Perceptions of Mental Health in low-middle-income South Africa

Thesis

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PLAGIARISM DECLARATION

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Abstract

Mental health is an important contributing factor to well-being. Understanding mental health is crucial in influencing an individual's help-seeking behaviour. This study aimed to explore and discover perceptions of mental health in Low-Middle income (LMI) communities in the South African context, as well as gain an in-depth understanding of what informs the perceptions of mental health. Furthermore, the aim was to establish information on the role of perceptions of mental health. Finally, the aim was to contribute to the current scope of knowledge on perceptions of mental health and improve the academic research attention given to perceptions of mental health in the South African context. The study employed a qualitative approach and used one-on-one, semi-structured interviews as a method of data collection. Seven individuals above the age of eighteen years were invited to be participants. Based on the findings, mental health is recognised in LMI communities however, it is also stigmatised. It has been discovered that financial strain and joblessness are major contributors to mental health issues among LMI communities. Additionally, individuals have reported insufficient mental health resources and care within these communities, including a shortage of qualified professionals in public clinics. This study has the potential to improve the awareness on the prevalent perspectives and stigma surrounding mental health and other significant mental health issues in LMI communities, such as resource allocation. The study also highlights the urgency of developing effective policies and tailored interventions that are context-sensitive to address the disparities in quality mental health care in LMI communities.

Keywords

context-based interventions; Low-Middle Income communities; mental health; socioeconomic status; South Africa; well-being.

INTRODUCTION CHAPTER

Introduction

A multitude of factors contribute to the state of one's mental health, including the environment, culture, information capital, availability and access to mental health resources, support from caregivers and family, as well as the perceptions attached to mental health (Fusar-Poli, 2020). Leighton and Dogra (2009) maintain that the physical, mental, and social factors affecting mental health do not exist separately but are interdependent to the holistic mental health of individuals. As such, mental health is not only caused by biological factors such as chemical imbalances but by the interaction between numerous factors that have the potential to affect well-being. This varied dependency creates different mental health dynamics for every unique community based on the magnitude and the presence or absence of these contributing factors (Hill & Maimon, 2013). In essence, the maintenance of mental health is context sensitive.

South Africa (SA) has been criticised for having inadequate mental health care and preserving the values of Apartheid such as inequality (Vogelman, 1990). South Africa has upper-income communities and low-middle-income (LMI) communities. Low-middle-income communities are characterised by their poor socioeconomic status, unemployment, poor maintenance of basic needs, and restricted access to essential resources such as mental health care (Phadi & Ceruti, 2011). In SA, poor communities are diverse and fall under different categories. For some, poverty looks like child-headed households, having someone with a disability but with no support, the rural poor, unemployment etc. (Aliber, 2003). A study investigating the relationship between household size and poverty in the northern Free State of SA found that 84% of households of the sample (n=2900) consist of three to seven persons per household and lie below the poverty line (Meyer & Nishimwe-Niyimbanira, 2016). According to the World Bank (2022), LMI communities are characterised by a Gross National Income (GNI) per capita between USD1,036 and USD4,045, the equivalent of R19 914,82 and R77 763,51. This information is important in revealing the various socioeconomic issues affecting persons within LMI communities such as having households with a large size and insufficient income, which potentially contribute negatively to their mental health.

The specific variety of LMI communities that this study was interested in are those with environmental and socioeconomic deficiencies such as unavailability of, or inaccessible mental health care facilities, inadequate mental health care support systems, poor mental health care promotion, and lack of interventions (such as trauma therapy, group counselling programs, rehabilitations centres, mental health awareness campaigns) for the betterment of the community. Alibar (2003) maintains that one of the predominant constraints of policies is failing to have a clear understanding of the nature of the problem, and the people, and executing ideas that do not meet those underlying structures. To effectively address mental health challenges and create sustainable change that will improve mental health care, curb mental health stigma and develop sustainable mental health interventions, a clear understanding of all the factors involved and how they affect one another is key for this mandate to be successful as well in preventing the reoccurrence of the same problems.

'Perception' is when individuals create, interpret, and make meaning of their experiences (Pickens, 2005). The attitudes that communities develop regarding mental health play an important role towards their awareness, commitment, and prevention of mental illnesses (Ferrin, 2020). Perceptions play an instrumental role in the extent to which individuals maintain their health and those around them. The ideas people carry about an illness or health aspect can motivate or demotivate them to improve, prevent, or manage their health (Ferrin, 2020). Therefore, the help-seeking behaviour of communities is highly dependent on the perceptions they have developed.

For the longest time, there has not been a consensus on a fixed definition of 'mental health', and this has been a barrier to the inclusion of mental health in global health interventions (Manwell et al., 2015). However, from the understanding of the concept, there have been definitions developed and approved by health professionals which are widely used. According to the World Health Organisation (WHO) 2004, 'mental health' involves the condition of one's mental well-being which allows one to cope under various stressful events. It is the ability for one to be aware of their capacities and to be productive in one's respective environments. Risal (2012) outlines that the most common mental illnesses include anxiety, panic disorder, depression and all those that fall under neurotic disorders, such as Post Traumatic Stress Disorder (PTSD) and obsessive-compulsive disorder (OCD).

The terms ‘psychosocial disability’ and ‘mental illness’ will be used interchangeably throughout this thesis because of the diverse social, cultural, and political implications of having a mental illness. ‘Psychosocial disability’ is considered to be any impairment that is caused by a variety of cognitive, mental, and emotional factors, which affect an individual’s ability to achieve their day-to-day goals. These impediments may affect one’s social, psychological, or physical area of one’s life (Ringland et al., 2019). Attributes of psychosocial disability include poor self-esteem, poor self-identity, and poor social engagement (Jose et al., 2016).

Rationale

As per the definition of mental health by WHO (2004), mental health is central to the all-encompassing network of human functioning and well-being. Layous et al. (2014) define ‘well-being’ as relatively high fulfilment with life and frequent experiences of positive affect. Therefore, it is necessary to have a study that seeks to gain insights into how people in LMI communities perceive mental health and to learn how their perceptions affect their efforts towards taking care of their mental health given that mental health is a core aspect of their lives.

