contact

As has been previously explained, people who have had positive prior contact with mental illness and/or people with mental illness are more likely to seek mental health treatment. This contact may be *indirect*, through media exposure, or *direct,* such as through contact with family and or close friends, or even persons unknown to the individual. This study explored all three of these types of contact with mental illness and sought to determine whether negative contact or an absence of contact exists as a potential barrier for seeking professional psychological treatment among these participants.

4.6.1 Indirect contact

In answering questions regarding indirect contact through the media, all eight participants explained that they had been exposed to psychological disorders in television shows and films. Disordered people in these media portrayals were often depicted as suicidal and dangerous despite receiving treatment for the disorder. For example, Makhaya provided an example of one of the films that he had watched,

> *And, somebody was trying to harm her and she had to go through some counselling. But she also killed herself* (M174).

The portrayal of the ineffectiveness of psychological treatment may impact negatively upon the viewer's perceptions of psychological treatment. Other participants believed that psychologically-disordered people were described as needy and suffering in order to garner sympathy in the form of donations from the viewer (Ayanda). The other experience of such media portrayals was that disordered people are portrayed as more disturbed than they really are and that they are often depicted as murderous and dangerous serial killers (Wezile and Calvin). Calvin specifically felt that psychological disorders are repeatedly equated with demon possession,

> *Like sometimes they say people who are not well up in the brain they go around eating people…* (C184).

These findings are noteworthy in light of previous research which found that more than half of all persons with psychological disorders in television dramas are shown to be violent and in fact, murderous (Signorielli, 1989, as cited in Minnebo & Van Acker, 2004). This can be contrasted with the fact that more than ninety percent of all persons who develop a psychological disorder never demonstrate violent or aggressive behaviour (Minnebo & Van Acker, 2004). Nevertheless, this violent depiction of psychological disorders and people with psychological disorders may perpetuate the stigma that they are dangerous and violent and has the accumulative effects of decreasing contact, increasing stigma surrounding mental illness, and thus increasing the avoidance of psychological treatment (Vogel et al., 2007). However, while these participants have experienced indirect contact with mental illness through this media exposure, it was important to examine whether these representations were perceived to be accurate and believable by the participants. This would influence whether the contact would have an effect on their own attitudes and beliefs surrounding mental illness including those related to contact and stigma.

Significantly, only three participants (Calvin, Ayanda and Wezile) argued that the media representations are grossly exaggerated and thus cannot and should not be taken as realistic portrayals by viewers of such films and television programs.

> *Well, sometimes they portray the wrong image* (C184).

These findings are important as they show that these three participants do not allow negative and exaggerated media portrayals to influence their perceptions of mental illness and people with mental

illness and thus this indirect negative contact with mental illness would most likely not constitute a barrier to their seeking professional psychological treatment nor contribute to stigma surrounding psychological disorders. However, this can be contrasted with other remaining participants who felt that the portrayals of psychological disorders in the media are both accurate and realistic. The most disconcerting belief from these participants was voiced by Vukile, who felt that bizarre and unfounded behaviour such as excessive eating of a specific item of food was a realistic portrayal of a psychological disorder.

> *…in Casino you see the person going around eating beans and stuff. The people be laughing at you, because you don't really, act yourself and yeah. Yeah* (V112).

These incorrect perceptions contribute to the stigma of mental illness and avoidance of professional psychological treatment and may constitute a barrier to seeking treatment for these particular participants. Furthermore, it may actually prevent disclosure and hence treatment of any kind through a fear of being associated with such behaviour. Moreover, this fear directly contributes to the avoidance of contact with a psychologically-disordered person, as explained by Ayanda,

> *I definitely know if my sisters was watching a horror movie and they, it did have someone with psychological disorder and stuff but then she went to sleep… but then..so if I were to tell her let's go to a place you know, she would probably hesitate as well* (A103).

This provides an illustration of how negative indirect contact through the media can increase stigma surrounding mental illness which, as shown above, increases the likelihood of the avoidance of mental health treatment. However, opposing views emerged that these media portrayals can actually reduce the stigma of mental illness, and subsequently, improve the utilization of mental health services. Despite Ayanda's previous explanation of how the media can increase mental illness stigma, he also felt that the exaggeration of psychological distress in the media is conducted in order to garner viewer sympathy as well as to inspire an interest in helping organisations that deal with psychological disorders. Another participant felt that psychological disorders are embellished in the media to indicate their severity and to illustrate how early interventions can prevent the aggravation of the disorder.

> *…They're trying send a message that you know, yes this disorder stuff exists and..if you don't get help in time..you might end up dead* (M175).

Nevertheless, a belief in the realism of negative media portrayals is likely to increase those participants' mental illness stigma as well as decrease their openness to interacting with people with mental illness, and the final outcome of preventing them from seeking treatment.

4.6.2. Direct contact

Five of the participants indicated that they had experienced direct contact with a disordered person who was unknown to them. Of noteworthy importance, Sandile, Calvin and Frank felt that the homeless people they have encountered were psychologically-disordered. This perception of the homeless as disordered primarily arose due to the unhygienic nature of the homeless, which, according to these participants, epitomises the bizarre behaviours characterised by psychologically-disordered people.

> *They be dirty, they don't bath, you know and they talking..to themselves, yeah and they keep on talking I mean the way they sleep...* (F154).

Calvin further described how destitute people "just go around eating stuff from bins…" (C173). This relationship between poverty and psychological disorders, as well as the influence of such beliefs, was explained in Section 4.5.1 above.

Direct contact with unknown persons other than the homeless or very poor was acknowledged by only Ayanda and Vukile. Vukile's contact consisted of a brief encounter at his local clinic, however this contact was negative as it increased his stigma towards mental illness.

> *Just see them moving around, sometimes you just stare at them, like…who, why is the world like this? Why is it like this? It's so tough* (V108).

On the other hand, Ayanda's contact continued for a much longer period and reduced his stigma as he was given the opportunity to freely interact with the psychologically-disordered which he previously would have avoided, and through this contact discovered that disordered people are not violent and dangerous as he had previously believed. This contact may have improved Ayanda's likelihood of seeking psychological treatment, or at least of disclosing the existence of a disorder, thus increasing the opportunity for non-professional treatments such as the help from friends and family members.

Three other participants expressed a prior direct contact with a family member or friend who had had a psychological disorder. For Sandile, this person was his uncle, Makhaya had had contact with both a male cousin and a male friend from school, and for Frank the disordered individual was a male friend with whom he was in high school. Makhaya's cousin and friend as well as Sandile's uncle all received psychological treatment for their disorders and have subsequently recovered. Direct contact with a person who was successfully treated with professional treatment has been found to increase the likelihood of seeking treatment (Vogel et al., 2007) and thus we may assume that this direct contact with mental illness and its treatment would not present as a barrier to seeking treatment for Makhaya and Sandile. The positive nature of the contact with these disordered family members and friends is also evident in Makhaya and Sandile's continuation of this contact. In contrast, Frank's high school friend has yet to receive professional treatment and his disorder has since drastically worsened.

> *He's not better. People well I haven't seen him but people just say..that now he just does some funny things like you know wear ties, ties the other way round, he just keeps on talking to himself..you know and he just does..some funny things* (F156).

Therefore, this negative direct contact may have increased Frank's stigma towards mental illness and have affected his potential to seek and utilize mental health services. Therefore, it has been shown that contact has a significant impact upon mental illness stigma and upon seeking professional psychological treatment. The final overarching theme to emerge in the analysis was that of normality versus abnormality, and the discussion relating to this theme completes the thematic structure of this thesis.

