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IDENTIFYING THE UNDERSTANDING OF MENTAL ILLNESS OF MENTAL HEALTH CARE USERS OF MIXED ANCESTRY GROUP ATTENDING A COMMUNITY MENTAL HEALTH CLINIC

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A Research Report submitted to the

Faculty of Health Sciences, University of the Witwatersrand, Johannesburg

in partial fulfilment of the requirements for the degree

of

Master of Science in Nursing

DECLARATION

I, Arunaben Ramanlal, declare that this research report is my own work. It is being submitted for the degree of Master of Science (Nursing) in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

Signature : A. Ramanlal

Date : 29 June 2012

DEDICATION

To all the Mental Health Care Users,

for allowing me the privilege of sharing

their views of mental illness.

ACKNOWLEDGEMENTS

I would like to thank the following individuals who have been very helpful during the course of this study.

My supervisor, Dr Gayle Langley, for her guidance, patience and encouragement.

Professor Elena Liebhaber, for providing statistical assistance and support.

To the Mental health care users, who willingly participated in this study.

Miss Shelley Schmollgruber, for her support and guidance.

ABSTRACT

The purpose of this study was to elicit how mental health care users from a mixed ancestry group, otherwise called "Coloureds" at a Mental Health Clinic in an urban South African context, understood mental illness. "Coloured" peoples perceptions about mental illness in not well documented as few studies have addressed the needs of this population group in South Africa.

The purpose was addressed within a closed questionnaire schedule using the Illness Perception Questionnaire - Mental Health, which was administered over a two month period, from 3rd June 2011 to 29th July 2011, using a non experimental, prospective, descriptive research design survey method. Data were collected by means of a self administered questionnaire and analysed by means of descriptive statistics.

According to the statistician no confidence level was necessary as the instrument used was already tested to be valid and reliable. Since the study was descriptive, no comparative statistics were necessary.The analysed data revealed evidence of poor identification of mental illnesses. This could be a contributory factor to the inadequate adherence to treatment strategies and high re-hospitalization rates in this community. There was also a lack of collaboration between health workers and mental health care users and inadequate imparting of mental illness information by the mental health care practitioners. The positive results that have become evident in this study of good community support, good personal control of illness, a belief in the importance of taking medication and low stress levels, may be utilized effectively to empower this community with knowledge about mental illness. This may allow this community to assume responsibility and be supportive in the efforts to destigmatise mental illness and to ensure that community mental health care services move efficiently and effectively.

TABLE OF CONTENTS

DECLARATION ii

DEDICATION iii

ACKNOWLEDGEMENTS iv

ABSTRACT v

TABLE OF CONTENTS vi

LIST OF FIGURES xi

LIST OF TABLES xi

CHAPTER 1: INTRODUCTION

1.1 BACKGROUND TO THE STUDY 12

1.2 STATEMENT OF THE PROBLEM 14

1.3 RESEARCH METHODOLOGY 12

1.4 RESEARCH QUESTIONS 15

1.5 PURPOSE OF THE STUDY 16

1.6 OBJECTIVES 16

1.7 OPERATIONAL DEFINITIONS 16

1.8 IMPORTANCE OF THE STUDY 17

1.9 SUMMARY 18

1.9 CONCLUSION 18

CHAPTER 2: LITERATURE REVIEW

2.1 LITERATURE REVIEW 19

2.2 INTRODUCTION 19

2.3 IMPACT ON TREATMENT OUTCOMES 20

2.4 SIGNIFICANCE OF BELIEF SYSTEMS 22

2.5 CONCLUSION 23

CHAPTER 3: RESEARCH METHODOLOGY

3.1 RESEARCH METHODOLOGY 24

3.2 PARADIGMATIC PERSPECTIVE 24

3.2.1 Metatheoretical l assumptions 24

3.2.2 Methodological assumption 25

3.3 RESEARCH METHODS 25

3.4 RESEARCH DESIGN 26

3.5 RESEARCH SETTING AND TARGET POPULATION 26

3.6 POPULATION SAMPLE AND SAMPLING METHOD 26

3.6.1 Sampling process 26

3.7 ELIGIBILITY CRITERIA 27

3.8 RESEARCH INSTRUMENT 27

3.9 PILOT STUDY 30

3.10 DATA COLLECTION 30

3.10.1 Procedure 31

3.11 ETHICAL CONSIDERATIONS 31

3.12 CONCLUSION 32

CHAPTER 4: DATA ANALYSIS AND DISCUSSION OF RESULTS

4.1 DATA ANALYSIS 33

4.2 INTRODUCTION 33

4.3 DATA ANALYSIS PROCESS 33

4.4 FINDINGS AND DISCUSSIONS 36

4.4.1 Diagnosis 37

4.4.2 Gender and age distribution 39

4.4.3 Analysis of perceived Identification of mental illmess- Question 1 to 12 39

4.4.4 Analysis of perceived Structure of mental illness Questions 13 to 46 40

4.4.5 Analysis of the understanding of Cause of mental illness Questions 47 to 67 41

4.5 SUMMARY 44

4.6 CONCLUSION 44

CHAPTER 5: SUMMARY AND CONCLUSION

5.1 INTRODUCTION 45

5.2 SUMMARY OF THE STUDY 45

5.3 BACKGROUND 46

5.4 MAIN FINDINGS 47

5.5 LIMITATIONS OF THE STUDY 48

5.6 RECOMMENDATIONS 48

5.6.1 Clinical practice 49

5.6.2 Mental health education 50

5.6.3 Further research 50

5.7 CONCLUSION 51

LIST OF REFERENCES 52

APPENDICES

Appendix A Questionnaire 55

Appendix B Clearance certificate 57

Appendix C Approval from Post Graduate Committee 58

Appendix D Letter from Chief Director - Johannesburg Metro Districts 59

Appendix E Authors permission to use instrument 60

Appendix F Patient information letter 61

Appendix G Consent form 62

Appendix H Demographic data collection sheet 63

Appendix I Demographic Profile of Mental health Care Users 64

Appendix J Analysis of Data according to Diagnosis 65

Appendix K Analysis of Data according to perceived identity, structure and cause of Mental Illness 66

Appendix L Analysis of participant's responses to each Question in the Questionnaire 67

LIST OF FIGURES

Figure 4.1 Response to questions in questionnaire 36

LIST OF TABLES

Table 4.1 Demographic profile of mental health care users in the Community Clinic under 63

- ❖ Age
- ❖ Gender
- ❖ Diagnosis
- ❖ Overall Question Range

Table 4.2 Analysis of Data according to Diagnosis 65

Table 4.3 Analysis of Data according perceived Identity. Structure and Cause Of Mental Illness 66

Table 4.4 Analysis of participant's responses to each question in Questionnaire. 67

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

South Africa is a nation of diversity, with over 49 million people and a wide variety of cultures, languages and religious beliefs. According to the estimates from Statistics South Africa (2011), the country's population stands at 50.59 million. Black Africans comprise the majority, making up 79% of the population, while the White population is estimated at 4.57 million, the mixed race or "Coloured" population at 4.57 million and the Indian/Asian population at 1.27 million.

For the purpose of this study, people of mixed ancestry group will be referred to as 'Coloured' people. According to the cultural profile compiled by the Strategy Leader Resource kit - (SLRK) on the Coloureds of Southern Africa - 27 August 2010, approximately 85% of the Coloured people live in the Western Cape Province in South Africa. South Africans classified as 'Coloureds' are people of mixed lineage, descended from slaves brought to the country from east and central Africa, the indigenous Khoisan who lived in the Cape at the time, indigenous Africans and White, Chinese or Indian persons. Christianity is the most common religious practice among the White and Coloured South Africans, being the faith of 86.8% of the people in both groups.

The various Coloured communities in Southern Africa originated from events of the Dutch Colonisation of South Africa. Though overlooked or ignored in traditional political histories of South Africa,early settlers in the Dutch colony were not only of Dutch origin, but also of German and Swiss origin, which almost inevitably resulted in a 'mix' that was further enriched by Indians and Africans resulting in offsprings amongst these various groups. These settlers also had mixed offspring's with the indigenous people, the Khoikhoi (also known as Hottentots), the San (also known as Bushman) and later the Xhosa. The Strategy Leader

Resource kit - 27 August 2010 further states that an additional contribution to the gene pool was provided by the 'slaves' imported from West Africa. The various other Coloured people also intermarried with the Khoikhoi (Hottentots), who were the indigenous people of the Cape,

until they were largely absorbed into the Coloured population. A large portion of the origins of the 'Coloured' people was suppressed and perhaps lost during the apartheid era due to the suppressive laws and restrictive movements enforced by the apartheid regime at the time.

However, in the "New South Africa" following the democratic election in 1994, there has been much open significant, varied discussion among the members of the Coloured community on aspects of their identity and history. Various Coloured communities are searching for answers to the questions relating to their history and identity, developing their own identity along different lines in the new open democratic society. Although Afrikaans is the predominant language among the Coloured people, a large proportion also speak English.

In the absence of reliable statistics about the prevalence of mental illness among the 'Coloured' population group, historically it has been accepted that mental illness has always been embedded in mystery and approached with awe. In a Johannesburg "Poverty and Livelihoods Study" (2008) undertaken by the University of Johannesburg, it was confirmed that socio-economic conditions such as poverty, unemployment, and crime did appear to have an impact on the prevalence of mental illness. The authors concluded that prevailing negative attitudes and perceptions had allowed mental illnesses to become marginalised, essentially accentuating its stigma.

Attitudes and perceptions therefore are considered to aptly describe the ultimate experience and understanding of the world. To change attitudes the cognitive and emotional components of what a person requires needs to be addressed. The questionnaire used in this study addresses both these components. Perhaps attitudes and perceptions do shape the way the world is understood, therefore they can be utilized positively to influence behaviour towards the acceptance of mental illness.

According to the South African Depression and Anxiety Group (SADAG) 2009, almost one in five South Africans suffer from a mental illness. The World Health Organisation had predicted that by 2010 mental illness will rank second in terms of disease burden world wide.

The increased incidence of mental illness world wide is alarming and the causative factors contributing to the prevalence rate needs to be investigated urgently. According to Zulu (2005), one in five people in South Africa suffer from mental illnesses. According to the South African Federation of Mental health (2011), South Africans would rather die than admit to mental illness. The multi- cultural environment in South Africa contributes to multiple perceptions which are further influenced by cultural practices, community norms and belief systems.The denial of mental illness and stigmatization that the denial would impact on the treatment compliance, if perceptions of mental illness are negative. The manner in which the mental health care users understand their illness, and choose to continue treatment being offered at some point in their illness, remains a challenge.