The socioeconomic and environmental context of LMI communities is not conducive to good mental health (Pickett & Pearl, 2001). Community-based mental health care exists in only 50% of African countries (Burns, 2011), while globally, only 60% of LMI contexts have the resources necessary to equip health care workers with mental health care (Burns, 2011). Communities and healthcare workers must be cognisant of ways in which mental illness can be managed or prevented according to their unique environmental conditions. This study sought to attend to this matter by focussing on the mental health perceptions of the LMI communities and critically examining the contextual factors that inform those perceptions. This analysis is important in guiding the practical mental health solutions that can be employed and to further develop context-sensitive interventions that will help mitigate the potential harms created by possible misconceptions or negative connotations regarding mental health by people in LMI communities.

Dogra (2017) highlights the worthiness of the consideration of mental health literacy between professionals and non-professional members of society. The professional/clinical

conceptualisation of mental health disorders is the ideal understanding that communities should be exposed to and from which perceptions of mental health must be drawn (Hugo et al., 2003). However, the lack of information and other necessary tools for mental health care support systems in LMI communities have the potential to act as an impediment to this critical understanding. This is the reason why the stigma of mental health prevails in such contexts.

According to Carbonell et al. (2020), mental health is one of the most stigmatised domains of health. This is rooted in the limited mental health education, mental health care, and the covert nature of mental health (for some mental illnesses such as depression). For example, South African communities have attitudes and beliefs about mental illness that are related to ideologies of atypical and shameful actions among people with a mental illness, such as public nudity, violent behaviour, and aggression (Mannapula-Mazabane & Peterson, 2021). However, mental illness can also be experienced in subtle ways, and that does not reduce its threat (Segwick, 1972). For people to be diagnosed with a mental illness they do not always have to show signs of severe psychological disorientation, for illnesses vary according to the symptoms and progression rate (Michaud, 2005). This knowledge and access disparities contribute to the type of attitudes developed towards mental health in LMI communities. As a result, further information is needed to address and attempt to close this knowledge gap, specifically in LMI contexts, including in parts of SA, something this study sought to achieve.

Mental illness has been a fast-increasing health crisis in SA, which calls for concern from different platforms, in academia it calls for more research engagement. For example, according to The South African Depression and Anxiety Group (SADAG) report (2017), for every person who commits suicide an estimated ten people attempt to. More attention should be devoted towards studies that investigate the different dynamics of mental illness. Hence, this study aimed to explore the role perceptions of mental health play. This study aimed to discover information that will contribute towards knowledge and prevention of mental illness, specifically in LMI communities.

Some studies have investigated mental health in LMI contexts and a variety of issues were highlighted. According to Phadi and Ceruti (2011), poverty contributes to poor mental health, the inability to meet basic needs, find a job, or access necessary resources to make life better is a highly contributing stressor to the chronic distress that people in LMI communities face. The World Bank (2017) reported that the poverty rate was at a threshold of R18,69 daily in

terms of purchasing power parity (PPP) within LMI areas of SA. Moreover, depression is attributed as the leading cause of both disability and ill health globally, with more than 300 million people reported to be living with depression, there was more than an 18% increase between the years 2005 and 2015 in SA (SADAG, 2017).

On the other hand, it is argued that individuals in the lower-class/income groups are characterised by subjugation and oppression thus they develop a sense of distrust, fear and paranoid beliefs which may lead to major mental illness (Hiday, 1995). Several studies have declared the elevated levels of victimization experienced by those who are mentally ill, most notably from children and adults who are abused by spouses (Breyer et al., 1997; Hiday, 1995).

Another facet that depreciates the mental health of people living in LMI contexts is the neglect of mental health care. In the year 2014, it was reported that one-third of South Africans are diagnosed with a mental illness and within that only 25% have the means to receive treatment (Pillay, 2019). "A South African study found that only 5,0% of the total 2016/17 budget towards health was dedicated to mental health" (Docrat et al., 2019, p. 706). In a study exploring mental health service users (MHSU) and their caregivers' perceptions, conducted in Cape Town, multiple caregivers from the study felt the obligation to take care of the MHSUs because there was no one else to do it. Furthermore, the caregivers expressed that they face several challenges while trying to take care of those who are mentally ill such as food insecurity and substance abuse that led to poor adherence to treatment.

Mental health literacy is also another notable challenge in LMI contexts. A study that focused on the mental health literacy of the community of Tshwane aimed to determine the understanding of three mental health disorders namely, Generalised Anxiety Disorder (GAD), schizophrenia, and depressive disorder (Madlala et al., 2022). The expected answer for every question was 'mental illnesses'. However, 65,5% of the population failed. These are alarming results which highlight the knowledge gap evident in LMI communities and call for more action towards improving mental health literacy especially in LMI communities.

While all the aforementioned studies highlight important and concerning information regarding mental health in LMI communities, research that explores mental health perceptions is still limited.

Research Aims

This research project aimed to explore and discover perceptions of mental health in LMI communities in the South African context, as well as gain an in-depth understanding of what informs the perceptions of mental health. Furthermore, the aim was to establish information on the role of perceptions of mental health. Finally, the aim was to contribute to the current scope of knowledge on perceptions of mental health and improve the academic research attention given to perceptions of mental health in the South African context.

Research Questions

1. What are the perceptions of mental health in South African LMI communities?
    a. How do individuals in South African LMI communities understand mental health?
    b. What role do perceptions of mental health play in LMI communities?
    c. How can an understanding of mental health perceptions inform community mental health interventions?