4.7 Normality Versus Abnormality

4.7.1. Normal versus abnormal behaviour is representative of psychologically healthy versus psychologically disordered

It is widely accepted in psychological discourse that psychological disorders are clustered at the end spectrum of the normal to abnormal continuum of behaviour (Maddaux, 2004). This is interpreted to mean that normal and abnormal functioning, and thus the difference between those who are psychologically healthy and those who are psychologically-disordered, can be accounted for by quantitative differences or degrees and therefore there is no clear distinction between them (Maddaux, 2004). Many of the participants consented with this professional assertion (Vukile, Calvin, Ayanda and

Frank). Furthermore, it was believed that once behaviour surpasses the threshold into abnormal behaviour it can be deemed a psychological disorder but that the parameters of this threshold are determined by the particular culture in which that behaviour is exhibited.

> *When it can vary from culture to culture, what their definition of normal is* (A65).

This declaration that abnormality, and consequently psychological disorders, is culturally-determined is significant in that this is one of the primary assertions and motivations behind the development and proliferation of cross-cultural psychopathology and the inclusion of culture-bound disorders in the DSM (Long & Zietkiewicz, 2002). Furthermore, it may have implications for when African males see their behaviour as encroaching upon abnormality and thus necessitating treatment. For example, auditory and visual hallucinations are commonly experienced by traditional healers in African cultures whereas similar symptoms seen in a western institutional setting would automatically be classified as indicative of schizophrenic functioning (Draguns & Tanaka-Matsumi, 2003; Long & Zietkiewicz, 2002). Many of the participants further explained that a general rule in determining abnormality is that it is behaviour which is contrary to what the majority of people are exhibiting. Therefore, as clarified,

> *He's not normal. Like, it's not, it's out of the norm. It's not like other people..yeah* (C126).

This idea of abnormality being contrary to conventional behaviour further reinforces the above description of the normal versus abnormal continuum. However, the difficulty in determining when behaviour becomes abnormal was demonstrated by the participants' disagreements over whether depression should be classified as a psychological disorder.

> *Psycholo-I do not consider depression as a psychological disorder. Depressed? Well, I, I, I think depression can lead to psychological disorder but I do not consider as, as a psychological disorder as I consider it something one can go through due to circumstances or stuff like that but like I actually do not think it is a psychological disorder* (A47).
>
> *Uh (laughs), well let's see um…nah, not really. Not really. Maybe depression maybe it's just something which comes natural* (F74).

Depression, perhaps the most common and widely known psychological disorder (Ng et al., 2008) is one of the primary psychological problems affecting South African citizens (Pillay et al., 2009; Stein et al.,

2008). However, previous studies have found that the symptoms associated with depression such as sadness and insomnia, are perceived as less abnormal and, hence, less indicative of a disorder, than the severely abnormal symptoms associated with schizophrenia (Angermeyer & Dietrich, 2006; Lauber et al., 2003; Phelan & Basow, 2007). Therefore, the determination of whether behaviour is normal depends on how 'acceptable' and commonly seen it is. Moreover, while this finding is unremarkable, it may be detrimental for these participants' mental health as they may not seek treatment for their depression if they view it as part of the natural progression of life. Furthermore, the dismissal of the dangerousness of depression could help explain the high rates of suicide due to depression among young, African males within South Africa (Burrows, 2005). The normal versus abnormal continuum of behaviour also had implications for the participants' help-seeking pathways as it appeared that for some participants, the 'normal' challenges in life were approached and treated differently from psychological disorders, thus having implications for the utilization of mental health services.

4.7.2. 'Normal' challenges support structures versus 'Abnormal psychological disorder' help-seeking pathways (Support and refutation for Cognitive Dissonance Theory)

There emerged a number of different help-seeking pathways that participants were willing to utilize if they were to develop a psychological disorder. These pathways consisted of 1) only utilizing alternate treatments and completely avoiding professional psychological treatment, 2) first accessing alternate treatments and only seeking professional psychological treatment if the alternate treatments fail, and 3) immediately accessing professional psychological treatment.

The first pathway of only utilizing informal treatments and completely avoiding professional psychological treatment was supported by Wezile and Frank. The alternate treatments that they would utilize would be help and counselling from their mother (Wezile), help from their father (Frank) and de-stressing exercises such as listening to music, watching films or spending time with friends (Frank). Wezile's preference for his mother's assistance replicates his support structures for his previous challenges.

> *Mostly I talk to my mom. When I'm down she's there. She's the first person that comes to mind, yeah* (W101).

This theme of the significance of a mother's support correlates with the literature on the socialisation of South African men whereby mothers, through their role as the primary caregivers, are also the customary providers of men's emotional support (Mtebule, 2002). In contrast, while other participants also identified that their mother has previously been their primary recourse for help, they did not believe that they would rely on their mother for help with problems so severe that they could be classified as a psychological disorder (Ayanda and Calvin). This may be related to the above finding that confiding in family members was not seen as a substitute treatment for African males (see Section 4.4). Frank's reliance on his father's help for a psychological disorder similarly replicates his father's role in helping and supporting him through his previous challenges and problems. Furthermore, it coincides with the substitute treatment for African males of confiding in elders, as shown in Section 4.4. However, as explained, these two participants agreed that they would never seek the help of a mental health professional for a psychological disorder. They were then asked if they would ever consider receiving help from the CCDU or Emthonjeni Centre, which were assumed to be less stigmatising than hospital-based psychologists. However, they similarly asserted that they would never access such help.

> *I can't really explain…I don't think there would be something in me that would tell me to go and see a psychiatrist or a therapist.* (W122).

Four of the participants felt that for a psychological disorder, they would adopt the second help-seeking pathway, that of first trying alternative treatments and then seeking professional psychological help if these were unsuccessful (Calvin, Ayanda, Vukile and Thabang). Such alternate treatments were confiding in family (Calvin, Thabang, Ayanda and Vukile) and using prayer (Calvin). If these treatments were unsuccessful then these participants stated that they would seek professional psychological help, specifically those which are available at counselling centres such as the CCDU (Calvin, Thabang and Vukile).

> *So, if it was me I believe that I would be much more close to my friends and family and then if I see that it's not really working then I can start seeking for a professional.* (T102).

Thabang's willingness to utilize professional psychological treatment may stem from his previous experience with psychological treatment from the university's counselling centre which he subjectively felt that he benefitted from.

It was helpful in a way because it..it actually..uh, put me in a situation whereby I have to choose whether I want to change or not. So, if ever you are in that kind of situation, you can not run away from it. It's either you change or you don't. So, you have to sit down and ask yourself, do I want to change or I don't want to? So, that's how it was actually (T24).

Furthermore, these participants' reliance on family members has been found to be particularly important in their past experiences and thus they do not appear to discriminate between the help-seeking pathway(s) for normal distress and those for psychological disorders. For example, confiding in family members, particularly the older generation, has previously helped relieve these participants' pressure and anxiety.

They were always just comforting me and trying to make things look normal and to make things normal yeah (C72).

A noteworthy point of contention for both Calvin and Vukile was that despite previous support and help from girlfriends and female classmates, they were not mentioned as possible help pathways for psychological disorders. This may be related to the fact that confiding in women was seen as contrary to hegemonic male gender roles (see Section 4.4).

However, contrary to the other participants, Ayanda explained that he would not access the available campus mental health facilities because he does not see the mental health practitioners who work there as professionals or view the campus facilities as reputable and professional. This has implications for his psychological treatment as he may not have access to a hospital-based psychologist.