In previous local and international studies, perceptions of the Caucasian, Black and Indian people towards mental illness have been described and are discussed later in this study - Hugo (2003), McCabe (2004, Lehner (2007) and Nilamadhab (2008). Currently, in South Africa not much is known about the perceptions of the Coloured people towards mental illness. There is also no statistical information available on the prevalence of mental illness in the different racial populations. Therefore for this study a sample of the Coloured population living in one city and attending one mental health care clinic has been chosen to determine their perceptions and understanding of mental illness and treatment.

1.2 STATEMENT OF THE PROBLEM

Community mental health services in South Africa have, over the years, undergone a transformation from segregated services for the different racial groups to the integration of mental health services into the primary health care model. This transformation provided a unique opportunity to study the different racial groups and their perceptions of mental health. The “Coloured” group of mental health care users have over the years provided challenges to

the health system, although specialised services and personnel and newer psychiatric drugs are available, the relapse rate in this community remains high. An increase in the numbers of service users admitted to the acute in - patient mental health care unit at Helen Joseph Hospital, in Johannesburg, was observed. A total of 2143 admissions were recorded over a four year period from 2004 to 2007, of which a total number of 436 mental health care users were diagnosed with schizophrenia. Most of the mental health care users were admitted once over the four year period, while twenty percent (n=88) had multiple re-admissions (Janse Van Rensburg, 2010). These results are indicative of the problem that needs to be addressed urgently, as it is affecting the health budget and overall allocation of health resources in the Johannesburg Region, South Africa.

In order to address the issue of frequent hospitalisations as in the discussion above and as cited by Janse Van Rensburg (2010),and to foster positive treatment strategies and improve clinic attendance by the mental health care users, it might be useful to understand the population, in this case, the 'Coloured' community, to achieve these goals. Very little is known about the Coloured community in the North-West region of Johannesburg, and no previous study has been conducted to elicit the views and understanding of this community on mental illness. This community under study has a predominantly 'Coloured' population attending the provincial mental health care clinic. Presently there are approximately 250 Coloured mental health care users on register in the clinic. It thus provides an ideal platform for investigating their views and understanding of, not only mental illness but also of its treatment management.

1.3 RESEARCH METHODOLOGY

A quantitative research method was chosen for this study, using a non experimental, prospective and descriptive research design. A valid and reliable instrument was administered to participants, with the necessary permission from the author. The population sample was from a mental health community clinic based in Johannesburg. Details of this methodological process are discussed further in chapter3.

1.4 RESEARCH QUESTIONS

This study addressed the following questions:

- What perceptions influence the understanding of mental illness in this group of mental health care users attending the out patient clinic facilities?
- What knowledge do mental health care users in the mental health clinic under study have about their mental illness?

1.5 PURPOSE OF THE STUDY

The aim of this study was, therefore, to understand how mental health care users of the mixed ancestry or the 'Coloured' population groups attending an out patient mental health care clinic in the North -Western area of Johannesburg, perceive mental illness and management thereof.

1.6 OBJECTIVES

- To identify the perceptions of persons from the mixed ancestry 'Coloured' race group, toward their illness, attending a clinic in the North - Western area of Johannesburg,
- To elicit the mental health care users' knowledge about mental illness.

1.7 OPERATIONAL DEFINITIONS

The following operational definitions were applicable for this study

- Perceptions: An idea, belief, or an image you have as a result of how to see or understand something. (Oxford Advanced American Dictionary - Oxford University Press - 2011)

- Mental Illness: A behavioural or psychological syndrome or pattern associated with present distress or disability. (Diagnostic & Statistical Manual of Mental Disorders: DSM-IV-TR- 2000)
- Mental Health Care User: Used as a generic description of the people who use mental health care services. (Mental Health Foundation - England - 2011)

1.8 IMPORTANCE OF STUDY

South Africa's diverse ethnic and cultural background poses a challenge in terms of understanding the diverse viewpoints regarding health issues, particularly mental health issues. The different cultural and religious belief systems that contribute towards the perceptions held regarding mental illness, challenge the health care worker to formulate a culturally sensitive practice, in which the views and understanding of mental illness by the mental health care users can be understood. This in turn could help the mental health care providers to tailor their interventions to address the expectations and needs and encourage the regular attendance and adherence to medication - a challenge that continues to frustrate the health professionals.

The Johannesburg Poverty and Livelihood Study conducted by De Wet (2008) concluded that respondents in the study from areas such as Riverlea - a predominantly Coloured township, Alexander - a predominantly Black township and other respondents from other research sites in Johannesburg, were affected by high levels of chronic illnesses such as tuberculosis and diabetes. The overall incidence of symptoms of mental disorders measured in terms of SRQ20 (De Wet, 2008) - a screening tool that was used to assess the prevalence of mental health symptoms, was 40%. Unfortunately many of these challenges are difficult to overcome, therefore the understanding and participation of mental health care users in their own treatment regimes might facilitate better understanding of the mental health of these mental health care users. This would then allow the mental health care users to take responsibility for their own health and illness episodes, and foster the desire to want to change and perhaps become more functional and manage basic daily functions.

The study's findings will reflect on the perceptions of the mental health care users towards mental illness, and also inform health professionals about the users' perspectives so that treatment regimes can be planned co-operatively.

1.9 SUMMARY

Understanding attitudes and perceptions is complicated and a difficult task. The manner in which the mental health care users view the world and their interaction there in, determines their outlook on their illness and perhaps it influences their direct involvement in self care. This direct involvement and the need to take responsibility for self care has remained a challenge to health professionals for years. Given the availability of effective medication and psychosocial treatments, studies indicate that adherence to medication by the mental health care users' remains a challenge due to the different causative perceptions. Health care providers can assist mental health care users to understand their illnesses, and explore the benefits of adhering to medication, by being empowered by themselves to understand the perspective that the mental health care users has towards the dynamics of mental illness, and the predisposing factors contributing to mental illness. The ultimate goal would thus be to improve the disease profiles of mental health care users in the community.

2.0 CONCLUSION

This chapter of the research report focused on the introduction to the study. A background to the issue is given, the problem is stated, the research questions are posed and the purpose, objectives and importance of the research are discussed. Terms are defined and the essential elements of the report are detailed.In the next chapter a review of the literature will be discussed. Subsequently the methodology, the paradigmatic and theoretical perspectives, the ethical considerations, data analysis, description and interpretation of research findings will be discussed. Finally, the limitations of the study, summary of research findings, conclusions and recommendations for future research will be presented.

CHAPTER 2

2. 1 LITERATURE REVIEW

This chapter introduces the impact of previous laws on mental illness, the impact on treatment outcomes based on previous studies and the significance of belief systems in understanding mental illness.

2.2 INTRODUCTION

In 2005, in recognition of the role of social factors in increasing health inequities, the World Health organisation established the Commission on the Social Determinants of Health. South Africa is among the most unequal societies in the world. It faced serious public health challenges, including an elevated burden of chronic disease, and high levels of violence (Mathee, 2009). These challenges were further compounded by the Segregation Act No. 49 of 1953 of the apartheid era in South Africa, which resulted in many communities of different population groups forcibly being removed and relocated to other locations. The Coloured community was one of them. This resulted in extensive social and racial isolation intensifying the marginalization for these communities.

The disease profiles of mental illness of these communities, therefore, becomes dynamic and challenging as factors such as unemployment, overcrowding, crime and violence arose and continue to affect the health status of the community including and especially the mental health of the population, as cited by JPLS(2008) study. The mental illness disease profiles are also largely influenced by the population's belief systems, the manner in which they perceive their illness and the impact of the socio-economic environment on their perceptions. Therefore the understanding of the attitudes and perceptions of illness becomes the cornerstone to creating a partnership between the health care worker and the mental health care user to facilitate treatment adherence – a challenge that is still eluding the professional world.

2.3 IMPACT ON TREATMENT OUTCOMES

Many studies have explored the attitudes and perceptions of Caucasian, Black and Indian people e.g. Hugo (2003), McCabe (2004), Lehner (2007) and Nilamadhab (2008) , but few studies have addressed the attitudes and, the perceptions of Coloured people in the South African context. Taking the Coloured population's disease profile into account and if health care workers attempt to see a positive change in the treatment outcomes, it is posited that they need to understand the Coloured people's attitudes and perceptions of mental illness.

The frequent hospitalisations cited by Janse Van Rensburg (2010), reinforces the importance of understanding the views of the mental health care users by the health care practitioners since, their belief in their ability to control their illness may influence medication compliance.

Kabir (2004) found that the recognition of mental disorder also depended on a careful evaluation of the norms, beliefs and customs within the individual's cultural environment. Furthermore, the community and mental health care user's attitudes and beliefs played a role in determining their help seeking behaviour and the successful treatment of the mentally ill. Unarguably, ignorance and stigma prevents the mental health care user from seeking the appropriate help required/needed (Kabir, 2004).

Gureje (2005) studied community knowledge and attitude to mental illness in Nigeria, and the outcome was that poor knowledge of the causation of mental illness was common.

Generalizing across conditions and medical regimes, Horne (1999) had asserted that medication beliefs were 'the hidden determinant of treatment outcome' (Aikens, 2008).

Hugo (2003) studied community attitudes toward knowledge of mental illness in Cape Town, South Africa. The respondents viewed mental illness as having a biological component, was a consequence of the lack of will power and illness being stress related. The preferred treatment was psychotherapy. McCabe (2004), studied four ethnic groups in United Kingdom, Caucasians (Whites), Bangladeshis (Indians), African Caribbean's (Black) and West Africans (Black). Despite being third generation, the British citizens who were born in Britain, the Black respondents viewed mental illness as a supernatural phenomenon and the preferred

treatment was faith healing. The Indian respondents thought the reasons for mental illness were socially related and the White respondents thought mental illness was attributed to a biological cause.

Lehner (2007), conducted a study on interventions in outpatient treatment adherence and serious mental Illness in Illinois U.S.A. The study cited a need for improved collaboration between mental care users and the health professional to improve treatment adherence. Nilamadhab Kar (2008), conducted a study on persons resorting to faith healing practices in mental illness in Orissa in the eastern state of India. The outcome was that 75% of the participants resorted to faith healing before seeking medical help, as they essentially believed in supernatural causation of mental illness. Emsley (2001), a South African Psychiatrist and researcher suggested that the "rainbow" nation of South Africa provides the ideal and unique opportunities for investigating cultural aspects of psychiatry due to its multi cultural and diverse ethnic population

Evidence suggests that treatment adherence is a complex, multifactorial phenomenon affected by and affecting a number of interacting characteristics within mental health care users, clinician and user-clinician relationships as well as the larger systems in which the user and clinician operate in (Breen and Thornhill, 1998). Any comprehensive understanding of problems related to treatment adherence must take into account the factors from different cultural backgrounds, individuals, families, communities and societies, and also the interpersonal processes that may exist between the patient and the health care workers at both cognitive and emotional levels.