Outline of thesis

The rest of the thesis comprises the following chapters: a literature review chapter which provides a comprehensive overview of the relevant research about mental health. It underscores the understanding of mental health, the role of context on mental health, the burden of mental illness in LMI communities, the psychosocial factors and causes of mental illness in LMI communities, perceptions of mental health, the state of mental health in SA, and radical transformation for mental health. Following, is the methodology chapter which outlines the research design and theoretical framework, sample and sampling, instruments, procedure, data analysis, trustworthiness and reflexivity, and the ethical considerations of the study. Followed by the findings chapter which presents the discoveries of the study drawn from the data collected by the researcher. Followed by the discussion chapter which provides a detailed interpretation and critical analysis of the findings which are also compared to previous studies. Thereafter, the discussion chapter explains the significance and implications

of the research findings. At the end of the thesis is the conclusion chapter which summarises the important findings of the study and its implications. It also identifies the limitations of the study and provides key recommendations.

LITERATURE REVIEW CHAPTER

The areas of concern for this study are in relation to the way people think about mental health as a foundation towards their help-seeking behaviour and the long-term condition of their mental health. Furthermore, the understanding of context is important and central to this study, specifically that of mental health perceptions within LMI communities. Therefore, the literature to be reviewed follows this guide and will specifically focus on understanding mental health – defining and referencing mental health, the role of context on mental health, the burden of mental illness in LMI communities, psychosocial stressors and causes of mental illness in LMI communities, perceptions of mental health on a broader context, the state of mental health in SA, and finally the need for a radical transformation of approaches to mental health.

Understanding mental health

Mental health, perhaps unlike other illnesses, is interconnected to other aspects of health and the balance between these aspects ensures the steadiness and prosperity of one's mental health. As a result of its multifaceted nature, mental health can be defined and understood in different ways. Sartorious (2002) provides three dimensions in which mental health can be defined, the first being the absence of disease, which means when an individual is not experiencing an illness or disease. Interestingly, the use of the term 'mental health' emerged in the 1960s as an attempt to reduce stigma against mental illness (Rowling et al., 2002). Second, the state in which an individual can fully execute all their abilities without any handicaps. Finally, the balance between oneself and their physical and social conditions. Sartorious (2002) adds that the satisfaction of basic needs is important for the dependence of mental health, meaning that improved mental health is dependent on the fulfilment of resources that lead to better health such as food, shelter, and social support.

The reality that human beings are inherently social beings and do not live in isolation means that they will be affected by their social surroundings. In light of this, Rowling et al. (2002) define mental health as the ability for the interaction between people and their environment to enhance their well-being, ideal growth, and achievement of both personal and collective goals that are aligned with justice.

The World Health Organisation (WHO) provides a definition that encapsulates similar views. According to WHO (2004), mental health is concerned with the psychological well-being of individuals and how it allows people to manage through manifold stressful circumstances, and the ability to perform well within their environments.

While most definitions of mental health are entrenched in well-being and the effect of surroundings. Galderisi et al. (2017) proposed a definition of mental health that is not socio-culturally bound, but rather one that is more inclusive. According to Galderisi et al. (2017), mental health pertains to the constantly changing internal balance that gives one the capacity to exist in harmony with universal principles of society. In essence, this means when an individual's psychological equilibrium can adapt to the changing phases of life, it can grant them the ability to be aligned with fundamental ways of living, which is important for mental health.

The role of context on mental health

There are multiple dynamics to the stability of mental health. Some are internal (e.g., biological factors), while some are external (e.g., socioeconomic status) which are not personally attached to an individual (Rohmi & Pandin, 2021). The type of environment or community often contributes to susceptibility to mental illness. Research suggests that the characteristics of a neighbourhood may cause variation to mental health (Hill & Maimon, 2013). Factors such as the level of education, social issues such as crime, marginalisation, cultural beliefs, poor mental health education etc. (Havenaar et al., 2008). It is argued that individuals in the lower-class/income groups are characterised by a threat towards victimisation and powerlessness, which may have consequences on their mental health. For example, the prevalence of violence is likely to be high in LMI communities (Hiday, 1995).

According to Hill and Maimon (2013), a neighbourhood is distinguished by its conditions and boundaries. These authors describe conditions as the pre-existing factors one is subjected to under one’s residence in that area, this includes political, economic, and physical factors. Boundaries are described as the characteristics of the neighbourhood that are formed informally by the residents such as perceptions, landmarks etc. (Hill & Maimon, 2013). With research (e.g., Meyer et al., 2019) supporting the association between context and mental health, it is presumable that boundaries/attitudes may be informed by the conditions that

communities are faced with, such as lack of resources, which shows the importance of the consideration of context in mental health research.

Burden of mental illness in low-middle income communities

'Psychosocial disability' refers to people who have experienced strenuous mental illness (NDIS, 2022). The term 'psychosocial disability' is used to emphasise the criticality of mental health and how it is burdensome to those who experience it (Kleintjes et al., 2013). Burden of illness are the various ways in which an illness introduces limitations and predicaments in the life of the affected or infected individual (Sahthiya & Rajakumari, 2018). The phrase 'burden of illness' refers to the cost of illness, which includes the holistic challenges that causes an individual to suffer in one or more aspects of their lives (Sahithya & Rajakumari, 2018). The consequences of mental disorders are different, ranging from personal to social and they are quite considerable (Hugo et al., 2004). Although the social costs of illness are not quantifiable, they are easily observable because of the magnitude of the problems that they create (Kurdyak & Patten, 2022). It is unfortunate that not everyone finds themselves in the best position to manage the burden of illness. For some, it is difficult to cope under the new circumstances they find themselves in when they develop a mental illness because of lack in various areas. It can be a lack of finances, for example several South Africans cannot afford medical aid, therefore they suffer the consequences of not receiving the most readily available treatment for their conditions (Benatar, 2013). It can also be a lack of support, such as not having enough family support during a time of need. Therefore, for people who come from LMI communities the burden of disease/illness is enormous by the social and economic deficiencies i.e., lack of resources, lack of access, poor socioeconomic status etc. (Haveaar et al., 2008). An illness inevitably disrupts the normalcy of an individual's day-to-day life (Christensen et al., 2020). When one is sick, they are compelled to adapt to new lifestyle changes because of the challenges that an illness presents.