I, I just feel a bit more secure at a proper place i.e. basically a hospital or something there (A111).

The final help-seeking pathway for a psychological disorder was that of immediately seeking psychological treatment. Makhaya and Sandile both argued that they would immediately see a mental health professional if they developed a psychological disorder. Makhaya's rationale was based on the fact that he had previously received professional psychological treatment for more than six months and further acknowledged that psychological disorders left untreated can lead to greater distress and even suicide.

Cause now I know..that.at some point if you won't go for help it might..end up worse or you might end up killing yourself cause..you can't take it anymore (M188).

Sandile's own reasoning was also driven by fear of suicide and ill health. Makhaya, who like Thabang, has also previously received counselling from the CCDU, explained that the centre would be his first avenue for finding psychological help. Furthermore, he added that he would also look in the media, such as in newspapers or on the internet, for information on available mental health services if the CCDU or Emthonjeni Centre were no longer available to him. However, Sandile explained that while he would prefer a hospital-based psychologist for more serious psychological problems, he would still access the campus facilities for minor problems and stressors.

These participants' beliefs in the immediate help of a mental health professional are significant in light of the fact that they did not mention their previous support systems, their girlfriend (Makhaya) and female friends (Sandile), neither of which are mentioned as substitute treatments for African males (see Section 4.4). However, Sandile explained that he has previously confided in his uncles (elders) as well as used alcohol to make it through difficult times in his life.

Uh..sometimes, sometimes I do that like first semester when I like fail a test ah go drink, drink, drink (S183).

These were mentioned as substitute treatments and negative coping mechanisms for African males and while it is encouraging that Sandile no longer sees alcohol abuse as a viable coping mechanism, it begs further investigation as to why he would not confide in his elders for a psychological disorder. Significantly, a wide variety of coping mechanisms previously used for stressors and challenges were not mentioned by participants as viable options when faced with a psychological disorder. However, some of these findings are positive in that they indicate the seriousness with which participants view psychological disorders. For example, one coping mechanism which was mentioned for previous stressors, but not for psychological disorders, was that of having a strong conviction in being able to overcome the problem (Vukile, Thabang and Sandile). For example,

So, that's one thing that keeps me going all the time..cause when I wake up in the morning I always tell myself that no, if someone managed to do it..why not me? (T43).

Additional coping mechanisms not included for psychological disorders, but used for previous challenges were acceptance of the problem (Frank) or religion and spirituality (Thabang and Makhaya). Furthermore, a momentous discrepancy between previous support systems for general stressors and hypothesised help-seeking pathways for psychological disorders related to the importance of male friends. All eight of the participants expressed that they have previously relied on their close male friends during times of psychological distress. Frank provided an example of how talking with male friends who have experienced similar challenges helped him to cope with and overcome such challenges,

> *Yeah I told a couple of friends and actually when you tell someone you know that's when you realize like..they also having the same problem you are and sjoe yeah* (F60).

Sandile also provided a concrete example of how his friends have helped him in the past by explaining that they helped foster his courage to get tested when he was faced with the risk of HIV infection. It thus seems that while these male participants have previously been able to confide in other males about their problems, they would not do so for a psychological disorder. This can be contrasted with their above explanations that men and African men confide in other men as substitutes for psychological treatment (see Section 4.3 and 4.4). This phenomenon has been observed in psychiatric settings where many of the men who access mental health services acknowledge an inability to confide in their male friends (Pasick et al., 1990). Therefore, fundamental discrepancies exist between what these participants say that other African men do and what they themselves are actually willing to do.

An additional theme to emerge was that participants recommended different help-seeking pathways for themselves (for a psychological disorder) than for other people. A number of help-seeking pathways were recommended for someone other than the participant. In this study, the 'other' was stated as a mother or other close family member if the participants' mothers were deceased or absent. The choice of the 'other' was based on the assumption that the participants would not give much thought or care to a stranger's mental illness and thus a rich comparison between the help seeking pathways for the other and the self would not have been possible.

The help-seeking pathways which were elicited for the other included: 1) a defeatist belief that the other cannot be helped, 2) first utilizing alternate treatments and then seeking professional psychological treatment, and 3) immediately seeking professional psychological treatment. The only participate to

recommend the first pathway was Vukile, who did not think that the disordered other would be able to be helped as they would be unable to comprehend advice or assistance. However, Vukile added that he would recommend that people simply spend time with and create a safe and comforting environment for the disordered individual.

> *Those, all I have to do is…be there for them…and just be there…Just treat them special..yeah, cause…if you, you can't advise someone who's really not like kind of, thinking that way.*(V148).

However, in further questioning, Vukile contradicted this belief when he disclosed that if the person's psychological disorder was the result of bewitchment then he would advocate that they seek the help of a traditional healer, whereas if the etiology was not culturally related then, he would propose the help of a psychologist. This belief was further contradicted by the help-seeking pathway that he would recommend for himself, which was first speaking to his family and then utilizing mental health services. Therefore, this provides evidence of the tensions and incongruities in identifying treatment with oneself or with others and, hence, support for the validity of the Cognitive Dissonance Theory in this study.

The second pathway which emerged in the analysis was that many participants believed that the disordered 'other' should first try alternate methods and then access formal psychological treatment if these methods were ineffective. Half of the participants felt that they would be able to counsel the disordered other and thus treat the disorder in this manner (Calvin, Thabang, Wezile and Frank). For example,

> *Maybe I'd also try and talk to her because she also talks to me at times and yeah. I'd also try and talk to her the way she talks to me when I'm feeling somehow yeah depressed or something* (W121).

The other alternate treatment was that they would encourage the disordered other to remain positive and hopeful (Thabang and Calvin).

> *Well, I would just advise the person not to lose hope* (T99).

The participants also explained that should the above alternative treatments fail, or the disorder be too severe, then they would recommend that the disordered other seek professional psychological treatment.

Thabang provided an example of how he had previously recommended that a good friend seek psychological treatment after his attempts to counsel her himself were unable to alleviate her suffering. Notably, Calvin and Thabang's recommendations for the other coincided with their recommendations for themselves and so this does not provide evidence for the hypothesised tensions and incongruities in identifying treatment with oneself, or with others. This advocacy of informal counselling from family members replicates the substitute treatments for African persons as shown in Section 4.3. However, Wezile and Frank's choice of this pathway for the disordered other is contradictory to their above recommendations for themselves whereby they stated that they would never access professional psychological treatment. Therefore, while they view mental health treatment as beneficial to others, they perceive it as unnecessary for themselves. This provides crucial evidence of the tensions and incongruities in identifying treatment with oneself or with others.

As previously stated, the third help-seeking pathway which participants would recommend to the disordered other would be to immediately seek professional psychological treatment (Sandile, Ayanda and Makhaya). It was further explained, that these participants would do their upmost to force the disordered other to seek this treatment, including sharing their own past experiences with psychological problems and/or their treatment.

> *You know, cause sometimes people they, they don't want to go to counselling cause they feel like people will judge them. So, I'll just have to share a bit of my story with them and tell them..how I went through..certain things..that I thought nobody could help me* (M181)

However, while Ayanda would recommend formal psychological treatment for the disordered other, he also felt that he would prefer for this treatment to be conducted by a variety of people, such as through community help and organisations, so as to ensure the greatest chance for recovery. This view coincides with his previous statements in Section 4.5.1.2 where he believed in the effectiveness of multi-disciplinary treatments for psychological disorders. It is important to note that this help-seeking pathway and the one that Makhaya and Sandile recommended for themselves are identical. Therefore, this finding also disputes the hypothesis that incongruities arise when identifying treatment seeking with oneself or with the disordered other.