Thus research on adherence has explored both the individual and treatment concerns, yet little attention has been focused on the interpersonal relationship between the patient and the health care worker (Deegan, 2005). It is the nature of this relationship that is recognised as being pivotal to treatment and is a likely source to impact on treatment adherence. Research also suggests that patients may conceal their non-adherence or motivation for non-adherence from health care workers for fear that their concerns may not be taken seriously or their ways of coping may be disparaged. Compliance of outpatients has been put forward as the main rationale behind the implementation of the outreach Community Psychiatric Nursing Team in

the early 1990's in an attempt to slow down the "revolving door" admissions (Crabtree, 1999). According to Leibrick (2002), the personal perspective on recovery lies in the acceptance of the illness and the use of this experience as a means of discovering a spiritual dimension that must come to the fore, in order that real healing may take place.

Therefore, mental healths care user's understanding of the causative factors of mental illness, in categories such as psychological factors eg. upbringing, events in the past, relationships - biological factors eg. chemical imbalance, genetic disposition - structural factors eg. support systems and stress factors eg. death, violence, trauma, retrenchment and chronic illness, may all influence the manner in which the mental health care user embrace the illness. Furthermore, acceptance of the chronicity of mental illness, the importance of adhering to treatment regimes, taking personal control of the illness and the psychological and emotional roller coaster that may be experienced, may ultimately determine treatment outcomes.

2.4 SIGNIFICANCE OF BELIEF SYSTEMS

In South Africa, the multi-cultural and ethnically diversified population compels culture and beliefs to be an integral aspect of an individual. The belief systems of the coloured population group in South Africa remains varied from Christianity to Islam. Therefore, the attitudes and perceptions with which they view life becomes more interesting. Faith healing, a form of traditional healing, is reported to be practised as an alternative medicine in almost all parts of the developing world (Chadda *et. al.*, 2001).This continues as people of different backgrounds will always attempt trying anything from biomedicine to culturally sanctioned traditional therapies that may help them (Bhui & Bhugra, 2003).

Non medical explanatory models for mental illness are more commonly seen in developing countries compared to developed countries and so are some coloureds influenced by this (McCabe and Priebe 2004). In a comparative study Furnham and Perreira (2008), found that Shri Lankans of all educational levels favour superstitious family and sociological causes to explain the development of schizophrenia, while British people favoured more biological explanations. Furthermore Nilamadhab (2008), in India, believes that families in India also

reported that readjustment and reintegration into society after faith healing were better than that after treatment from a psychiatric hospital.

Adherence to treatment programs may make a significant difference in long term outcomes as a dynamic process and indeed is not achieved in only a few days. Although Patel and Musara (1995), are of the opinion that both biomedical and traditional healers could help mentally ill persons by resolving different issues relating to the same illness, it needs to be noted that there is a strong cultural base in India, as opposed to the Coloureds in South Africa, where there is a variety of beliefs, from Christianity to Islam. Roe and Swarbrick (2007) however felt that modern medicine had no satisfactory approach for dealing with some culture bound phenomena.

As the population of South Africa is so ethnically and culturally diverse, and was further complicated and stereotyped by the previous apartheid regime, it becomes important to understand the various groups and their unique attitudes and perceptions so that treatment interventions are appropriate to support adherence. It has therefore become imperative for all health care workers to become culturally sensitive and congruent in the therapeutic environment. Health workers need to ask whether mental health care users understand what mental illness is and ascertain their perceptions about mental illness.

2.5 CONCLUSION

This chapter explored how mental illness is perceived and the preferred treatment methods among the different race groups. As psychiatric treatment is essentially dominated by the biomedical model, studies have highlighted the need to integrate faith healing and traditional healing methods into the biological model, if we as health workers want to improve the treatment outcomes of the mental health care users. This can only be facilitated by the non judgemental understanding of the views of the mental health care users regarding mental illness, taking into consideration the socio-economic factors in a developing county that may influence the mental illness spectrum and the understanding thereof.The following chapter will discuss the research methodology.

CHAPTER 3

3.1 RESEARCH METHODOLOGY

In the previous chapter literature pertaining to the mental illness was discussed. This chapter will explore the research methodology used for this study under research design, population and sample, data collection, the research instrument used, pilot study and ethical considerations.

3.2 PARADIGMATIC PERSPECTIVES

This study is based on the following humanistic assumptions, as in mental health care nursing, the relationship between the individual's optimal health and feelings of self worth, personal integrity, self fulfilment and creative expressions are particularly important to recognise and nurture.

3.2.1 Metatheoretical assumptions

This approach is also known as symbolic interactionism, a term introduced by Herbert Blumer (1969) to describe a relatively distinctive approach to the study of human conduct. It is based on three simple philosophical premises:

1. Human beings act toward things on the basis of the meaning that the things have for them.
2. Life experiences may have different meanings to different people.
3. The *meaning of things* in a person's life is derived from the social interactions that person has with others. We learn meanings during our experiences with others.

People handle and modify the meanings of the things they encounter through the interpretive process. They come to their own conclusions (Wilson &Kneisl, 1988).

3.2.2 Methodological assumptions

The interactionism approach, based on the theory of life centered on human beings which is known as humanism, is recognised and acknowledged for this study. It is a philosophy of service for humanity using reason, science, and democracy.

- Human beings have the power or potential to solve their own problems.
- Human values are grounded in life experiences and relationships, and our highest goal must be the happiness, freedom, and growth of all people.
- The human being's mind is indivisibly connected with the body, (Kniesl and Trigoboff, 2009).

- A functional approach has been adopted for the study in that the research has been undertaken for the purpose of understanding mental health care users more effectively ((Kniesl and Trigoboff, 2009).

3.3 RESEARCH METHODS

Although attitudes and perceptions are better understood using the qualitative research methodology, a quantitative research design appears to be a more appropriate method of eliciting information from mental health care users, since their ability to concentrate for long periods of time is reduced and their preoccupied cognitive processes may be increased.

3.4 RESEARCH DESIGN

A quantitative research approach was used to answer the research questions. Following an in-depth community survey, a non experimental, prospective and descriptive study was undertaken. Its purpose was to understand how mental health care users view their mental illness and what, in their opinion were / are the causative agent in the illness spectrum. Thus the most logical tool appears to be a non-experimental, prospective and descriptive research design using the closed questionnaire survey method. A closed questionnaire has been chosen as it is an uncomplicated method of obtaining data from mental health care users.

3.5 RESEARCH SETTING AND TARGET POPULATION (n= 105)

The Westbury community mental health clinic in region B - Gauteng was selected as the study population. The community and the majority of the mental health care users attending the clinic are of mixed ancestry - 'Coloured' group. For the past six months, June 2011 to November 2011 the monthly clinic attendance has averaged to 240 with an estimated default rate of 30 per month. The Westbury clinic register has an estimated 275 mental health care users on their register.

3.6 POPULATION SAMPLE AND SAMPLING METHOD

Following discussions with a statistician a sample size of 105 (n=105) mental health care users was found to be the most appropriate to obtain statistically significant results.

3.6.1 SAMPLING PROCESS

A non-experimental, prospective and descriptive research design using the closed questionnaire survey method was used. The study sample was the total clinic monthly attendance of 250 Coloured mental health care users who all had an equal chance of

participation. The participants were identified by the racial categorisation according to the South African Identity document. All the mental health care users attend this clinic on a voluntary basis and were able to give consent autonomously. The total number of participants for this study was (n) =105.

Reliability was maintained by ensuring consistency and accurate recording of data. This was achieved through compliance by the researcher with the data collection checklist. Being a prospective study, there was no manipulation of variables. A large sample counteracted the effect that participants could be lost during the research due to exclusion criteria or death thus ensuring internal validity. External validity was ensured by selecting the entire clinic sample for the study. This ensured that the characteristic sample was representative of those of the population from which it was drawn.

3.7 ELIGIBILITY CRITERIA

The mental health care users had to be 'Coloured' over the age of 18 years. Both genders (male and female) mental health care users were eligible to participate. The users had to be presently attending the community mental health clinic. The users also had to be fluent in the English language.

3.8 RESEARCH INSTRUMENT

The data pertaining to the perceptions and insights of the mental health care users regarding mental illness were collected using the "Illness Perception Questionnaire-Mental Health" (IPQ-MH), by Witteman 2010. Permission for use of the instrument was granted by the author (Appendix E). The instrument was developed using the original Illness Perception Questionnaire (IPQ) for somatic health and the adaption of the (IPQ-R) Moss-Morris R., Weinman, J., Petrie, K.J., et al (2002).

The Illness Perception Questionnaire – Mental Health (IPQ - MH) is a new method for assessing cognitive representations of illness. (Appendix A). It consists of three parts. Part 1, "the Identity Scale", concerns the perception of the identity of the problems and interrogates the views regarding these problems from questions one to 12. Part 2, "the Structure scale", is concerned with the perceived structure of the problems, that is: their duration, control over them, their consequences, coherence and the associated emotion from questions 13 to 46. Part 3, "the Cause scale", concerns the perceived causes of the problems from questions 47 to 67.

- **The Illness Perception Questionnaire – Mental Health (IPQ - MH).** It is a theoretically derived tool comprising of five scales that provide information about the five components that have been found to understand the cognitive representations of illness. The scales assess:

- *Identity* - the symptoms the patient associates with the illness - questions one to 8
- *Cause* - personal ideas about aetiology - questions 9 to 12
- *Timeline Chronic* - the perceived duration of the illness - questions 13 to 18
- *Timeline Cyclical - questions 19 to 22*
- *Consequences* - expected effects and outcomes - questions 23 to 27
- *Cure Control Personal* - how one controls, recovers from the illness -questions 28 - 33
- *Cure Co*ntrol Treatment - questions 34 to 36
- Coherence - *how do they understand their illness - questions 37 to 40*
- *Emotional Representations - emotions are evoked by the illness - Questions 41 to 46*
- *Causes of Illness - Psychosocial - questions 47 to 51*
- *Causes of Illness - Biological - questions 52 to 57*
- *Causes of Illness - Structural - questions 58 to 60*
- *Causes of Illness - Stress - questions 61 to 67*

The scoring system

The data collected were scored from one to 5.

- 1 = strongly disagree
- 2 = disagree
- 3 = neither agree or disagree
- 4 = agree
- 5 = strongly agree

High scores would be 4 and 5. High scores on the identity, timeline, consequences and cyclical dimensions represented strongly held beliefs about the number of symptoms attributed to the illness, the chronicity of the condition, the negative consequences of the illness and the cyclical nature of the condition. High scores on the personal control and coherence dimension, represented positive beliefs about the controllability of the illness and a personal understanding of the condition. These were scored in percentages.

According to Petrie (2008), the validity and reliability of this questionnaire in people with mental illness has generally been supported. The Illness Perception Questionnaire has been successfully used with patients with psychosis (Watson 2006) and depression (Fortune 2004).