When a person is diagnosed with a mental illness it means they are mentally ill, it is a psychological condition and not a trivial disturbance that they can simply eradicate (Leighton & Dogra, 2009). Their cognitive abilities and psychological state become compromised (Leighton & Dogra, 2009; WHO, 1992). Their mental state is affected, leading to difficulties in their functioning as opposed to the absence of the illness. Therefore, there is no way to

discard the psychological costs of a mental illness diagnosis. However, the cognitive and psychological effects of having a mental illness are not the only problems that arise (Christensen et al., 2020). One of the effects of a mental illness diagnosis involves the compromise of well-being. Being mentally ill makes it difficult for individuals to function at their optimum, to deal with life's stressors in an effective way, to maintain relationships, to fully participate in society, and to fully contribute to their designated workplaces, ultimately leading to a lack of fulfilment (Bodeker et al., 2021). The indirect costs of mental disorders can lead to reduced productivity and loss of employment which can potentially lead to suicide (Hugo et al., 2004). Leighton & Dogra (2009) outlines that mental illness deprives individuals of the ability to behave, think, process, and perform well. While some mental disorders are more neurological, others are more affective. However, they all share the same fundamental consequence which is poor well-being.

As a result of the stigmatisation of mental health, when policies and reforms of mental health are developed, people with mental illness or who have experienced such illness are seldom consulted because of the prejudicial beliefs that they lack the competence, capacity, and intellect to make constructive and meaningful contributions (Kleintjes et al., 2013). The failure to understand mental health is immense and leads to systematic gaps in policies and interventions. This ignorance has serious consequences for the outcome of the policies implemented as they often do not satisfy the needs and challenges of individuals with mental illness, eventually becoming null (Castillo et al., 2019). Subsequently, there will be gaps in the challenges faced by patients with mental illness and the desired or anticipated positive change. For example, it has been reported that South Africans with psychosocial disability have not been granted sufficient chances to contribute to the post-apartheid reforms for mental health (Kleintjes et al., 2013). The inclusion and participation of people with psychosocial disability in policy development and decision-making is imperative as it improves awareness of the deeper and unspoken issues that people with psychosocial disability face (Kleintjes et al., 2013). Their input is also a way of eradicating their under-representation and neglect in broader society. It can create a voice for them to be treated fully and catered for accordingly. Their participation also reinforces empowerment so that they do not feel isolated in society.

A mental illness does not only affect the person who has a mental disorder, but it also affects their family or caregiver. This is especially the case when the mentally ill person is not hospitalised or admitted to a psychiatric setting (Swain & Behura, 2016). Expectedly, the family is left with the responsibility to look after the ill person. The most common burden on the family/caregiver is emotional strain. It is difficult for the family to witness a family member suffer from a mental illness (Sahithya & Rajakumari, 2016). For example, when someone is diagnosed with chronic depression, they experience incessant sadness, social withdrawal, and self-neglect (Sahithya & Rajakumari, 2016). Therefore, these are behavioural changes that can be difficult to witness and deal with daily and can put an emotional and mental strain on the caregivers and family members. Some of the mental impacts that the caregiver is likely to encounter are depression and high levels of stress (Singh & Dubey, 2016). Someone who is not trained to deal with someone who suffers from a mental illness might find it difficult to provide the most consistent and adequate support. Caregivers also dedicate a lot of their time to taking care of their loved ones. They commit themselves to being present to ensure the safety of their loved ones. A person with a psychosocial disability is vulnerable and it is of utmost importance that they are not left alone frequently (Ainamani et al., 2020). Therefore, this can be burdensome to a caregiver as this can take away from their own personal lives and can further affect their level of productivity.

Being mentally ill can be financially costly, another burden of mental illness. When one is diagnosed with a mental illness, they might need medication, treatment, therapy, and in some instances hospitalisation (Jaiswal et al., 2020). For many people in LMI communities, this is a need they cannot afford or even access which serves as a barrier to their health and functioning. The socioeconomic status of the people in LMI communities makes it difficult for them to comprehensively take care of their mental illness (Docrat et al., 2019).

Psychosocial factors and causes of mental illness in low-middle income communities

Low-middle income (LMI) communities comprise a variety of psychosocial challenges which lead to issues in mental health. It is important to understand the psychosocial factors that are associated with mental health in LMI communities to build solutions that will sufficiently close

the existing gaps in LMI communities' health care, specifically for mental health (Shibulani & Geyer, 2014).

One of the most predominant issues affecting the LMI population is poverty (Havenaar et al., 2009). The inability to meet basic needs, find a job, or access necessary resources to make life better is a highly contributing stressor to the chronic distress that people in LMI communities face (Phadi & Ceruti, 2011). This is exacerbated by the hopelessness for circumstances to change. Some of the challenges existent in LMI communities have been in existence for years with no efforts put into turnover of the situation. Examples of poverty include food insecurity, informal settlements, lack of sanitation, crime, and limited access to healthcare. These factors play a role in the day-to-day fulfilment of people (Schierenbeck et al., 2013). Living under such circumstances can be demotivating and stressful leading to psychosocial disability. Low-middle-income communities face heightened levels of substance abuse such as alcohol and drugs (Mbandlwa & Dorasmy, 2020). With poverty being the central socioeconomic issue, individuals experience high levels of distress, limited economic opportunities and poor living conditions, crime and the absence of positive role models create difficulty for some people to engage in positive activities (Phadi & Ceruti, 2011). As a result, resorting to drugs and alcohol becomes an easy option. According to Mbandlwa and Dorasamy (2020), the use of recreational drugs increases the potential for one to have mental disorders. This is because of the neurological and chemical effects that recreational drugs cause (Milani & Perrino, 2021). Common mental disorders that drugs cause include depression, schizophrenia, bipolar, anxiety, and psychosis (Baldachinno & Tolomeo, 2014). When these psychological effects are left untreated, they can be dangerous not only to the individual but for the family and community.

The exposure to violence in LMI communities is prevalent (Hiday, 1995). Frequent experiences of violence lead to feelings of distress and anxiety. In communities where violence is frequent, there are increased reports of rape and assaults and witnessing such tragic events can lead to PTSD and anxiety (Gersons & Carlier, 1992). "For example, those living in shacks (41 %) were more likely to feel powerless, compared with those living in formal housing (27%) or traditional dwellings (20%)" (Hirschowitz & Orkin, 1997, p. 178). Therefore, violence is also one of the major contributing factors to poor mental health in LMI communities that needs to be addressed.