Therefore, it appears that the participants are quite encouraging and positive towards disordered others seeking professional psychological treatment. However, a contradictory finding that emerged was that

despite previously declaration of African persons' use of traditional healers or elders in the treatment of mental illness, none of the participants recommended these treatments for their disordered other. Therefore, tensions exist between their hypothetical explanations of the treatment of mental illness and the tangible examples referred to in this section and further research into these tensions is necessary.

CHAPTER FIVE
CONCLUSION

5.1 Summary of Central Findings

The primary aim of this study was to explore the reason(s) for the under-utilization of mental health services by young, African males in South Africa. The study was prompted by the findings that African males are the least seen population group in professional psychological treatment (Kohn et al., 2004), and also have one of the highest suicide rates in the country (Burrows, 2005). Were it not for this extraordinarily high suicide rate among this population, their under-utilization of professional psychological treatment would be seen as indicative of their decision to utilize alternative, more preferable, treatments for psychological disorders and would not immediately demand attention for mental health research in South Africa. However, their avoidance of such professional psychological treatments as well as their poor mental health (indicated by their increased risk for suicide), may be perceived as suggestive of their absence of sufficient, available alternate treatments, thus prompting this particular investigation.

The research found that these young, African male participants have been, or were currently exposed to a significant number of mental health impairing stressors. The most grievous and acute of these stressors was the strain caused by their recent transition into tertiary education and its associated anxieties and pressures. The considerable influence of this stressor on the participants' mental health highlights the importance for greater efforts to ensure an easier transition for first year university students, as well as the increased promotion of services which are aimed at helping students adjust to the demands of a university education, such as those offered by the Career and Counselling Development Unit at the University of the Witwatersrand. In addition, the participants' inexperience with self-identification and concepts such as ethnicity highlight the importance for greater research to be conducted into adolescents' and young adults' self perceptions in South Africa. For example, it needs to be determined whether the youth in South Africa (particularly tertiary education students) are sufficiently self aware in order to make important life changing decisions such as the choice of future career. Furthermore, it seems that ethnicity may not be an important aspect for young, African males as racial classifications continue to dominate divisions in South Africa. Therefore, it highlights the need for the re-structuring of efforts to promote unity in this country.

The reasons for the under-utilization of mental health services by young, African males in South Africa to emerge included: African cultural beliefs, hegemonic male gender role beliefs, stigma, contact and beliefs surrounding perceptions of normality versus normality. The only barrier to emerge which was not expected from the literature review involved the theme of normality versus abnormality, thus confirming the role of these barriers to mental health services in South Africa.

The primary themes which emerged with regard to the overarching theme of the influence of an African cultural ideology, were that: psychological disorders are manifested, interpreted and treated alternatively according to different tribal groups; that certain disorders are culture-bound and thus must be treated accordingly, of which treatment primarily consists of healing from traditional and indigenous healers; and that Psychology as a profession in South Africa is viewed by many African persons as elitist, exclusionary to non-Whites and too costly to be perceived as a viable option for the treatment of psychological disorders. What these findings reveal is that Psychology has not been transformed in post-Apartheid South Africa and remains biased towards White citizens. There needs to be a greater effort spent on training culturally sensitive psychologists and providing incentives for them to practice in areas that have previously been excluded from psychological treatment. The presence of culture-bound disorders has been found in other, international countries (Lopez & Guarnaccia, 2000) and this study confirms that they also exist in South Africa. Therefore, this raises questions as to whether the formal field of Psychology can be universally applied, or is even necessary, especially in South Africa whereby such diverse and entrenched ideological frameworks exist influencing the perception(s) of disease.

Furthermore, it was found that these participants see themselves, and other males, as both endorsing and rejecting hegemonic male gender roles that prohibit seeking professional psychological treatment. Thus, it was found that these hegemonic male gender role beliefs continue to constrain men and in fact, not only disallow seeking professional psychological treatment, but also prevent the expression of emotion and reliance on healthy, alternate treatments such as being able to confide in friends and family. This highlights the importance for greater research on males as the majority of gender studies have focused on the feminine perspective. The presence of these hegemonic male gender roles also has wider applicability in that they can be seen as influencing a wide variety of male behaviours, especially that of violence.

Stigma emerged as a primary constraint on mental health care seeking and was manifested in low mental health literacy and associated incorrect beliefs. This highlights the need for greater education for the

public on psychological disorders and treatment, similar to other health concerns, such as HIV/Aids and cancer awareness programmes. Furthermore, a particularly disconcerting finding was that there emerged a perception of a direct relationship between poverty and psychopathology, with homelessness being described as an exemplar for psychological disorder. Correspondingly, indirect contact from negative media representations of psychological disorders was shown to be influential in both the creation and maintenance of mental illness stigma, and further presented as a considerable barrier to seeking professional psychological treatment.

Finally, the perception that behaviour exists on abnormal to abnormal continuum emerged as a primary factor in the participants' choice of treatments. There further emerged discrepancies in the participants' choice of help-seeking pathways for themselves and those they would recommend for others, thus providing evidence for the incongruities in mental health treatment beliefs. Therefore, this belief in personal invincibility can perhaps be targeted through educational efforts to improve the mental health literacy of the public in South Africa.

5.2 Theoretical Analysis of Central Findings

As the results of the study have already been discussed according to the Cognitive Dissonance Theory (see Section 4.7.2), this section focuses on a brief analysis of how the Theory of Planned Behaviour was used to interpret the findings of the study. The TPB was described above (see Section 2.7.1) whereby it was explained that behaviour (in this study operationalised as seeking professional psychological treatment) results from an intention to behave, which is in turn informed by the three components of attitudes towards the behaviour, subjective norms, and perceived behavioural control (Azjen, 1991). Furthermore, attitudes towards the outcome of the behaviour refer to the positive and negative attitudes surrounding seeking psychological treatment, subjective norms consist of social pressure to seek or avoid psychological treatment, and perceived behavioural control refers to whether the person believes that they can cope with their psychological disorder on their own, or if they believe it would require expert assistance (Azjen, 1991).

Based on the central findings of this study, it is clear that all three of these components emerged as fundamental influences on these young, African males' seeking professional psychological treatment. For example, there emerged both positive and negative attitudes towards seeking psychological treatment. Although many of the participants expressed positive attitudes about the efficacy and need for

psychological treatment, the majority of attitudes expressed were negative in nature. For example, a central finding was that a strong belief in a traditional African cultural ideology is associated with the negative attitude that professional psychological treatments are too expensive, and that it is viewed as elitist and thus, not a viable treatment option for African persons. Thus, these negative attitudes would cement an intention to avoid professional psychological treatment in favour of more culturally sanctioned treatments. As such, we can ascertain what factors should be targeted in order to improve African persons' willingness to seek professional psychological treatment.

An illustration of how subjective norms prevent seeking treatment can be found in other central findings that a strong belief in hegemonic male gender roles includes the fear of being perceived by others as weak, and the high levels of mental illness stigma which emerged in the study. It was expressed that there is a pervasive social insistence that men must not admit to an inability to cope with the demands of life. As such, the admission of requiring professional treatment for a psychological disorder, is negatively received. This subjective norm would shape an intention to behave that is in opposition to seeking professional treatment, such as the denial of necessity and subsequent avoidance of any form of treatment. Similarly, the effects of mental illness stigma (a subjective norm) would prevent the disordered individual from either admitting to having the disorder or actively seeking treatment and help for the disorder for fear of social and public recriminations.