Witteman (2010) concluded that the Illness Perception Questionnaire – Mental Health (IPQ-MH) can reliably assess patient's mental health problem perceptions. The questionnaire was administered to 274 mental health care users irrespective of specific disorders or treatment in Netherlands.

Since the instrument language was simple and applicable to the South African Coloured population in Westbury, no changes to the instrument were necessary

3.9 PILOT STUDY

A pilot study was conducted prior to the commencement of the main study after relevant authorisation was obtained. The data collection tool was used on 15 mental health care users who fulfilled the selection criteria at a different site to the study site. The pilot study was a small scale trial run of all the aspects for use in the main study. Its purpose was to help the researcher fine- tune the study for clarity, administration duration and to determine whether the methodology, sampling, instruments and analysis were adequate and appropriate (De Vos et.al.2005). The results obtained from the pilot study were not used in the main study.

Participants were able to answer the questionnaire without any difficulty. Responses to the questions were categorised and filed for statistical analysis. The Microsoft EXCEL computer package was used for data capturing. The Statistical package Microsoft Excel was also used for data processing and a printout of frequencies and responses were made. Data on the printout were reviewed and analysed.

3.10 DATA COLLECTION

Questionnaires (Appendix A), were administered to all 'coloured' mental health care users, who met the inclusion criteria, attending the clinic over a 2 month period. The questionnaires were administered by a trained assistant on Thursdays and Fridays, from 08h00 to 16h00 until an adequate sample size of approximately 105 or more had been achieved. These questionnaires were completed in a private room at the clinic, as this arrangement facilitated data collection while the mental health care users awaited their turn to be consulted by a doctor or the professional nurse. As only one assistant was administering the questionnaire the inter-rater reliability was not compromised. After participation a colour coded sticker was placed on the file to avoid duplication of participants. A collection box was made available at the clinic and placed for safe keeping in a locked cupboard. All completed questionnaires were placed in a sealed envelope and deposited into a locked collection box which was opened weekly by the researcher. Data were grouped and entered into the computer. The data on the computer were only accessible to the researcher and supervisor. The assistant administered the

questionnaire and assisted with the filling out of the questionnaire where the need arose. This ensured the adequate completion of the questionnaire and enabled the researcher to identify and refer identified problems to appropriate resources timeously.

3.10.1 PROCEDURE

Data were collected during the period June to July 2011. Questionnaires were administered to mental health care users attending the clinic in the private room within the designated study periods. They received a verbal as well as written explanation of the purpose of the study. Participants were informed of risks and benefits, time required for the administration of the instrument schedule, procedure involved measures in place to ensure confidentiality and anonymity, and voluntary involvement status. A copy of the signed consent, as well as a letter of explanation of the study was given to each participant, (see Appendix F).

3.11 ETHICAL CONSIDERATIONS

The research proposal was submitted to the Human Research Ethical Committee (Medical) of the University of Witwatersrand to ensure compliance with ethical standards. A clearance certificate was issued by the committee, (see Appendix B).

The research proposal and instrument were also submitted to the Post Graduate Committee of the Faculty of Health Sciences of the University of Witwatersrand for permission to undertake the research. Permission was obtained, (see Appendix C).

Permission to conduct the study at the institution was obtained by the Chief Director of the Johannesburg Metro District Health Services and the Clinical Head of Psychiatry, Johannesburg Metro District Health Services (see Appendix D).

Informed consent was obtained in writing from all participants. Data were coded to ensure anonymity and confidentiality during data collection and recording, (see Appendix G).

Participation in the study was voluntary and the participants had the right to withdraw from the study at any time without any consequences. Furthermore, confidentiality and anonymity of participants were observed and protected by using the research code numbers during data collection and reporting.

3.12 CONCLUSION

This chapter outlined the research methodology implemented as well as the process of the design and testing of the research instrument. The instrument was used at the pilot study and was found to be successful in achieving the objectives of the study.

The following chapter will discuss the data analysis and the discussion of the results.

CHAPTER 4

4.1 DATA ANALYSIS AND RESULTS

In the previous chapter the research methodology used for this study was discussed and this chapter discusses the data analysis approach, results of the study and the discussion of the results.

4.2 INTRODUCTION

Data files were set within the computer Microsoft Excel statistical package 2003. Data were entered once and then verified during the second direct data entry. Descriptive statistics were used to achieve the study objectives. The descriptive tests (frequency, mean distributions and percentages) were used to synthesize mental health care users' demographic data. The percentages in these findings were taken to the nearest whole number. As a validated instrument was utilized for this study, there was no need to employ further validation values. Findings will be discussed on diagnostic, scale and item levels.

In this chapter, the descriptive statistics employed to synthesize the data and interpretation of research findings will be presented.

4.3 DATA ANALYSIS PROCESS

Research study codes were allocated according to the DSM-IV-TR. Diagnoses were allocated in the following codes:

Personality Disorder - 285, Schizophrenia - 295, Bipolar Mood Disorder (BMD) - 296.80

Schizoid-affective - 295.70 Dysthymia & General Anxiety Disorder (GAD) - 300

Major depressive disorder (MDD) - 296 Substance Induced Psychosis - 292

Data were analysed according to the plan outlined by the author of the instrument, Cilia Witteman. The instrument IPQ-MH consists of three parts which is detailed in table 4.3 in appendix K).

Part one, the identity scale, questions one to12, concerned the perception of the identity of the problems: How do the mental health care users view them (Table 4.3).

Part two, the structure scale, questions 13 to 46, is concerned with the perceived structure of the problems, that is: their duration, control over them, their consequences and coherence and the associated emotions (Table 4.3).

Part three, the cause scale, questions 47 to 67 concerned the perceived causes of the problems (Table 4.3).

The data collected were scored from one to 5.

- 1 = strongly disagree
- 2 = disagree
- 3 = neither agree or disagree
- 4 = agree
- 5 = strongly agree

High scores would be 4 and 5. The statistician advised for the collapse of categories so that scores could be grouped to facilitate statistical analysis.

Scores 1 and 2 were grouped as not at all/ disagree,
4 and 5 were grouped as often/ agree,
3 were neutral.

High scores (4,5) on the identity, timeline, consequences and cyclical dimensions represented strongly held beliefs about the number of symptoms attributed to the illness, the chronicity of the condition, the negative consequences of the illness and the cyclical nature of the condition (see table 4.3 in appendix K).

High scores (4, 5) on the personal control and coherence dimension, represented positive beliefs about the controllability of the illness and a personal understanding of the condition, (see table 4.3 in appendix K).

THE DEMOGRAPHIC DATA were presented and synthesized using the following categories:

Age, Gender, Diagnosis are discussed later in the chapter (also see table 4.1 in appendix I).

The understanding of the questionnaire was ascertained by summarising the responses to the questions in the questionnaire.

Out of a total of 7035 questions in the questionnaire, 3096 responses chose the 'disagreed' option to questions, 3560 chose the 'agreed' option to questions and only 379 responses were 'neutral'.

This indicates that the research tool was effective in eliciting information. Overall responses of 3560 were the 'agreed' option indicating some positive understanding and knowledge of mental illness. All participants responded to all the questions.

Figure 4.1 is a graphic representation of the responses (also see table 4.1 in appendix I).

Out of the total of 7035 questions, only 5% of the total sample of 105 answered neutral. Fifty one % of the sample agreed and 44% of the sample disagreed .Therefore there is evidence that

the questionnaire was understandable and answerable. Results of this process are also summarized in table 4.1 in the appendix I.

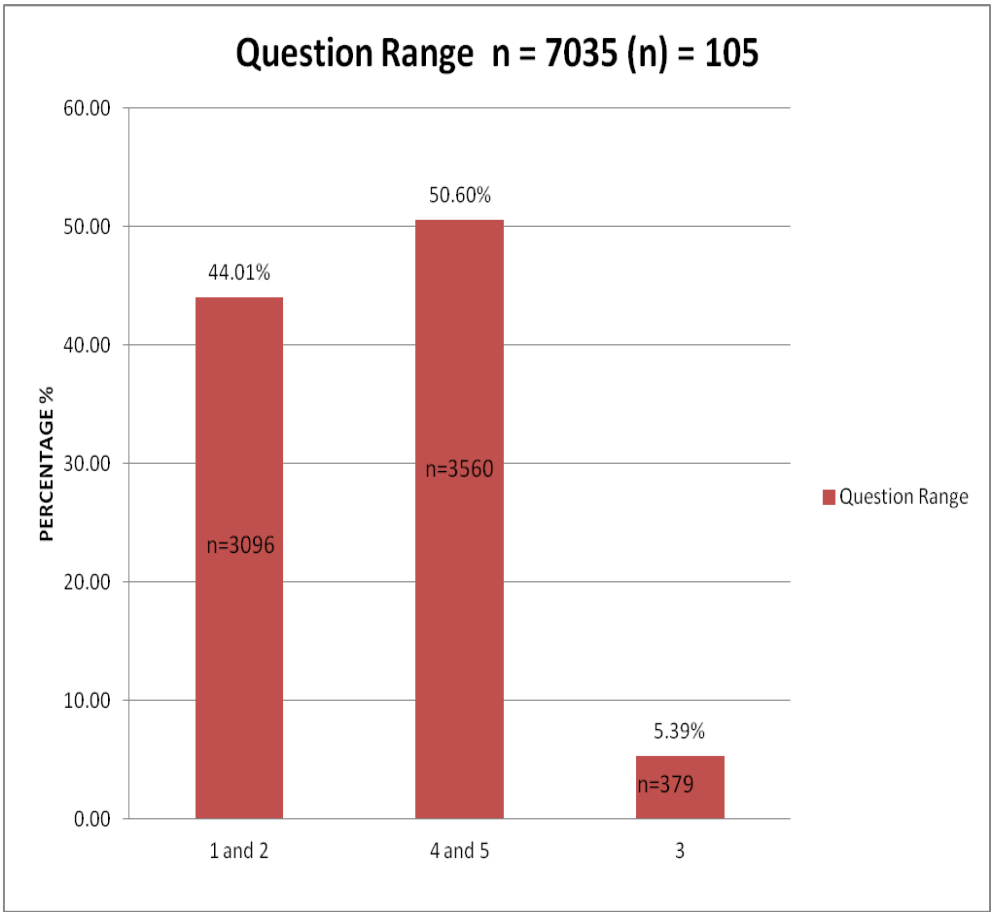


Figure 4.1 Graphic representation of the response to questions in questionnaire

4.4 FINDINGS AND DISCUSSIONS

A total of (n) =105 mental health care users participated in this study. Results and findings will be discussed according to the categories presented.Findings were also synthesized into tables as summarized in the appendix.

4.4.1 Diagnosis

Three diagnosis were prominent among the seven established. Schizophrenia was predominant with 42 (40%) participants.

Major depressive disorder was second with 31 (30%) participants, and bipolar mood disorder third with 21(20%) participants.