Perceptions of mental health

Communities are made up of social beings, which implies that people are born into pre-existing notions, and these are based on conventional perceptions developed as a collective (Pickens, 2005). Perception operates in such a way that the ability to be, think, and feel is dependent on the existence of knowledge (Pickens, 2005) Therefore, when a community of people with similar circumstances are located together it is likely that they develop perceptions of the same kind. Informal education occurs on different levels, from group learning to broader societal learning. Human capital which is obtained from informal learning is the acquired knowledge and capacities from adequate learning and experience (Popescu & Diaconu, 2009).

Informal education comprises advantages and disadvantages. The advantage is that it provides people with rich and subjective nuances of the world that are not readily represented by academic or scientific/professional education (Kapur, 2019). Individual education allows for the enhancement of individual skills and capacities in one's environment, up until one is an adult and able to reason independently (Ferrin, 2020). Furthermore, Johan and Harlan (2014) maintain that at a group level, informal education promotes humanity and understanding among people of different backgrounds, races, ethnicities, and more. However, the disadvantage is that the information acquired is often inaccurate and sometimes invalid, leading to harmful attitudes and behaviour (Eben, 2022). An example of a harmful perception is the stigma surrounding albinism. The lack of information and understanding leads to increased discrimination towards individuals living with albinism. "Throughout Africa, an indeterminate number of individuals with albinism, especially children, have been the victims of brutal attacks and murder in the name of witchcraft, superstition, and wealth" (Cruz-Inigo et al., 2011, p. 79). These attitudes form part of what is called perceptions (good or bad). This is why there are visible differences in the way that people in poor socioeconomic areas and those in well-developed or higher socioeconomic areas experience mental health. For instance, people who had poor psychological well-being were found to live in rural areas, had poor education, and were unemployed (Pillay, 2019).

Mental health perceptions have evolved with time, medical improvement, and access to newly developed data. However, not every community comprehends new theoretical

knowledge of mental illness. Mental health stigma constitutes negative stereotypes and beliefs about people with mental illness (Corrigan, 2004). The stigma around mental illness is informed by various factors. In Africa, mental illness is associated with certain cultural beliefs and traditions (Egbe et al., 2014; Petersen & Lund, 2011). Families of individuals living with a mental illness are vulnerable to stigma by association (Nxumalo & Mchunu, 2017), and are vulnerable to negative emotions like those with mental illness, e.g., low self-esteem, shame, and anger (Shi et al., 2020). Unfortunately, sometimes families can neglect their own because of shame in the community, which adds to the difficulty for patients with mental illnesses to be treated well and deemed socially acceptable (Eben, 2022).

One of the widely proposed solutions to stigma reduction is having community-based interventions. Approaches that are multi-sector and community-based can combat inequalities in society through the promotion of well-being and focusing on the social factors of mental health (Castillo et al., 2019). A 2015 Cochrane review described three assumptions that underlie community interventions. The first is an awareness of the multiple forces that exist at all social-ecological levels (i.e., individual, interpersonal, organisational/institutional, community, and policy) that facilitate or obstruct mental health. The second is investment in participation to provide resources and inform interventions, recognising expertise outside of the healthcare system. The third is the prioritisation of community mental health and social outcomes (Castillo et al., 2019).

Studies exploring perceptions of mental health in LMI communities are limited. However, from those available in which similar concepts are investigated, there is valuable information which highlights the importance of having a study such as the current one to make some contribution to the existing gap in mental health research that is context-based. For example, a study exploring mental health service users (MHSU) and their caregivers' perceptions was conducted in Cape Town. According to the results of the study, multiple themes emerged including the perceptions of the factors that affect the process of caregiving, the reasons that led to the assumption of a caregiving role, and the perceptions of the mediation with regard to the experience of caregiving (Sibeko, 2016). Multiple caregivers from the study felt the obligation to take care of the MHSUs because there was no one else to do it. One of the challenges that was raised was that food insecurity and substance abuse were some of the leading patterns that led to poor adherence to treatment (Sibeko, 2016). From this study, it

is fair to presume that there is a great need for studies that focus on the perceptions of mental health, especially in LMI communities due to the existing challenges that prevail. Furthermore, a participant from the study mentioned that "better mental health knowledge was helpful but could still be further reinforced" (Sibeko, 2016, p. 517).

Another study that focussed on the mental health literacy of the community of Tshwane aimed to determine the understanding of three mental health disorders namely, Generalised Anxiety Disorder (GAD), schizophrenia, and depressive disorder (Madlala et al., 2022). The expected answer for every question was 'mental illnesses'. However, 37,3% of the population chose physical illness for depressive disorder, 20,6% chose physical illness for schizophrenia, and 7,6% did not know the answer. These results are concerning and call for more efforts to be put toward mental health awareness and education, as well as more studies committed to gaining an understanding of the way people in LMI communities comprehend mental health.

The state of mental health in South Africa

In the year 2014, it was reported that one-third of South Africans are diagnosed with a mental illness and within that only 25% have the means to receive treatment (Pillay, 2019). The quality of mental health care and the provision of funds towards mental health plays a crucial role in the state of mental health in a country overtime. "A study in SA found that the expenditure towards public mental health care during 2016/17 was USD615.3 million, which is 5.0% of the total public health budget" (Docrat et al., 2019, p. 706).