Finally, evidence was found for the perceived behavioural control component of the TPB and how this influences the intention to behave. Many of the participants expressed the experience of negative indirect contact with mental illness through the media. The disordered individuals depicted in the media were described as fearful and it was implied that they had little or no chance at recovery. These depictions may coerce the participants (and other young, African males) into believing that not even professional psychological treatment can help you overcome a mental illness, and thus shape the perception that treatment is unnecessary and worthless. Consequently, this perception of the inability to control and overcome a mental illness may influence the intention to hide the existence of a disorder and/or to dismiss seeking treatment for it. An additional example is that a central finding emerged that participants struggled to determine the difference between normal behaviour and the type of abnormal behaviour that requires professional treatment. If they were to maintain that their depression was 'normal' then they would believe that they could control and overcome it on their own, thus forming the intention to self-manage rather than to seek professional help.

In summation, it is clear that the Theory of Planned Behaviour provides insight into how the central findings of the study can be viewed as affecting the outcome behaviour of seeking professional psychological treatment. Additionally, the use of this theory highlights the areas in which interventions can and should be made in order to positively shape the intentions to seek treatment.

5.3 Limitations

In spite of the importance and necessity of this research study, a number of limitations must be identified and discussed. To begin, this study employed participants who were students in their first year of tertiary education. University students are not truly representative of the general population due to their augmented education and exposure to various ideologies and perspectives. Furthermore, they reside in the urban hub of Johannesburg, which allows them to experience more westernised ideologies. Owing to the qualitative nature of the study, the participants' perceptions of psychological disorders, treatment and their rationale for why many young, African males do not seek treatment cannot be said to represent other young, African males' perceptions. In addition, the area that this research investigated appealed to a distinct group of young, African males and their interest in participation in such research has likely influenced their perceptions of Psychology.

A methodological limitation relates to the use of interviews as the measure for these participants' perceptions. Although individual interviews were identified as the most advantageous choice for the study, other measures such as focus groups may have created greater discussion and debate of perceptions, which would likely have illuminated how such perceptions are constructed and contested. Furthermore, the researcher's position as a student in the department of Psychology, together with the intimate and personal nature of individual interviews, may have influenced the participants to voice perceptions which they thought the researcher would most likely wish to obtain. However, this respondent bias was prevented insofar as possible, through the prior construction of the semi-structured interview schedule in consultation with the researcher's supervisor and subsequent piloting of the schedule.

A chief limitation related to the researcher's position as a White female investigating African males' perceptions of psychological disorders and professional psychological treatment. While this may have prevented the participants from freely expressing their perceptions, it was not subjectively observed by

the researcher during the interviews or after careful analysis of the transcripts. Moreover, the interviews appeared to be facilitated by this social distance as the participants provided in depth explanations surrounding their perceptions. This absence of the demonstration of this limitation was epitomised in the example whereby participants explained that it is unacceptable to talk to women about their problems but confided both this fear as well as very personal experiences of stressors and challenges to the researcher.

5.4 Recommendations for Future Research

The research uncovered a number of important issues and concerns which can and should be investigated in future research. For example, it would be interesting to see if very different perceptions or barriers to seeking treatment were to emerge if the research was conducted by an African male, who would likely be more familiar with these perceptions and be able to challenge them in greater detail. Future research could also employ different measures, such as focus groups or the combination of quantitative and qualitative approaches in order to obtain a more holistic understanding. Additionally, research could examine differences between tribal groups in their perceptions and reasons for under-utilization. Future research should also explore some of the inconsistencies which emerged in this study, such as whether men in South Africa really do confide in one another and the depth to which they reveal their problems and emotions. It is also imperative that future research investigate additional ways to integrate cultural practices into Psychology and psychological treatment, for example how traditional healers and psychologists can co-operate in the treatment of a patient. Future research should determine whether older African males (and females) would hold similar perceptions to these young, African male participants. It would be important to replicate the study with females and other population groups in order to ascertain the overarching barriers to the mental health treatment in South Africa. This would provide the direction for the future development of the field. Future research could also explore the help-seeking pathways of patients who do utilize mental health treatment in order to determine the types of alternate treatments which they first employed. Finally, research should explore how to maximise the potential of alternate treatments of psychological disorders, so as to reduce the burden on the mental health budget in the country.

5.5 Implications and Conclusion

The paucity of research into the mental health of young, African males and their choice of treatments for psychological disorders in South Africa, highlights the need for studies of this nature to be conducted. This research can assist mental health professionals in understanding the under-utilization of mental health services by this population and illuminates the necessity to transform Psychology to become more relevant and less 'foreign' so that all South African citizens feel that professional psychological treatment is an available option for the treatment of psychological disorders. Furthermore, it has an influence external to psychological treatment by illustrating how hegemonic male gender roles continue to constrain and limit males' beliefs and behaviours in South Africa. In conclusion this study forms an important basis for recognising the areas which need to be addressed in order to promote Psychology and psychological treatment in the future South Africa. South Africa is a unique country for mental health treatment owing to its wide variety of ideological frameworks, influencing beliefs about psychological disorders and their treatment. Therefore, the purpose of this research was not to dismiss all other treatments other than professional psychological treatment, but to highlight the areas that the field of Psychology in South Africa needs to examine if it wishes to become more relevant and beneficial for the large, at risk population of young, African males.

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APPENDIX A

Interview Question One:

Please tell me about yourself – how would you describe yourself?

Prompting Questions:

How old are you?

How would you define your ethnicity?

What is your home language?

What is important to you?

Interview Question Two:

How do you feel about your life in general?

Prompting Questions:

How are you finding university life?

What facilities do you access on campus – for example are you part of any clubs, do you use the library resources, medical centre, CCDU?

Tell me about your social life?

Tell me about your relationships?

Where and with whom do you live?

Interview Question Three:

What are some of the challenges that you have had to deal with?

Prompting Questions:

Why was it challenging?

Did you tell anyone about this problem/challenge?

How did you deal with the challenge(s)?

What kind of support did you have during this challenge in terms of friends and family support?

Interview Question Four:

What are psychological disorders?

Prompting Question:

Why do people develop psychological disorders?

How do people develop psychological disorders?

What does your culture say about psychological disorders?

Who decides who is psychologically disordered?

Why?

Interview Question Five:

How are psychological disorders treated?

Prompting Questions:

What do you think about psychological treatment?

What do you think is the best way to treat psychological disorders?

What does your culture say about treating psychological disorders?

Can a psychologist help people from outside their own cultural grouping?

Why/ Why not?

Are urban/rural factors important?

Interview Question Six:

Where have you come across psychological disorders before?

Prompting Questions:

Do you know anyone with a psychological disorder?

Did that person overcome the psychological disorder?

If so, how did that person overcome the psychological disorder?

How often do you see or speak to this person?

What is your relationship with this person like?

Have you come across psychological disorders in the media – TV, print etc?

What do you think of those representations?

Interview Question Seven:

How would you feel if someone you knew developed a psychological disorder?

Prompting Questions:

Would it make a difference if the person was a family member (for example your mother) or if it were someone you are not very close to and see only occasionally?

How would you feel about spending time with them?

What would your advice be to this person with the psychological disorder?

Interview Question Eight:

What would you do if you were experiencing psychological problems?