Other diagnoses were schizoid-affective disorder 4 (4%), substance induced psychosis 4(4%), Dysthymia and general anxiety disorder 2(2%) and personality disorder 1(1%). These were few in number, therefore insignificant to comment on (also see table 4.1 in appendix I).

Table 4.1

Diagnostic profile of Mental Health Care Users in the Community Clinic (n=105)

Item	Group	Demographic Variable	n = value	Percentage
1.3		**Diagnosis**		
	1	295 - Schizophrenia	42	40.00
	2	296 - Major Depressive Disorder	31	29.52
	3	296.80 - Bipolar Mood Disorder	21	20.00
	4	295.70 - Schizo-affective Disorder	4	3.81
		292 - Substance Induced Psychosis	4	3.81
		300 - Dysthymia /General Anxiety Disorder	2	1.90
		285 - Personality Disorder	1	0.95

Schizophrenia turned out to be the dominant diagnosis in the total sample of 105. Of significance was the question response rate to scores (1, 2) - disagree and (4, 5) agree and (3) neutral. Of the 42(40%) mental health care users treated with schizophrenia 20 (48%) answered ‘disagree’ and 20 (47%) answered ‘agree’. Only 2 (5%) answered ‘neutral’. These scores are indicative of the mental health care users understanding of mental illness and its consequences and the results are summarized in table 4.2 in appendix J.

These findings indicate the lack of insight about mental illness identification which may influence early detection of the illness, and contribute to the repeated hospitalizations and increasing medical care burden. Treatment adherence therefore can be questionable. This finding is consistent with studies undertaken by Thorneycroft (2006) in which negative attitudes to mental distress were found to be common and seen as a form of "internalized stigma" among mental health care users. Sadik (2010) also reiterates that the understanding of the nature of mental illness and its implication for social participation and management remains negative.

Janse Van Rensburg (2010), confirmed that the majority of mental health care users admitted to the regional hospital in the study area were suffering from schizophrenia, in their late thirties, predominantly male, proportionally more white and coloured of whom almost half abused alcohol and cannabis prior to admission. They are also known to be non adherent or discontinued treatment. Furthermore, Janse Van Rensburg (2011) also outlined the cost involved in the hospitalisation of the mental health care users. The cost of mental health care users with schizophrenia (n=138 i.e. 26.5% of total) at 34% (2.8 million) of the total cost of the hospital budget, was the highest for a particular diagnostic category: with an average cost per user of R20 178.30 per hospitalisation. He also cited that 20% (n=88) had multiple readmissions.

In the current study sample, of the 31 (29%) mental health care users with major depressive disorder, 17 (56 %) 'agreed' to questions across the questionnaire, indicating a good understanding of mental illness and its control(see table 4.2 in appendix J).

Of the sample of 21(20%) of mental health care users with bipolar mood disorder, 11(52 %) 'agreed', also indicating some understanding of mental illness. Results of this process are summarized in table 4.2 in appendix J.

4.4.2 Gender and Age Distribution

Females accounted for 65(62%) and males 40(39%).

The majority of the sample 58(55%) were between the age group 40 to 59 years, 32(31%) of the sample were between 18 to 39 years and 15(14%) of the sample between 60 to 79 age group. Results of this process are summarized in table 4.1 in appendix I.

Table 4.1 Age and Gender profiles of Mental Health Care users in the Community

Item	Group	Demographic Variable	n = value	Percentage
1.1		**Age** 18-39 40-59 60-79	 32 58 15	 30.5 55.2 14.3
			105	100
1.2		**Gender** Male female	 40 65	 38.10 61.90
			105	100

4.4.3 Analysis of the perceived identification of mental illness (questions 1 to 12)

These questions were directed towards eliciting information from the mental health care user about the perceptions on identifying mental illness, their signs and symptoms such as anger sleeping problems, lack of concentration, somatic complaints etc (also see table 4.3 in appendix K).

On the identity scale 66 (63%) of the total sample 'disagreed' with the identification of illness and its symptoms, and 37 (35%) 'agreed', 3 (3%) were ' neutral'. This indicates the negative beliefs about or lack of insight or perhaps even denial of mental illness and the number of symptoms attributed to it. Therefore early detection and identification of mental illness is fragile. This is consistent with the South African Federation of Mental health (2011) comment

that South Africans would rather die than admit to mental illness. Baby (2009) found that insight into mental illness is a strong predictor of compliant behaviours: lack of insight significantly predicts non compliance. Lehner (2007) also cited that the lack of collaboration between user and the health professional could be contributory to the lack of insight in identifying mental illness. Results of this process are summarized in table 4.3.

Table 4.3 Analysis of data on the Identification of mental illness (n=105).

	QUESTION	CONTENT	n	DISAGREE 1 & 2 - %	n	AGREE 4 & 5 - %	n	NEUTRAL 3 - %	n	%
Identity Scale	1 to 8	Currently most important psychological problem / complaint	66	63	37	35	3	3	105	100
	9 to 12	See problem as reaction to events, a result of the way I live or expression of my personality	66	63	32	30	7	7	105	100

4.4.4 Analysis of the perceived structure of mental illness (questions13 to 46)

These questions were directed towards the perceived structure of problem, ie. their duration, control over them, their consequences and coherence and the associated emotions involved (also see table 4.3 in appendix K).

Fifty eight (55 %) of total sample 'agreed' on the timeline ie. that mental illness is cyclical and 46(44%) of the total sample believed that mental illness was not chronic, 58 (55%) 'agreed' that there were negative consequences of the illness (see table 4.3).

Sixty four (61%) of the total sample 'agreed' they were responsible for their own personal control of their illness (question 28 to 33). This also indicated the positive belief about the controllability of the illness and the personal understanding of the condition (see table 4.3).

Eighty three (79%) of the total sample 'agreed' that their treatment was effective in controlling their symptoms (questions 34 to 36). This indicated the positive understanding by the users of the importance of taking medication (see table 4.3).

Seventy six (72 %) of the total sample 'agreed ' that various emotions such as feeling depressed, being upset, worried, angry, afraid and anxious controlled their lives (questions 40 to 46). This indicated that volatile emotions were frequently experienced that may possibly further aggravate the symptoms of the mental illness and necessitate the increasing need for sedatives. Results of this process are summarized in table 4.3

Table 4.3 Structure of mental illness (n=105)

	QUESTION	CONTENT	n	DISAGREE 1 & 2 - %	n	AGREE 4 & 5 - %	n	NEUTRAL 3 - %	n	%
Structure Scale	13 to 18	Timeline - chronic	46	44	45	43	14	13	105	100
	19 to 22	Timeline - cyclical	43	41	58	55	4	4	105	100
	23 to 27	Consequences	41	39	58	55	5	5	105	100
	28 to 33	Personal control	34	32	64	61	7	7	105	100
	34 to 36	Treatment	17	16	83	79	5	5	105	100
	37 to 39	Coherence	51	49	49	47	4	4	105	100
	40 to 46	Emotional effects	26	25	76	72	3	3	105	100

4.4.5 Analysis of the understanding of the cause of mental illness (question 47 to 67)

These questions were directed towards understanding the cause of mental illness. The causes could be as a result of psychological factors such as their own upbringing and events experienced in the past, biological factors such as chemical imbalance in the body and genetic traits in the family, structural factors such as support systems or treatment or caused by stress factors such as death or loss of a loved one.

Seventy two (69 %) of the total sample agreed that their illness was affected and influenced by their past, upbringing and family dynamics (questions 47 to 51 in appendix L).

According to Zwi (1993), 80% of mental health care users have had some precipitating life event prior to a psychiatric breakdown. Therefore it is possible that mental illness can exist and is cultivated and triggered by social conditions.

This is further reemphasised by McCabe (2004) in which Bangladeshi participants who were immigrants to Britain cited social conditions as the cause of mental illness. Results of this process are summarized in table 4.3 in appendix K.

Sixty (57%) of the total sample disagreed to being stressed (question 61 to 67), indicating that the participants were not stressed and stress was not a precipitating factor in the mental illness spectrum.

This is contradictory to the study conducted by Hugo (2003) who found that mental illness was caused by stress related incidences. This may imply that these participants have over time learnt to deal with the adversities such as drug use, unemployment, crime and poverty in their lives with the positive cultivation of resiliency.

This is also consistent with the metatheoretical assumption that people handle and modify the meanings of the things they encounter through the interpretive process. They also come to their own conclusions. Therefore the meaning of things in a person's life is derived from the social interactions that the person has with others. Results of this process are summarized in table 4.4 in appendix L.

Table 4.3 Analysis of the understanding of the cause of mental illness (n=105)

	QUESTION	CONTENT	n	DISAGREE 1 & 2 - %	n	AGREE 4 & 5 - %	n	NEUTRAL 3 - %	n	%
Cause Scale	47 to 51	Psychological causes	28	27	72	69	3	3	105	100
	52 to 57	Biological causes	54	51	43	41	8	8	105	100
	58 to 60	Structural causes	58	55	43	41	4	4	105	100
	61 to 67	Causes due to stress	60	57	41	39	4	4	105	100

Of interest was that 53 (50%) of the sample agreed that there was a genetic disposition to mental illness (question 56), whilst 8 (8 %) of the total sample was neutral in their response (see table 4.4 in Appendix L).

Also 54 (51 %) of the sample of the participants ' disagreed' about the lack of supportive community (question 59) indicating that these participants found their community to be supportive, with positive cohesion and support among this community, despite facing many challenges such as unemployment, frequent drug use, poverty and crime (see table 4.4 in Appendix L).

Table 4.4

Analysis of Participants responses to each question in the questionnaire for the total population (n=105)

	Item	Questionnaire Statement	Total Population (n=105)					
			Agree (4+5)		Disagree (1+2)		Neutral (3)	
			n	Percentage	n	Percentage	n	Percentage
		What do you see as the causes of your problems						
Biological causes	52	A chemical imbalance inside my brain	54	51	39	37	12	11
	53	My body's physical make-up	39	37	54	51	12	11
	54	Since I stopped taking medication	23	22	75	71	7	7
	55	My body's sensitivity to certain substances	35	33	65	62	5	5
	56	Certain genes inherited within the family	53	50	41	42	8	8
	57	A chemical imbalance in my body	53	50	46	44	7	7
Struct	58	Unhelpful attitudes held by others because of where I come from	45	43	55	52	5	5
	59	The lack of supportive communities	48	46	54	51	3	3
	60	Unhelpful attitudes held by others because of my age	37	35	63	60	5	5

4.5 SUMMARY

In summary the study highlighted the lack of knowledge of participants in effectively identifying signs of mental illness, which may be a contributory factor in hampering early detection and the implementation of treatment strategies.

There was also evidence of a lack of information about the chronicity of mental illness as 46 (44%) of the total sample thought mental illness was not chronic, and this may be influencing the medication compliance of the mental health care users.