South Africa carries a history of trauma and a governmental system that did not commit to maintaining the mental health of all its people (Kale, 1995). The implication of this means that the current government has a burden to reform the system and provide efficient and accessible service. This history also means it leaves the previously colonised generation susceptible to a great knowledge gap, misconceptions, and lack of understanding of what mental illness is (Kale, 1995). Moreover, it also means that they are unlikely to pass down the right information to their successors causing individuals to be unaware of fundamental factors that cause or contribute to mental health problems. This further makes LMI contexts more susceptible to misinformation as there are already mental health care and education disparities in their communities. Marginalised communities will increasingly become uneducated and less informed about mental illness and continue to stigmatise those who are

affected. Post-apartheid SA continues to experience social ills which embed conditions of oppression and violence (Gibson, 2003). South African mental health professionals must begin to establish new strategies for improved mental health (Pillay, 2019). Therefore, the Department of Health becomes the primary tool to close the gap and to improve the systematic mechanisms that focus on setting a better mental health care service for all. The vision for a new mental health service has been articulated in the 'White paper for the transformation of the health system in South Africa', which states: ''A comprehensive and community-based mental health service should be planned and coordinated at the national, provincial, district and community levels, and integrated with other health services'' (Lund, 2004, p. 136).

There have been efforts put into improving the mental health service in SA. The Mental Health Care Act (MHCA) of 2002 was executed and was rated as one of the most well-developed mental health legislations in the world (Burns, 2011). The following principles were stipulated in the legislature: less forceful measures, rehabilitation, and reintegration (Burns, 2011). However, there are still great flaws in the strategies, planning, and execution of these proposed implementations. "Progress in service delivery is challenged by inadequate usage of national-provincial dissemination channels to communicate and promote the [Mental Health Policy Framework] (MHPF) and [Mental Health Care Act] (MHCA), a lack of technical support around policy implementation within provinces, as well as a weak health information system leading to a lack of information about the true burden of [Mental Neurological and Substance use] (MNS) disorders, patterns of mental health service access" (Docrat et al., 2019, p. 708). For example, more efforts are put into treatment solutions than structural plans to minimise the occurrence of mental health problems (Lund et al., 2004).

If it has been established that SA has a national problem of mental illness, then the determinants for overcoming this challenge should be apparent (Pillay, 2019). The increasing rate of diagnoses and increasing adaptation to harmful habits and social perceptions need to be accounted for (Burns, 2011). Issues such as unaffordability, limited access to mental health care services, lack/limited information, and poor context-based interventions continue to reflect the inability of the government to improve the system, making the state of mental health in SA continuously poor (Burns, 2011). The National Department of Health (NDOH) outlined the need for a radical transformation in the service of mental health (Pillay, 2019).

Failure of the state leads to the failure of its people. When people lack information or do not have adequate access to resources, they are easily prone to conforming to notions and perceptions that are unsolicited (Popescu & Diaconu, 2009).

The call for urgency in mental health care is proven by the unavoidable statistics. Depression is attributed as the leading cause of both disability and ill health globally, with more than 300 million people reported to be living with depression, there was more than an 18% increase between the years 2005 and 2015 in SA (SADAG, 2017). Suicide is reported to be a global health predicament which leads to economic and social detriments. In the year 2012, more than 800,000 deaths globally were attributed to suicide. For people between the ages of 15-29 years, suicide is reported to be the leading cause of death (SADAG, 2017).

Radical transformation for mental health

Changing communities' attitudes is a difficult mandate. Perceptions and behaviour are often generational and concrete such that they are deemed as the truth and what is 'right' or justified (Popescu & Diaconu, 2009). Therefore, it is not easy to deconstruct ideologies, perceptions, and attitudes that have existed for a long period (Duurheim et al., 2011). Moreover, it is even more challenging to reinforce positive and informed attitudes towards mental health when there are no psychologists, no mental health programs available, or when these services are not easily accessible (Phadi & Ceruti, 2011). In this case, people lack the motivation to take care of their mental health as these disadvantages serve as barriers.

Mental health workers, researchers, and the government must implement more radical solutions which are going to engage human rights, policy reforms, allocation of resources, and effective campaigning (Gostin et al., 2011). Radical transformation is a way of addressing the source of the problem and ensuring change that promises certainty and permanency (Temper et al., 2017). It is implementing solutions that are contextual and meet the challenges that are presented. Overall, radical transformation is the maximum effort to critically dissect every part of a problem (Temper et al., 2017). Therefore, a radical moral transformation is an attempt to change the negative views adopted by people in communities that lack adequate education, services, and interventions. It is an attempt to revolutionise mental health attitudes in disadvantaged communities and engage the fundamental cause of the negligence of mental health and misguided perceptions (Gostin et al., 2017).

When HIV/AIDS was discovered and spread around the world, many communities did not believe it was a real illness, which if not medically attended could lead to death (Colvin & Robins, 2010). The communal ignorance was significant and proven by rapid infections of HIV/AIDS and loss of lives. HIV and AIDS statistics reported that 68% of the 31.6 million population in Sub-Saharan Africa, with SA included were living with HIV in 2010, (Shibulane & Geyer, 2014; UNAIDS, 2011). An example of an effective campaign that helped to minimise stigma and reshape communities' attitudes was the Khomanani campaign, the term is a phrase in Tsonga that means 'caring together'. The campaign was established specifically for resource-constrained communities with and based on the theory of behavioural change, aimed at eradicating harmful behaviour that perpetuates more stigma against HIV/AIDS (Shibulane & Geyer, 2014; Department of Health, 2006). HIV social mobilisation interventions brought about significant changes in condom use as well as HIV testing (Cornish et al., 2014). This shows how crucial a more radical intervention is in influencing the behaviour of people in resource-constrained communities.

Mental illness unlike any other illness requires extensive efforts towards curbing the barriers that increase its prevalence, specifically, the barriers that are perpetuated by society itself. (WHO, 2011). These include stigma, misconceptions, ignorance, and discrimination (Castillo et al., 2019). Most mental illnesses are affective disorders, e.g., depression, and anxiety which means they are commonly associated with internal attributes such as emotions, feelings, and moods (Manwell et al., 2015). As such it is often difficult for people to distinguish general distress from a mental illness. This is why it is crucial to have radical ways to educate, inform and make people aware of mental illness.