Prompting Questions:

What kind of treatment would you seek, if any?

Where would you get this treatment from?

Would you access help on campus – CCDU, Emthonjeni?

Who would you tell that you were experiencing psychological problems?

Who would you tell that you were receiving psychological treatment?

Interview Question Nine:

Why do many men not seek psychological treatment?

Prompting Question:

In what ways do men deal with psychological problems other than seeking professional treatment?

Interview Question Ten:

Why do you think that many people from the African culture do not seek formal psychological treatment?

Prompting Question:

In what ways do African people deal with psychological problems if they do not seek professional psychological treatment?

Interview Question Eleven:

Why do you think that many young African men do not seek formal psychological treatment?

Prompting Question:

In what ways do African men deal with psychological problems if they do not seek formal psychological treatment?

APPENDIX B

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MPSYC/09/009 IH**
PROJECT TITLE:	Outside the cuckoo's nest: Investigating the reasons behind African males' underutilization of mental health services
INVESTIGATORS	Tanya Samouilhan
DEPARTMENT	Psychology
DATE CONSIDERED	15/04/09
DECISION OF COMMITTEE*	Approved

This ethical clearance is valid for 2 years and may be renewed upon application

DATE: 01 June 2009

CHAIRPERSON
(Professor K. Cockcroft)

cc Supervisor: Dr G. Mooney
Psychology

DECLARATION OF INVESTIGATOR (S)

To be completed in duplicate and **one copy** returned to the Secretary, Room 100015, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure, as approved, I/we undertake to submit a revised protocol to the Committee.

This ethical clearance will expire on 31 December 2010

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

APPENDIX C



UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa

Dear Sir/Madam,

My name is Tanya Samouilhan, and I am conducting research for the purposes of obtaining my Masters in Resea Psychology degree at the University of the Witwatersrand. My area of focus is that of the utilization and unc utilization of mental health services. Research has indicated that young, African males constitute the minority mental health consumers, despite the finding that they are significantly at risk for developing psychological problem

Participation in this research will consist of a face-to-face interview with me at a time and place which is most suita to each participant. Each interview will last approximately 45 minutes to an hour. Participation is voluntary and student will be advantaged or disadvantaged in any way for choosing to or refusing to take part in the interview. E participant will be assigned a pseudonym in the research report and characteristic descriptions will only be include they are invaluable to the analysis. These descriptions will be of a minimal and non-specific nature. Furtherm although direct quotes from participants' interviews will be included in the final research report, these will be mini and will only be used to illustrate group trends and not to reflect individual beliefs or perceptions. The interv material (tapes and transcripts) will only be heard by myself, my supervisor and possibly the external exami However, my supervisor and the external examiner will not know the identity of interviewees. If students choos participate or indicate their willingness to participate I will provide them with an information sheet on which contact details will be printed so that they may contact me to make an appointment for the interview. Your assista in allowing access to the students in their lectures to introduce the study and invite them to participate will be gre appreciated as this research will contribute to knowledge about mental health service utilization in South Africa as v how to improve these to ensure the optimal mental health development of South African citizens. Furthermor would also like to request your consent to return to invite additional participants to take part in the research shou receive an insufficient response.

Kind Regards

Researcher: Tanya Samouilhan
Tanya.samouilhan@students.wits.ac.za
……..

Supervisor: Dr Gillian Mooney
Gillian.Mooney@wits.ac.za
…….

Consent Form:

I ……. hereby consent to the researcher, Tanya Samouilhan, introducing her resea during my class/ in one of my courses in order to invite participants to take part in her research study.

Signature: …….. Date:…….

I……. hereby consent to the researcher, Tanya Samouilhan, re-introducing her resea during my class/in one of my courses if she fails to receive a sufficient amount of participants. However, this is o permitted once the researcher, Tanya Samouilhan, has contacted me to arrange an appropriate date and time.

Signature…….. Date……

APPENDIX D

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa

Hello. My name is Tanya Samouilhan, and I am conducting research for the purposes of obtaining my Masters Research Psychology degree at the University of the Witwatersrand. My area of focus is that of the use of mer health services in South Africa.

We live in a country where there are many dangers which impact upon our mental wellbeing. I would like to find why many young African males do not access formal psychological treatment services such as seeing a psychologis psychiatrist and what other services they may access instead of such treatment. I would like to invite you to particip in my research project so that I may identify and understand these reasons. This research will help contribute to a lar body of knowledge on mental health in this country as well as to a specific understanding of the use and benefit of available mental health services.

Participation in this research will involve being interviewed by me at a time that is most convenient for you. T interview will last approximately 45 minutes to an hour and will take place in my private office, which is located in Umthombo Building on East Campus. It is situated in a quiet part of the building and I will ensure that interviews scheduled in such a manner that fellow participants will not know each others' identity. Participation is voluntary, you will not be advantaged or disadvantaged in any way for choosing to participate or not to participate in the stu There are no personal or academic benefits to participating in the research. Although the area that the researcl investigating is not overtly sensitive and personal, should you feel that after completing the interview process that y wish to see a mental health professional, I will provide you with the details of organisations both on and off university campus which will be able to assist you free of charge.

With your permission the interview will be tape recorded. Although direct quotations will be used in the final resea report, these will only be used to support an idea or belief which the majority of participants discuss in the interv and not to reflect any individual participant's beliefs. All participants will be assigned different names such "Participant A" so as to ensure that this identifying information is kept anonymous and unknown to anyone other t myself. In addition, although characteristic information may be used in the research report, this will be of a very br nature and will only be used when these characteristics are fundamental to the analysis of the research. For example you live in a specific area or suburb in Eastern Johannesburg then this will be reflected in the report as 'an East suburb'. Therefore, your participation will be kept confidential and your identity will be protected in the publis research report.

The interview material (tapes and transcripts) will not be seen or heard by any person in this organisation at any ti other than myself and my supervisor. You may refuse to answer any questions you would prefer not to, and you m choose to withdraw from the study at any point. All tapes of the interview will be destroyed after the report's fi examination.

Please note that participation in the interviews will not constitute psychological treatment. The interview is not c therapeutic nature nor am I qualified to help you in such a manner. However, should you wish to receive psycholog services you may contact me and I can provide you with the contact details of organisations which will be able to h

you in this regard. Please note that if you do not wish to participate yet would nevertheless like to see a mental hea professional I have placed information sheets with the contact details of organisations which will be able to help y on notice boards in the Engineering building as well as those located on campus. You are welcome to take th details and to recommend the services to friends and/or family members although please note that the facilities campus are only free to registered students.

Should you choose to participate, prior to the interview you will be requested to sign the consent form for the interv as well as the consent to audio recording form. If you are willing to participate, please contact me on the num and/or email address below so as to set up an appointment for the interview. You may also send a 'please call me my cell phone number and I will call you back to set up an appointment. Alternatively you can leave a note under office door with your details and I will contact you to set up the interview. Your participation in this study would greatly appreciated.

Thank you for your time and for considering participating in the research study. If you would like to see the fi results of the research these will be available in an electronic form to all University of the Witwatersrand students fr March 2010 from the university's website. The results may also be published in an academic psychological journal.

Telephone No: 079 109 4116 Email: Tanya.Samouilhan@students.wits.ac.za

Office: Room U338 in the Umthombo Building, East Campus

Kind Regards,

Researcher: Tanya Samouilhan
Tanya.samouilhan@students.wits.ac.za

Supervisor: Dr Gillian Mooney
Gillian.Mooney@wits.ac.za

…….....