Sixty four (61%) of the total sample agreed that they had personal control over their illness indicating positive self control. Interestingly 83(79%) of the total sample agreed that it was important to take medication and that medication helped in controlling the illness symptoms.

Seventy six (69%) of the total sample were emotionally affected by the illness and 72(69%) of the total sample agreed that their illness was attributed to psychological causes such as upbringing and the past events in their lives. Of interest was that 60 (57%) of the total sample disagreed that their condition was attributed due to stress factors in their lives.

Schizophrenia was also the predominant diagnosis with 42 (40%) of the total sample agreeing that they have no clue about the aetiology of mental illness. This is of concern as most of the mental health care users that are frequently hospitalised as cited by Janse Van Rensburg (2010), suffer from schizophrenia.There were nil non respondents indicating that the questionnaire was understandable and user friendly in the South African context.

4.6 CONCLUSION

In conclusion, it can be deduced that these mental health care users' attitudes, life experiences, perceptions and beliefs could possibly influence the manner in which mental illness is identified, understood and interpreted. It can also be concluded that the research tool was successful in achieving the study objectives as the views of mental health care users from mixed ancestry group have become known.

CHAPTER 5

SUMMARY AND CONCLUSION

5.1 INTRODUCTION

This final chapter of the research report presents the conclusions of the study, followed by a discussion of the limitations and concludes with the implications and recommendations for clinical practice and further research that arises from this study.

5.2 SUMMARY OF THE STUDY

The purpose of this study was to understand how mental health care users of the mixed ancestry or the 'Coloured' race groups attending an out patient clinic in Westbury - North West of Johannesburg, perceive mental illness and the management thereof.

The first objective of the study was to identify the perceptions of persons from the mixed ancestry 'Coloured' race group attending a clinic in the Westbury clinic - North West of Johannesburg, toward their illness. This study effectively elicited the 'Coloured' mental health care user's knowledge about mental illness as, of the n=105 study participants, 66 (63%) of the participants seem to lack knowledge in identifying mental illness. This could be attributed to denial and possible negative beliefs about mental illness. Therefore it can be concluded that the perceptions of the 'Coloured' mental health care users have become known and that the first study objective has been fulfilled.

The second study objective was to elicit the mental health care users' knowledge about mental illness. This study managed effectively to ascertain the mental health care user's knowledge about the process of mental illness such as chronicity of mental illness, personal control, and importance of treatment. Mental health care users knowledge about the causative factors that

may be implicated in mental illness such as psychological factors e.g. past experiences and upbringing, biological factors e.g. genetic disposition and the effects of stress on mental illness have also become known. It can therefore be concluded that the second study objective has been met successfully.

This study has managed to understand how mental health care users of mixed ancestry or 'Coloured' race group attending an out patient clinic in the North West of Johannesburg, perceive mental illness and its management. Of the n=105 participants, 91 (87%) agreed on the importance of taking medication and the effectiveness of treatment in controlling mental illness symptoms. Therefore it can be concluded that this research study has been effective in achieving its aim.

5.3 BACKGROUND

The opinions of 105 mental health care users from mixed ancestry, 'Coloured' group were obtained through a validated questionnaire, on their understanding about mental illness and the causative factors of mental illness.

The study sample was part of the community of Westbury Township that grew when the apartheid government moved people from Sophiatown (forced removals), and settled people according to their ethnicity and tribes by the group areas act. It is a township that is on the north-west of Johannesburg. The township residents are mostly of mixed ancestry decent, who were moved from Denver, Vrededorp and Sophiatown.

The town has a rich history from the early days of apartheid, when most were victims of forced removals, to the days of gangsters', when the township was feared and given the tag 'one of the dangerous townships in South Africa (Mopai, 2010).

The community of Westbury, like other mixed ancestry communities in Johannesburg, have always lived life on the margins and shared in the experience of being socially and racially excluded from the mainstream of society (Field, 2001).

5.4 MAIN FINDINGS

In 2008, the University of Johannesburg undertook a Johannesburg Poverty and Livelihoods Study (JPLS). The aim of the study was to understand the multidimensional nature and extent of poverty and the way people survive and make a living in some of the poorest parts of City of Johannesburg. Seven sites were identified as 'deprived' wards. One of which was Riverlea- also a community predominantly made up of mixed ancestry citizens.

Of interest were the similarities between the findings of the JPLS study and the present study. Households in Riverlea had the least percentage of socio-economic changes with only 13% of households indicating that they were affected by the adverse events or risks. This is consistent with the present study in which the majority of the participants mental condition was not affected by the socio economic changes or events in their lives.

Also, in this study 54 (51%) of the sample disagreed about the lack of community support as they felt supported and trusted their community, (see Appendix L: Q-59). This is consistent with the JPLS study in which three quarters (75%) of all respondents felt part of their neighbourhood and on average 74% of people felt that they got along with people in their neighbourhood.

An average of 41 (39%) of the total sample felt that stress factors did not affect them (see table 4.3 - Q 61 to 67 in appendix K). This is contradictory to JPLS study in which high levels of stress were encountered in poor households with area variations. It can be assumed that poor households are employing diverse coping and adaptive strategies to survive.

The overall identification of mental illness was poor indicating ignorance and possible denial of the existence of mental illness, (see table 4.3 in appendix K). Part one, the identity scale, questions one to12, concerned the perception of the identity of the problems: How do the mental health care users view them? Sub minimal levels of mental health education are indicative of poor collaboration between the mental health care user and the health worker. This may be impacting negatively on treatment adherence and treatment.

72 (69 %) of the total sample agreed that psychological causes precipitated mental illness which is congruent to the history of Westbury Township, (see table 4.3 - Q 47 to 51 in appendix K).

These findings are suggestive that the past, upbringing and family dynamics seem to have some compounding effect on the users' mental illness. This is also consistent with the high levels of emotional levels present in this study as indicated by questions 40 to 46 of the questionnaire.

Table 4.3 Analysis of data on the perceived Identification and cause of mental illness in percentage (n=105)

	QUESTION	CONTENT	n	DISAGREE 1 & 2 - %	n	AGREE 4 & 5 - %	n	NEUTRAL 3 - %	n	%
Identity Scale	1 to 8	Currently most important psychological problem / complaint	66	63	37	35	3	3	105	100
	9 to 12	See problem as	66	63	32	30	7	7	105	100
Cause Scale	47 to 51	Psychological causes	28	27	72	69	3	3	105	100
	52 to 57	Biological causes	54	51	43	41	8	8	105	100
	58 to 60	Structural causes	58	55	43	41	4	4	105	100
	61 to 67	Causes due to stress	60	57	41	39	4	4	105	100

5.5 LIMITATIONS OF THE STUDY

The findings of this study are confined to the community of mixed ancestry 'Coloured' origin. There may be differences between other race groups not included in this study.

A limitation of this study, although it was not a study objective, was the fact that the finer nuances about the psychological and emotional causes were not evaluated. These would have been affirmed more concisely by using qualitative research methods e.g. focus groups and interviews.

However, the scope of this research project was limited by the nature of the study, which was completed in partial fulfilment of the requirements of the degree MSc (Nursing). As such, it is a first level descriptive study. The issues concerned here however, are vitally important and could form the basis for further studies.

5.6 RECOMMENDATIONS

Providing care to mental health care users within the framework of the Mental Health Act No. 17 of 2002 is an obligation of every mental health care provider. Therefore, it is imperative that health care workers are suitably skilled and educated to provide optimal care to assist in meeting the mental health needs of mental health care users, which will ultimately lead to improved treatment outcomes.

Replication of the study should be undertaken with other racial groups e.g. black, Indian and white participants not included in this study. This would allow for comparative studies to be undertaken within an afro centric context as most previous studies have been conducted in the Eurocentric and American contexts.

Replication of this study should also be undertaken using both qualitative and quantitative research methods, as attitudes and perceptions are difficult to articulate and define using the quantitative method alone.

Further studies can also be undertaken using the gender criteria, as disease profiles and treatment strategies of females vary from males.

In the interest of improving the quality of mental health care in South Africa, specific recommendations are made in relation to the understanding of mental illness. These recommendations can be subdivided into three categories:

5.6.1 Clinical Practice

The implication of the findings for clinical practice is based on the inability of mental health care users to identify the symptoms of mental illness and come forth promptly for treatment.

In our diverse culture, it is imperative for mental health care workers to be aware of cultural differences within the community of mental health care users to avoid the danger of misinterpreting the symptoms of mental illness and resort to other help e.g. faith and traditional healers. Therefore, practising mental health care workers in consultation with the multidisciplinary team should form task groups to develop:

- Develop programmes to educate the community about mental illness and services that are available.
- Create a forum in which traditional and faith healers are included in the mental health care users' treatment strategies for better collaboration and treatment outcomes.
- Create an efficient system to trace defaulters of treatment to ensure adherence to treatment.
- Improve collaboration between mental health care users and the health care professionals need to be established and sustained in order to identify weaknesses in the system.
- Develop assessment tools that address cultural variations and aspects of the different users.

A multidisciplinary approach to care, a culturally congruent assessment tool and regular service evaluations should become the norm in the practice.

5.6.2 Mental Health Education

As mental health has been incorporated into the Primary Health care model- it has become imperative to educate all the health professionals about the diverse and dynamic needs of the mental health care users within a culturally diverse and fragile socio-economic framework. The findings of this study indicate that, by understanding the life world of the mental health care users, better treatment outcomes are facilitated.

5.6.3 Further Research

In this study the mental health care professional's perceptions and cultural affiliations were not obtained. Recommendations for future research would be to evaluate mental health care professionals' perceptions about mental illness within a culturally bound context. The accuracy of mental health care professionals' perceptions would influence the identification and understanding of mental illness and its outreach.

Furthermore, the collaborative structure of the mental health clinics was not addressed in this study. Therefore, recommendations are made to conduct a multidisciplinary study to determine ways to identify mental illness early enough to improve illness prognosis and assist in destigmatization of mental illness.

5.7 CONCLUSION

In conclusion, this research report has highlighted to what extent the mental health care user of mixed ancestry, understands mental illness. These findings will be of use to healthcare management in the delivery and evaluation of mental health care services. This will allow the determination of the needs of the mental health care users in line with the realities of clinical practice, health policies and the socio-economic development of the country.

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Appendix A

Study ID Number _____

We are interested in your own personal views of how you see your current illness.

Please indicate how feel about your illness.