Mental health can be understood from multifaceted psychological underpinnings. It encompasses diverse aspects including emotional, social, and cognitive factors. The role of social, economic, and environmental conditions within communities have also proven to play a significant role in shaping the quality of an individual's mental health, making context an important factor in determining the potential prospectus of an individual's mental health. In SA, a combination of historical, cultural, political, and economic complexities affect the state of mental health, more particularly in LMI communities where socioeconomic disparities prevail. South Africa continues to face a crisis when it comes to mental illness, with statistics of illnesses such as depression on a constant increase (reference). Mental health stigma also

remains a challenge affecting how communities understand and maintain their psychological well-being. Thus, a pressing need for radical intervention strategies that are not only transformative but context-sensitive are required.

This literature review has provided valuable insights into the multifaceted nature of mental health and how it can be examined through various lenses. Across these perspectives, a common thread emerges: the relationship between one's psychological state and their environment is crucial to nurturing well-being. Moreover, this review underscores the importance of context in shaping mental health and mental health perceptions, particularly in LMI communities. In such settings, factors like socioeconomic status, violence, and cultural beliefs can have a significant impact on individuals' mental health and their understanding of mental illness. This review also illuminates the various burdens that mental illness can place on both those affected and their caregivers, from financial strain to emotional exhaustion. Additionally, the psychosocial factors that contribute to mental illness in LMI communities, such as poverty and violence, are explored. Furthermore, the role of cultural beliefs in perpetuating mental health stigma is examined, highlighting how informal education can have negative consequences for individuals living in LMI contexts. Finally, the literature review addresses the state of mental health in SA and advocates for a radical transformation of mental health systems to better serve LMI communities.

Methodology Chapter

Research Design and Theoretical Framework

The qualitative approach was used for the study's inquiry. This is because the study sought to unpack the understanding and experience of people from LMI communities with a focus on their perceptions of mental health. One of the central themes of qualitative research is to emphasise the experiences of people being studied in the most approximate form to their actual reality (Taylor & Trulijo, 2001). Therefore, the use of a qualitative approach was methodically suited for this type of study. Furthermore, the study sought to investigate the role of individuals' perceptions of their mental health. The study did not intend to develop any statistical data from the anticipated findings as in a quantitative study (Basanta, 2020).

The purpose of the study was to explore the in-depth role of perceptions of mental health in LMI communities in SA. Following this, the study was exploratory, as the aim involved gaining an in-depth understanding of the perceptions adopted in LMI communities (Maxwell, 2003). Using an exploratory technique for the study also helped achieve one of the aims of the study which was to contribute towards the current scope of knowledge regarding perceptions of mental health, particularly in LMI communities. In the case where little is known about the topic of the study, the researcher collects the data through exploratory study (Klopper, 2008). Additionally, the study was context-based in nature (Meyrick, 2006) because the area of interest leaned towards LMI communities. Context refers to any useful information that is used to distinguish an entity or environment (Dey, 2001). Therefore, the study is context-based in nature as it uses socioeconomic status (LMI) as a focal point.

The study adopted the constructivism paradigm as a philosophical framework. Constructivism is a worldview embedded in the belief that knowledge is created through human experience and conjectures (Li, 2001). It refutes the idea of an objective reality (Mills et al., 2006). This paradigm enhanced the overall systematic framework of the study as the focus of the study was on the knowledge and understanding that people establish on mental health, hence the term 'perceptions'. Furthermore, constructivism considers the participants to play an active role in the generation of knowledge, it asserts that knowledge is constructed and fluid (Adom, 2016). "Learners are viewed as active constructors of knowledge" (Li, 2001, p. 26). This was

appropriate for the study as it sought to uncover the subjective perceptions of mental health and discover the role these play in the mental health of LMI communities in SA.

A perspective that has contributed to the curricula of social constructivism which the study drew from is the one by Vygotsky, which maintains that learning is shaped by cultural and social interactions which in turn contributes to the construction of knowledge (Scott & Palincsar, 2013; Vygotsky, 1968). The focus point by Vygotsky is language and social interaction, that is, how language is used to symbolise concepts and how social interactions shape the process of knowing (Saleem et al., 2021; Knapp, 2019). Similarly, the study aimed to use this approach as a guide to how the social context (i.e., environmental and socioeconomic deficiencies) for individuals from LMI communities has played a role in their perceptions of mental health.

Assumptions of social constructivism are based on reality, knowledge, and learning (Saleem et al., 2021). These concepts serve as tools in which the study aimed to understand the perceptions of mental health in the LMI context. According to social constructivists, learning is a process through which meaningful social interactions allow people to learn from their experiences. Through this, social learning knowledge is created and passed on among people, then the constructed knowledge shapes the resulting reality that develops under the specific context (Fleury & Garrison, 2014).

Sample and Sampling

The study consisted of seven individuals. This sample size is considered adequate for a qualitative research study (Makanasu, 2020). Every participant was 18 years and above, varying from different areas of Johannesburg, Gauteng and one from Mpumalanga. Since the study aimed to gain an in-depth understanding of perceptions of mental health with regards to the population it represents, the individuals partaking in the study needed to be well informed of the subject, hence the criterion of 18 years and above as these are legally regarded as adults. Individuals under the age of 18 years are considered minors in SA and cannot consent without the presence of a guardian (Strode et al., 2011). The participants were all either currently residing in or originally come from LMI settings/communities in SA. LMI communities are regions where the locals possess relatively low levels of income (Lehohla, 2011). According to Stats SA (2011) relative poverty line is a measure of income levels in

comparison to the the proximate communities of a household. This ensured that the sample is representative of the stipulated context of the study. This also ensured that the views and opinions expressed were genuine to the target group and focus of the study to maintain the accuracy of the data. Finally, the participants were all English-speaking since data was collected in English. An exclusion criterion was that participants should not currently be diagnosed with a mental illness since this may have complicated their perceptions on the topic that was under discussion.