……

APPENDIX E

I wish to participate in this research study and herewith provide my details for the researcher to contact me regarding participation. ☐

Name: ……..

Email Address: ……

Telephone Number: …….

APPENDIX F1

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa

I _____ consent to being interviewed by Tanya Samouilhan for her study on the under-utilization of mental health services by young African males in South Africa.

Please tick the boxes to indicate your consent to that item.

I understand that:

□ My participation in this interview is voluntary.

□ I may refuse to answer any questions that I would prefer not to.

□ I may withdraw from the study at any time.

□ Direct quotations from my interview may be used in the final research report.

□ Direct quotations from my interview may be published in an academic journal along with the final results of the study.

□ I will be assigned a pseudonym that will protect my confidentiality and anonymity as my name and/or any specific identifying details will not be reflected anywhere on the transcripts of the interviews or in the final research report.

Signed …….. Date…….

APPENDIX F2



UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa

I _____ consent to my interview with Tanya Samouilhan for her study on the under-utilization of mental health services by young African males in South Africa being tape-recorded.

Please tick the boxes to indicate your consent to that item.

I understand that:

□ My interview tape (and its associated transcript) will only be seen or heard by the researcher, her supervisor and the external examiner of the report.

□ My interview tape (and its associated transcript) will be destroyed after the report's final examination.

□ Direct quotations from my interview may be used in the final research report.

□ Direct quotations from my interview may be published in an academic journal along with the final results of the study.

□ I will be assigned a pseudonym that will protect my confidentiality and anonymity as my name and/or specific identifying details will not be reflected anywhere on the transcripts of the interviews or in the final research report.

Signed…… Date……..

APPENDIX G

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa

Dear Participant,

Thank you very much for taking part in this research project. Your participation and enthusiasm to aid mental health research in South Africa is greatly appreciated. Should you wish to view the final research report, it will be available in the Wartenweiler Library as well as on the university's website from March 2010.

If you feel that you would like to speak to a trained mental health professional, please contact the following organisations. They are available on campus so as to ensure your convenience.

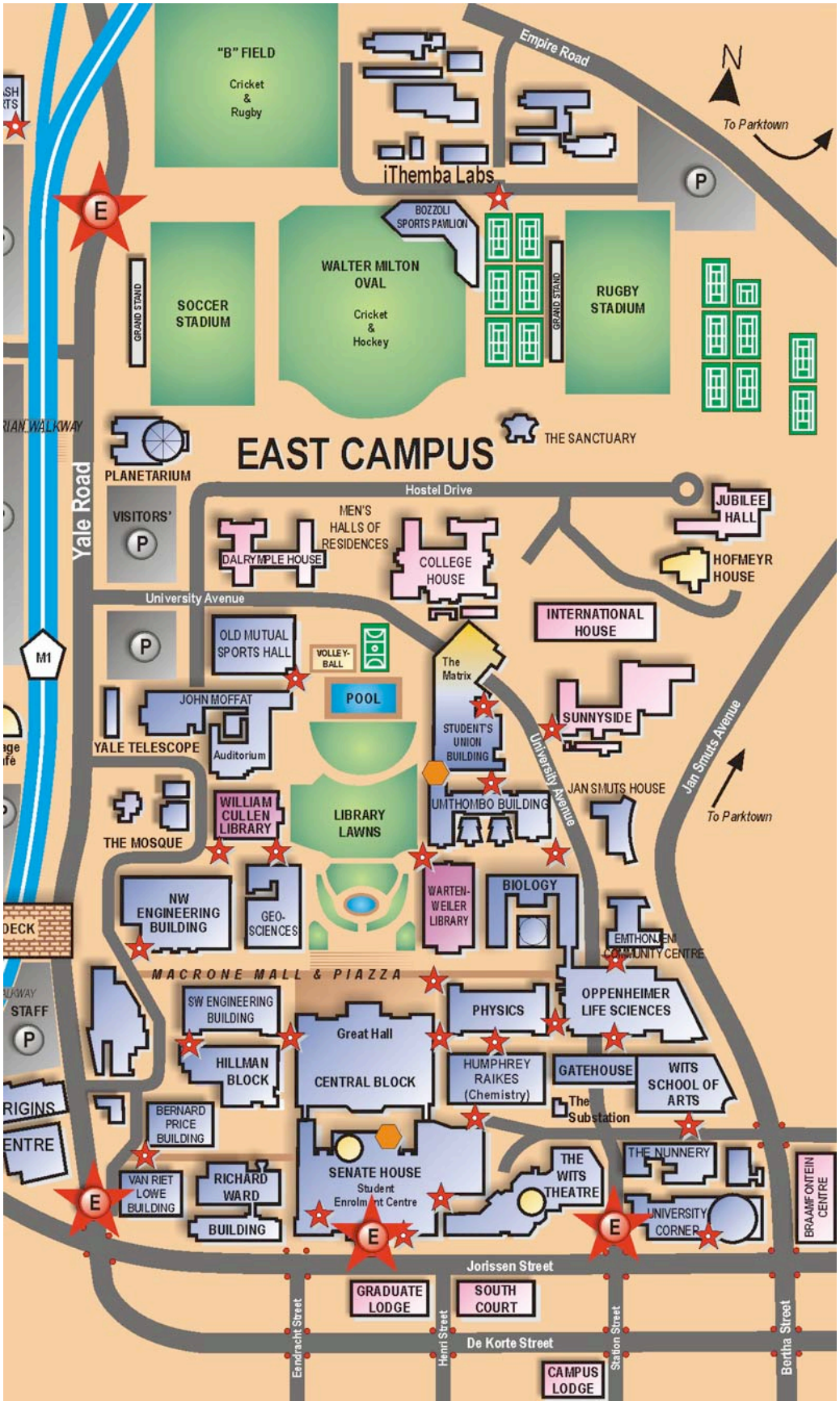
Emthonjeni Centre:
011 717 4513
Located on East Campus (please see first map attached)