	WHAT ARE CURRENTLY YOUR MOST IMPORTANT PSYCHOLOGICAL COMPLAINTS OR PROBLEMS	NOT AT ALL 1	SOMETIMES 2	NOT SURE 3	OFTEN 4	VERY OFTEN 5
1	Anxiety or fear including avoidance of frightening situations					
2	Sadness or depression					
3	Body complaints					
4	Social and/or relational problems					
5	Anger or aggression					
6	Lack of concentration, forgetfulness, worrying					
7	Over-controlling, repetition behaviour					
8	Sleeping problems					
	I SEE MY COMPLAINTS OR PROBLEMS AS					
9	A reaction to circumstances or events					
10	A symptom of my disorder					
11	An expression of my personality					
12	A result of the way I live my life					
	WHAT ARE YOUR CURRENT VIEWS ABOUT YOUR PROBLEM	**STRONGLY DISAGREE 1**	**DISAGREE 2**	**NEITHER AGREE OR DISAGREE 3**	**AGREE 4**	**STRONGLY AGREE 5**
13	My problems will last a short time					
14	My problems are likely to be permanent rather than temporary					
15	My problems will last for a long time					
16	These problems will pass quickly					
17	I expect to have these problems for the rest of my life					
18	My problems will become less serious over time					
19	The symptoms of my problems change a great deal from day to day					
20	My symptoms come and go in cycles					
21	My problems are very unpredictable					
22	I go through cycles in which my problems get better and worse					
23	My problems are serious					
24	My problems have major consequences on my life					
25	My problems do not have much effect on my life					
26	My problems strongly affect the way others see me					
27	My problems cause difficulties for those who are close to me					
28	There is a lot which I can do to control my problems					
29	What I do can determine whether my problems get better or worse					
30	The course of my problems depends on me					
31	Nothing I do will affect my problems					
32	I have the power to influence my problems					
33	My actions will have an effect on the course of my problem					

		STRONGLY DISAGREE 1	DISAGREE 2	NEITHER AGREE OR DISAGREE 3	AGREE 4	STRONGLY AGREE 5
34	My treatment will be effective in curing my problems					
35	The negative effects of my problems can be prevented/avoided by my treatment					
36	My treatment can control my problems					
37	My problems are a mystery to me					
38	I do not understand my problems					
39	My problems do not make sense to me					
40	I have a clear picture or understanding of my condition					
41	I get depressed when I think about my problems					
42	When I think about my problems, I get upset					
43	My problems make me feel angry					
44	My problems worry me					
45	Having these problems make me feel anxious					
46	My problems make me feel afraid					
WHAT DO YOU SEE AS THE CAUSES OF YOUR PROBLEM?						
47	Difficulty in forming close relationships					
48	Unpleasant events that have occurred in the past					
49	Difficulties experienced through upbringing					
50	Unresolved feelings resulting from the past					
51	Family relationship difficulties					
52	A chemical imbalance inside my brain					
53	My body's physical make-up					
54	Since I stopped taking medication					
55	My body's sensitivity to certain substances					
56	Certain genes inherited within the family					
57	A chemical imbalance in my body					
58	Unhelpful attitudes held by others because of where I come from					
59	The lack of supportive communities					
60	Unhelpful attitudes held by others because of my age					
61	Stress resulting from a recent very unpleasant event					
62	Conflict with my ex- partner following separation					
63	Experience of serious marital conflict					
64	Difficulties in coping with a loss through death or separation					
65	Being physically ill has made it harder to cope with emotional demands					
66	Family difficulty in adjusting to new living arrangements, e.g. children leaving home					
67	The threat of an unpleasant event such as repossession of house, vehicle, retrenchment					

Thank you very much for your participation and your opinions. After completing the questionnaire fold it and place it in the envelope provided. Kindly return the questionnaire to the assistant at the clinic or place it in the box provided at the clinic.

Appendix B

M110477

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Mrs A Ramanlal

CLEARANCE CERTIFICATE	**M110477**
PROJECT	Identifying the Understanding of Mental Illness of Mental Health Care Users of Mixed Ancestry Group Attending a Community Mental health Clinic
INVESTIGATORS	Mrs A Ramanlal.
DEPARTMENT	Department of Nursing Education
DATE CONSIDERED	06/05/2011
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 03/06/2011 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor : Dr Gayle Langley

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 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 to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

Appendix C

Faculty of Health Sciences
Medical School, 7 York Road, Parktown, 2193
Fax: (011) 717-2119
Tel: (011) 717-2076

Reference: Ms Salamina Segole
E-mail: salamina.segole@wits.ac.za
21 July 2011
Person No: 519381
TAA

Mrs A Ramanlal
P.O. Box 96573
Brixton
2019
South Africa

Dear Mrs Ramanlal

Master of Science in Nursing: Change of title of research

I am pleased to inform you that the following change in the title of your Research Report for the degree of has been approved:

From:	**Identifying the attitudes and perceptions of mental illness of psychiatric patients of mixed ancestry group attending a community mental health clinic**
To	**Identifying the understanding of mental illness of mental health users of mixed ancestry group attending a community mental health clinic**

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

Appendix D

Aruna Ramanlal
e-mail- 519381@ students.wits.ac.za
Supervisor: Dr G.Langley
6 February 2011

Mr M Makhudu
Chief Director
Johannesburg Metro District Health Services

Re : Permission requested to conduct a research study in Community Mental Health Clinic entitled "A Quantitative Research Study on the Attitudes and Perceptions of Psychiatric Patients and their impact on Medication Adherence - A Psychiatric Community Clinic Perspective in Region B – Gauteng"

Dear Mr Makhudu
I am presently working at the Crosby Mental Health Clinic (persal no. 10850325). I am reading for a Masters Degree in Nursing in the Faculty of Health Sciences of the University of the Witwatersrand, and as part of the degree I am required to complete a study under the guidance of an experienced researcher.

My study is focusing on Attitudes and Perceptions of patients from mixed ancestry race group and its impact on medication adherence. This study will attempt to reveal patient's attitudes and perceptions towards medication adherence and the outcome of the study can be utilized to develop assessment tools. These tools can be included in the crucial assessment phase that primarily supports the outcome of the patient's health status. In the presence of adequate assessment tools that address the patient's health status and the understanding of their illness medication adherence can be influenced. Cost of continual hospitalisations of these clients can be reduced.

The study will be conducted at the Westbury Mental Health Clinic in Region B - Gauteng. A study of this nature has not been conducted before in the community setting in Gauteng, I believe this study would set some standard for client assessment, treatment and progress in the community for psychiatric patients. I plan to conduct this study in 2011 over a 3 month period.

I trust the study will contribute favourably to improving service delivery and enhancing the health status of the mentally challenged individuals in the community and that permission to conduct the study will be granted.

Thank you
Yours sincerely

Aruna Ramanlal

Supported /~~not supported~~

Prof Moosa
Clinical Head of Psychiatry, Johannesburg Metro Districts
Date: 24/02/2011

~~Approved / not approved~~

Mr M Makhudu
Chief Director, Johannesburg Metro Districts

Appendix E

Authors Permission

My name is Aruna Ramanlal and I am presently studying my Masters in Nursing Science at the University of the Witwatersrand, South Africa.
I am planning to study the attitudes and perceptions of mentally ill patients and its impact on medication adherence.
It was with great interest I read your article “Development of the Illness Perception Questionnaire- mental health". The versatility and applicability of the questionnaire in various settings makes it very suitable to the multi-cultural and ethnically diverse population of South Africa.
I therefore request permission and assistance to use the instrument in my study. Your contributions in any form will be acknowledged in all articles and publications that might materialize.
Thank you once again for considering my request.

Kind regards

Aruna

> ----- Original Message -----
> > From: "C.Witteman" <C.Witteman@socsci.ru.nl>
> > Date: Friday, February 11, 2011 3:17 pm
> > Subject: Re: Research Study in South Africa
> > To: Arunaben Ramanlal <Arunaben.Ramanlal@students.wits.ac.za>

Dear Aruna,

of course you may use the instrument in your study, be our guest.

Good luck with your Masters,
best regards,
Cilia Wittema

Appendix F

PATIENT INFORMATION LETTER

A Research Study on the Understanding of Mental Health Care Users about their Illness

Dear Sir / Madam

My name is Aruna Ramanlal and I am a nurse attached to the Community Mental Health Services. I am currently reading for a Master's degree in Nursing at the University of Witwatersrand. As part of the degree I am required to complete a study under the guidance of an experienced researcher.

I am hoping to conduct a research study on how mental health care users view their illness. May I invite you to consider participating in a study to investigate how you as a patient have experienced your illness. Your participation in this study would be entirely voluntary and you are free to decline the invitation altogether or stop at any time without having to give any explanation and without affecting the care you receive and without any consequences.

If you agree to volunteer for the study, the assistant will ensure that you understand what is required and a questionnaire will be handed to you to complete. If you prefer, she can take you to a private room, and assist you to fill out the questionnaire. The nursing and medical staffs have been informed of the study and are aware that many patients will be approached and asked to assist. If you are queuing in the clinic, the assistant will ensure that you do not loose your place in the queue.

The questions ask about your understanding and perceptions about your illness. The questionnaire will take between 15 to 30 minutes to complete. Then you or the assistant will place it in a sealed envelope, and post the form into a sealed box. The questionnaire is completely anonymous. No names, the reason for attending the clinic or the clinic you attend will be written on any of the forms, so that no one who volunteers can be identified. You will also be asked not to mention any staff members by name or give details about specific treatments or problems you encountered. Only general information and opinions are needed.

You will be required to sign a consent form for statistical reasons only. You will not benefit personally in any way from volunteering and there are no risks if you do decide to participate. In both cases, you will not be able to be identified so we will not be able to contact you to follow up any requests, complaints or compliments.

Thank you for taking the time to consider participation. Should you need any more information, please feel free to contact me at the numbers given below. Once the study has been completed, the broad results will be posted on the notice board in the clinic. However, as indicated, no names, identities, individual units will be able to be identified in the reports.

Yours sincerely

Aruna Ramanlal Tel.No. - 011 8377449 E-mail: Arunaben.Ramanlal@students.wits.ac.za

Appendix G

CONSENT FORM

Mental health care users understanding about their mental illness

I agree to participate in this research study investigating the perceptions of mental health care users about their illness.

I have read the information letter and understand what the study is all about. I also understand that my participation is voluntary and that I can withdraw from the study at any time without any consequences.

I agree to answer the questions. All information will remain confidential and my name and identity will not appear anywhere on the questionnaire or the research report.

Number assigned:

Signature: _____ Date_____

Appendix H

DEMOGRAPHIC DATA

Please provide the following data that will be used solely for statistical purposes only.

Date: _____

File No: _____

Diagnosis: _____

How often do you attend the clinic?	
Once a month	
Twice a month	

Age	
Male	Female

Appendix I

Table 4.1

Demographic profile of Mental Health Care Users in the Community Clinic (n=105)

Item	Group	Demographic Variable	n = value	Percentage
1.1		**Age** 18-39 40-59 60-79	 32 58 15 **105**	 30.5 55.2 14.3 **100 %**
1.2		**Gender** Male female	 40 65 **105**	 38.10 61.90 **100 %**
1.3	1	**Diagnosis** 295 - Schizophrenia	42	40.00
	2	296 - Major Depressive Disorder	31	29.52
	3	296.80 - Bipolar Mood Disorder	21	20.00
	4	295.70 - Schizo-affective Disorder 292 - Substance Induced Psychosis 300 - Dysthymia /General Anxiety Disorder 285 - Personality Disorder	4 4 2 1 **105**	3.81 3.81 1.90 0.95 **100 %**
1.4		**Overall Question Range** Scores 1,2 (disagree) Scores 4,5 (agree) Score 3 (neutral)	7035 3096 3560 379 **105**	 44.01 50.60 5.39 **100 %**

Table 4.2 Appendix J

ANALYSIS OF DATA ACCORDING TO DIAGNOSIS was undertaken to ascertain the knowledge and views of the participants with different diagnosis. The results would give clarity on the reason why certain mental health care users are subjected to more frequent hospitalisations than others. The data also revealed the extent of understanding of mental illness by the participants

DIAGNOSE	n	%	GROUP	IDENTITY SCORE % 1,2	n	IDENTITY SCORE % 4,5	n	IDENTITY SCORE % 3	n	STRUCTURE SCORE % 1,2	n	STRUCTURE SCORE % 4,5	n	STRUCTURE SCORE % 3	n	CAUSE SCORE % 1,2	n	CAUSE SCORE % 4,5	n	CAUSE SCORE %	n	OVERALL DIAGNOSE SCORE %	n
SCHIZOPHRENIA - 295	**42**	40	1	70	29	25	11	5	2	37	16	58	24	6	3	54	23	42	18	4	2	1&2 - 484& 5 - 473 -5	-20 -20 -2
MAJOR DEPRESSIVE DISORDER - 296	**31**	29.52	2	48	15	48	15	4	1	30	9	62	19	8	2	40	12	52	16	8	2	1&2 -364&5 - 563 -7	-11 -17 -3
BIPOLAR MOOD DISORDER - 296.8	**21**	20	3	65	14	31	7	4	1	36	8	59	12	5	1	43	9	52	11	5	1	1&2 -434&5 -523 -5	-9 -11 -1
SCHIZO-AFFECTIVE DISORDER - 295.7	**4**	3.81	4	75	3	25	1	0	0	54	2	45	2	1	0	76	3	24	1	0	0	1&2 -654&5 -253 -0	-3 -1 -0
SUBSTANCE INDUCED PSYCHOSIS - 292	**4**	3.81		72	3	26	1	3	0	46	2	51	2	3	0	64	3	36	1	0	0	1&2 - 574&5 -413 - 2	- 2 -1 - 1
DYSTHYMIA - GENERAL ANXIETY DISORDER - 300	**2**	1.9		71	1	29	1	0	0	13	0	82	2	4	0	26	1	74	1	0	0	1&2 -284&5-703 -2	0.56 -1.4 0.04
PERSONALITY DISORDER - 285	**1**	0.95		58	1	42	0	0	0	42	0	58	1	0	0	43	0	57	1	0	0	1&2 -454&5 -553 - 0	0.45 0.55 -0

Table 4.3 Appendix K

Analysis of Data according to the perceived Identity, Structure and Cause of Mental Illness in percentage (n=105)

	QUESTION	CONTENT	n	DISAGREE 1 & 2 - %	n	AGREE 4 & 5 - %	n	NEUTRAL 3 - %	n	%
Identity Scale	1 to 8	Currently most important psychological problem / complaint	66	63	37	35	3	3	105	100
	9 to 12	See problem as	66	63	32	30	7	7	105	100
Structure Scale	13 to 18	Timeline - chronic	46	44	45	43	14	13	105	100
	19 to 22	Timeline - cyclical	43	41	58	55	4	4	105	100
	23 to 27	Consequences	41	39	58	55	5	5	105	100
	28 to 33	Personal control	34	32	64	61	7	7	105	100
	34 to 36	Treatment	17	16	83	79	5	5	105	100
	37 to 39	Coherence	51	49	49	47	4	4	105	100
	40 to 46	Emotional effects	26	25	76	72	3	3	105	100
Cause Scale	47 to 51	Psychological causes	28	27	72	69	3	3	105	100
	52 to 57	Biological causes	54	51	43	41	8	8	105	100
	58 to 60	Structural causes	58	55	43	41	4	4	105	100
	61 to 67	Causes due to stress	60	57	41	39	4	4	105	100

Table 4.4 Appendix L

Analysis of Participants responses to each question in questionnaire for total population (n = 105).

This is the analysis of every question in the questionnaire, depicting the percentage of groups 1, 2(disagree) and 4, 5(agree) and 3(neutral) responses.

Profile of Questionnaire in order of frequency agreement responses for the total population (n=105)

	Item	Questionnaire Statement	Total Population(n=105)					
			Agree (4+5)		Disagree (1+2)		Neutral (3)	
			n	Percentage	n	Percentage	n	Percentage
		What are currently your most important psychological complaints or problems						
Currently most imp problem	1	Anxiety or fear including avoidance of frightening situations	27	26	74	70	4	4
	2	Sadness or depression	43	41	59	56	3	3
	3	Body complaints	32	30	68	65	5	5
	4	Social and / or relational problems	27	26	76	72	2	2
	5	Anger or aggression	32	30	71	68	2	2
	6	Lack of concentration, forgetfulness, worrying	54	51	48	46	3	3
	7	Over-controlling, repetition behaviour	29	28	74	70	2	2
	8	Sleeping problems	46	44	59	56	0	0
		I see my complaints or problems as						
See problem	9	A reaction to circumstances or events	36	34	64	61	5	5
	10	A symptom of my disorder	30	29	61	58	14	13
	11	An expression of my personality	29	28	72	69	4	4
	12	A result of the way I live my life	32	30	67	64	6	6

Analysis of Participants responses to each question in questionnaire for total population (n = 105).

	Item	Questionnaire Statement	Total Population (n=105)					
			Agree (4+5)		Disagree (1+2)		Neutral (3)	
			n	Percentage	n	Percentage	n	Percentage
		What are your current views about your problem						
Timeline - chronic	13	My problem will last a short time	37	35	54	51	14	13
	14	My problems are likely to be permanent rather than temporary	48	46	46	44	11	10
	15	My problems will last for a long time	53	50	41	39	11	10
	16	These problems will pass quickly	32	30	53	50	21	20
	17	I expect to have these problems for the rest of my life	48	46	45	43	12	11
	18	My problems will become less serious over time	55	52	37	35	13	12
Timeline - cyclical	19	The symptoms of my problems change a great deal from day to day	54	51	47	45	4	4
	20	My symptoms come and go in cycles	62	59	37	35	6	6
	21	My problems are very unpredictable	58	55	44	42	3	3
	22	I go through cycles in which my problems get better and worse	59	56	43	41	3	3
consequences	23	My problems are serious	63	60	35	33	7	7
	24	My problems have major consequences on my life	68	65	34	32	3	3
	25	My problems do not have much effect on my life	32	30	59	62	9	9
	26	My problems strongly affect the way others see me	63	60	36	34	6	6
	27	My problems cause difficulties for those who are close to me	66	63	36	34	3	3
	28	There is a lot which I can do to control my problems	74	70	25	24	7	7
	29	What I can do determine whether my problems get better or worse	66	63	32	30	8	8

Analysis of Participants responses to each question in questionnaire for total population (n = 105).

	Item	Questionnaire Statement	Total Population (n=105)					
			Agree (4+5)		Disagree (1+2)		Neutral (3)	
			n	Percentage	n	Percentage	n	Percentage
Personal control	30	The course of my problems depends on me	67	64	32	30	6	6
	31	Nothing I do will affect my problems	37	35	55	52	13	12
	32	I have the power to influence my problems	67	64	32	30	7	7
	33	My actions will have an effect on the course of my problem	74	70	27	26	4	4
treatment	34	My treatment will be effective in curing my problems	72	69	27	26	6	6
	35	The negative effects of my problems can be prevented/avoided by my treatment	85	81	14	13	6	6
	36	My treatment can control my problems	91	87	11	10	4	4
cohere nce	37	My problems are a mystery to me	53	50	49	47	3	3
	38	I do not understand my problems	47	45	54	51	4	4
	39	My problems do not make sense to me	51	49	49	47	5	5
Emotional effects	40	I have a clear picture or understanding of my condition	76	72	22	21	7	7
	41	I get depressed when I think about my problems	80	76	24	23	1	1
	42	When I think about my problems, I get upset	74	70	27	26	4	4
	43	My problems make me feel angry	75	71	28	27	2	2
	44	My problems worry me	78	74	26	25	1	1
	45	Having these problems make me feel anxious	75	71	28	27	2	2
	46	My problems make me feel afraid	74	70	29	28	3	3

Analysis of Participants responses to each question in questionnaire for total population (n = 105).

	Item	Questionnaire Statement	Total Population (n=105)					
			Agree (4+5)		Disagree (1+2)		Neutral (3)	
			n	Percentage	n	Percentage	n	Percentage
		What do you see as the causes of your problems						
Psychologic	47	Difficulty in forming close relationships	66	63	34	32	5	5
	48	Unpleasant events that have occurred in the past	85	81	18	17	2	2
	49	Difficulties experienced through upbringing	68	65	32	30	5	5
	50	Unresolved feelings resulting from the past	75	71	27	26	3	3
	51	Family relationship difficulties	69	66	33	31	3	3
Biological causes	52	A chemical imbalance inside my brain	54	51	39	37	12	11
	53	My body's physical make-up	39	37	54	51	12	11
	54	Since I stopped taking medication	23	22	75	71	7	7
	55	My body's sensitivity to certain substances	35	33	65	62	5	5
	56	Certain genes inherited within the family	53	50	41	42	8	8
	57	A chemical imbalance in my body	53	50	46	44	7	7
Struct	58	Unhelpful attitudes held by others because of where I come from	45	43	55	52	5	5
	59	The lack of supportive communities	48	46	54	51	3	3
	60	Unhelpful attitudes held by others because of my age	37	35	63	60	5	5

Analysis of Participants responses to each question in questionnaire for total population (n = 105).

	Item	Questionnaire Statement	Total Population (n=105)					
			Agree (4+5)		Disagree (1+2)		Neutral (3)	
			n	Percentage	n	Percentage	n	Percentage
Causes due to stress	61	Stress resulting from a recent very unpleasant event	56	53	48	46	1	1
	62	Conflict with my ex-partner following separation	41	39	57	54	7	7
	63	Experience of serious marital conflict	36	34	64	61	5	5
	64	Difficulties in coping with a loss through death or separation	54	51	46	44	5	5
	65	Being physically ill has made it harder to cope with emotional demands	26	25	77	73	2	2
	66	Family difficulty in adjusting to new living arrangements, e.g. children leaving home	38	36	62	59	5	5
	67	The threat of an unpleasant event such as repossession of house, vehicle, retrenchment	34	32	68	65	3	3