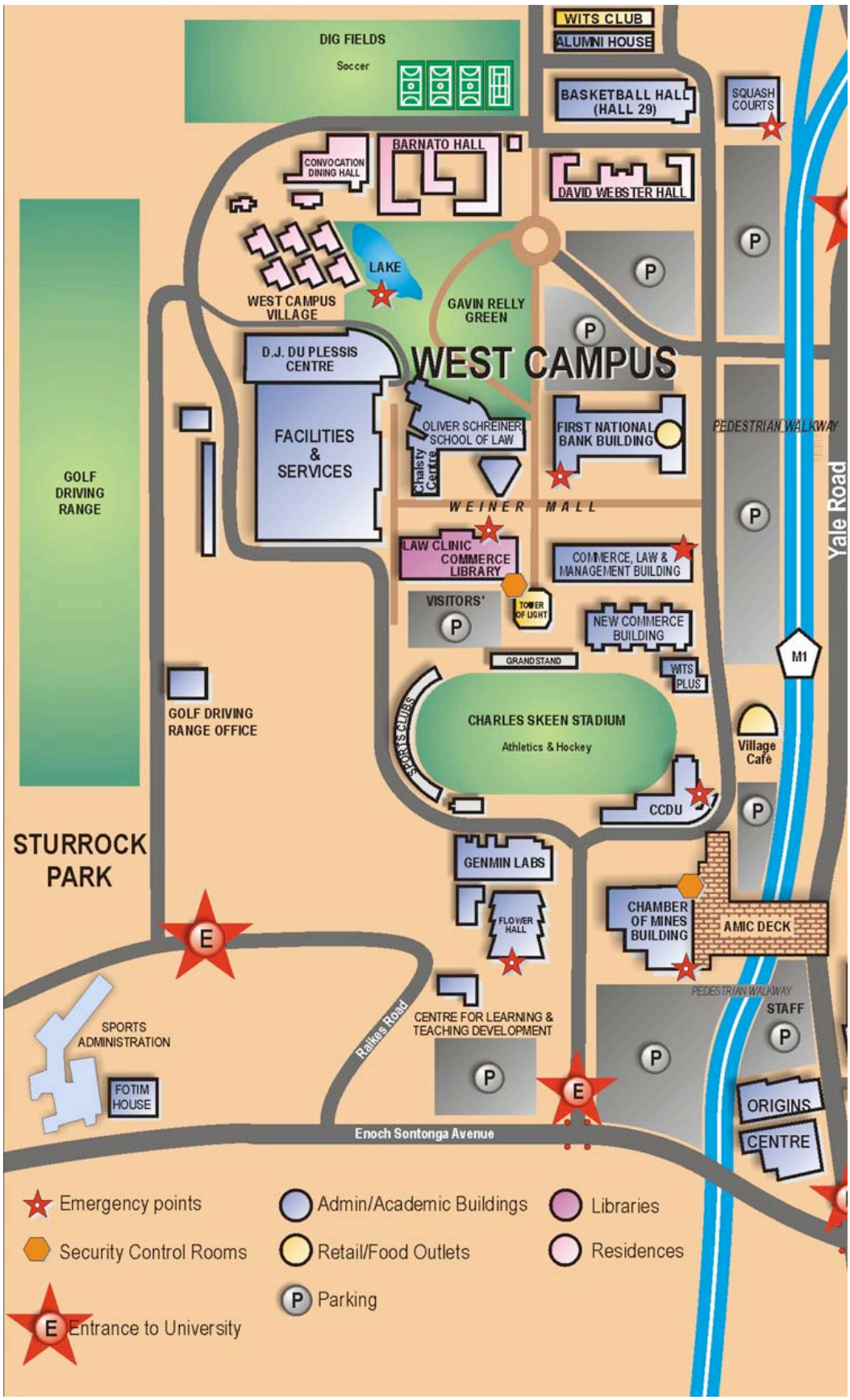
Career and Counselling Development Unit:
011 717 9140/32
Located in the CCDU building, West Campus, Gate 9, Enoch Sontonga Avenue, Braamfontein (please see second map attached).

Furthermore, if you do not feel comfortable with these services or would like to recommend that a non-student family member or friend speak to a professional, they can contact the **South African Depression and Anxiety Group** on their toll free number 0800 567 567 or on 011 262 6396. They offer telephonic counselling and can also refer you to free mental health services in your area as well as provide you with literature on mental health.

Thank you again.

Kind regards,
Tanya Samouilhan


"B" FIELD
Cricket
&
Rugby
Empire Road
N
To Parktown
iThemba Labs
P
E
BOZZOU
SPORTS PAVILION
WALTER MILTON
OVAL
Cricket
&
Hockey
GRAND STAND
SOCCER
STADIUM
GRAND STAND
RUGBY
STADIUM
EAST CAMPUS
THE SANCTUARY
PLANETARIUM
Yale Road
Hostel Drive
VISITORS'
P
MEN'S
HALLS OF
RESIDENCES
DALRYMPLE HOUSE
COLLEGE
HOUSE
JUBILEE
HALL
HOFMEYR
HOUSE
University Avenue
INTERNATIONAL
HOUSE
M1
P
OLD MUTUAL
SPORTS HALL
VOLLEY-
BALL
POOL
The
Matrix
JOHN MOFFAT
Auditorium
YALE TELESCOPE
STUDENT'S
UNION
BUILDING
SUNNYSIDE
University Avenue
Jan Smuts Avenue
JAN SMUTS HOUSE
To Parktown
WILLIAM
CULLEN
LIBRARY
LIBRARY
LAWNS
UMTHOMBO BUILDING
THE MOSQUE
NW
ENGINEERING
BUILDING
GEO-
SCIENCES
WARTEN-
WEILER
LIBRARY
BIOLOGY
EMTHONJENI
COMMUNITY CENTRE
MACRONE MALL & PIAZZA
STAFF
P
SW ENGINEERING
BUILDING
PHYSICS
OPPENHEIMER
LIFE SCIENCES
Great Hall
HILLMAN
BLOCK
CENTRAL BLOCK
HUMPHREY
RAIKES
(Chemistry)
GATEHOUSE
WITS
SCHOOL OF
ARTS
The
Substation
BERNARD
PRICE
BUILDING
THE NUNNERY
E
VAN RIET
LOWE
BUILDING
RICHARD
WARD
BUILDING
SENATE HOUSE
Student
Enrolment Centre
THE
WITS
THEATRE
UNIVERSITY
CORNER
BRAAMFONTEIN
CENTRE
E
E
Jorissen Street
GRADUATE
LODGE
SOUTH
COURT
Enndracht Street
Henri Street
De Korte Street
Station Street
Bertha Street
CAMPUS
LODGE


DIG FIELDS
Soccer
WITS CLUB
ALUMNI HOUSE
BASKETBALL HALL (HALL 29)
SQUASH COURTS
CONVOCATION DINING HALL
BARNATO HALL
DAVID WEBSTER HALL
LAKE
WEST CAMPUS VILLAGE
GAVIN RELLY GREEN
WEST CAMPUS
D.J. DU PLESSIS CENTRE
FACILITIES & SERVICES
OLIVER SCHREINER SCHOOL OF LAW
Chalsty Centre
FIRST NATIONAL BANK BUILDING
PEDESTRIAN WALKWAY
WEINER MALL
LAW CLINIC COMMERCE LIBRARY
COMMERCE, LAW & MANAGEMENT BUILDING
VISITORS'
TOWER OF LIGHT
NEW COMMERCE BUILDING
GRANDSTAND
WITS PLUS
GOLF DRIVING RANGE
GOLF DRIVING RANGE OFFICE
CHARLES SKEEN STADIUM
Athletics & Hockey
Village Café
CCDU
STURROCK PARK
GENMIN LABS
FLOWER HALL
CHAMBER OF MINES BUILDING
AMIC DECK
PEDESTRIAN WALKWAY
STAFF
SPORTS ADMINISTRATION
FOTIM HOUSE
Rellos Road
CENTRE FOR LEARNING & TEACHING DEVELOPMENT
ORIGINS CENTRE
Enoch Sontonga Avenue
Yale Road
M1
Emergency points
Admin/Academic Buildings
Libraries
Security Control Rooms
Retail/Food Outlets
Residences
Parking
Entrance to University

APPENDIX H

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa

Dear Sir/Madam,

If you feel that you would like to speak to a trained mental health professional, please contact the following organisations. They are available on campus so as to ensure your convenience.

Emthonjeni Centre:
011 717 4513
Located on East Campus (please see first map attached)

Career and Counselling Development Unit:
011 717 9140/32
Located in the CCDU building, West Campus, Gate 9, Enoch Sontonga Avenue, Braamfontein (please see second map attached).

Furthermore, if you do not feel comfortable with these services or would like to recommend that a non-student family member or friend speak to a professional, they can contact the **South African Depression and Anxiety Group** on their toll free number 0800 567 567 or on 011 262 6396. They offer telephonic counselling and can also refer you to free mental health services in your area as well as provide you with literature on mental health.