Table 1.1: Demographic information of the study's participants

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Participant 7
Age	20	24	23	23	26	25	21
Gender	Female	Female	Female	Male	Female	Female	Female
Race	Black	Black	Black	Black	Black	Black	Black
Education level	Matric	Honours degree	BA degree	Masters degree	Masters degree	Masters degree	BA degree
Original residence location	Katlehong	Witbank	Katlehong	Daveyton, Etwatwa	Tembisa	Soweto	Katlehong
Geographic income level	Low-middle income	Low-middle income	Low-middle income	Low-middle income	Low-middle income	Low-middle income	Low-middle income

The study employed a non-probability sampling strategy. A non-probability strategy is defined as a style of collecting data in such a way that participants of the study have an unknown probability of being selected (Vehovar et al., 2016). Convenience non-probability sampling was employed. This is a sampling strategy in which participants are included based on availability or proximity, essentially participants should be easily accessible and should meet the set criteria of the desired sample (Etikan et al., 2017). The nature of the study required that participants give in-depth and subjective views on the perceptions of mental health,

therefore, it was essential that the participants were enthusiastic to be part of the study so that they could share their experiences and views without hesitation. Additionally, this form of sampling selection was compatible with the social constructivist paradigm to ensure that people who hold different and unique perceptions were part of the study (reference).

A brief and well-detailed letter of invitation (please see Appendix A) was posted on various personal social media platforms of the researcher (Instagram, Facebook, Twitter (now X)) and posted on the University of the Witwatersrand's campus notice boards. Additionally, I approached students on campus who might be interested. In the letter, the title and purpose of the study, the location (University of the Witwatersrand), the duration of the interviews (30-90 minutes each) and the criteria for potential participants were shared. Most importantly, the contact details of the researcher were available. Individuals who showed interest were encouraged to contact the researcher (myself) via email/Whatsapp. I then responded with an email/Whatsapp text message containing the participant information sheet (please see Appendix B). When the participants confirmed their willingness to be part of the study, I and the participant discussed the time and date to collect the data.

Instruments

The study made use of semi-structured, in-depth, one-on-one (between researcher and participant only) interviews as a tool to collect substantive data from the participants of the study. Semi-structured interviews are an intermediate form of questions that are a combination of both open-ended (free-form) and close-ended questions (Adams, 2015). The interviews were one-on-one because the nature of the study was highly contextual and exploratory, therefore the data collected ought to be carefully derived without any influence or pressure to conform, as may occur in group settings (Ryan et al., 2009). The interviews were in-person with each interview lasting between 45 and 90 minutes. Interviews were arranged at a time and place suitable to each participant and were audio-recorded for transcription purposes.

A semi-structured interview schedule was used (please see Appendix C). This was designed based on a review of the relevant literature on the topic of study. The structure of the questions was open-ended and flexible as the aim was not to achieve objectivity rather it was

to authentically represent the views and perceptions of the people who come from South African LMI communities regarding mental health (Taylor & Trulijo, 2001).

Procedure

I started by ensuring that I obtained ethical clearance (please see Appendix E) from the Human Research Ethics Committee (non-medical) of the University of the Witwatersrand. Next, I distributed a brief letter of invitation (please see Appendix A) inviting potential participants to volunteer in the study. The letter of invitation comprised all the necessary details of the study, that is, the purpose, duration (30-90 minutes) and what was expected from potential participants. The individuals who showed interest in being part of the study were contacted via email or WhatsApp by me, as the researcher. In the email/ Whatsapp text message, the participant information sheet was shared to provide them with information regarding the study and their participation (please see Appendix B). Upon agreement to participate in the study, the consent form (please see Appendix D) was sent, which was an indication that they were voluntarily participating in the study and most importantly that they were giving informed consent. Then, the official date and time were discussed and confirmed for the interview. The interviews were conducted at the University of the Witwatersrand unless it was inconvenient for the participant then another private location was suggested by the participant, such as a private sections in community libraries near their place of residence. Interviews were held in private locations at a time suitable to the participant. The interviews were transcribed verbatim and analysed by myself.

Data Analysis

The study used thematic analysis (TA) which was established by Braun and Clarke and made public in 2006 to analyse the collected data after every conducted interview with the potential participants. Thematic analysis is a process of pointing out, interpreting, and reporting themes from data (Braun & Clarke, 2019). This method of data analysis was effective for a contextual study like this one because it is flexible and allows adequate exploration of data to be performed (Maguire & Dalahunt, 2017). Thematic analysis is useful for research that touches on aspects that go beyond the academic audience (Braun & Clarke, 2014). This was helpful for this study, as it was concerned with contextually relevant issues faced by LMI communities. The researcher went through careful inspection to find patterns and details

before an overall understanding of the data could be developed. According to Braun and Clark (2023), there are six phases for applying TA. Step 1 is when the researcher familiarises themselves with the collected data. I immersed myself in the data by reading, organising and examining the contents, the patterns and nuances. Step 2 involves finding initial apparent codes in the data. I carefully extracted evident yet relevant concepts and phrases that significantly stood out. Step 3 is searching and identifying themes. I searched for different broader ideas that connected the codes, therefore at the end, some codes were categorised under one idea/theme. Step 4 involves assessing the themes. I carefully examined the coherence and relevance of each theme to the basis of this research study and step 5 involves providing definitions for the identified themes. I did this by articulating what each theme means and ensuring that each meaning reflected the essence of what a theme sought to underscore. The final step involves writing the final/main themes of the data. These steps helped achieve the purpose and aims of the study by allowing the process of exploring and developing a clear pattern, which aided the understanding that the researcher aimed to discover (Maguire & Dalahunt, 2017).

Trustworthiness and Reflexivity

Qualitative research is highly contextual and therefore the context of the researcher also plays a role in the transparency of the interpretation of the data (Meyrick, 2006). I was cautious of my relationship with the subject of the study (Dodgson, 2019). I, as the researcher of the study, come from a local township in Johannesburg which also resembles a LMI community. Thus, I have some understanding of the role that my background may play in the collection and analysis of the data. Therefore, I ensured that the collected data was transcribed exactly as presented by the participants for analysis without altering their experiences and knowledge on the subject. Furthermore, I understand that my personal experiences on perceptions of mental health are subjective to my context which may not be the same as the ones I discovered during the study. For example, I have experienced the mental illness of a family member, who was diagnosed with depression because of persistent unemployment and lack of social support. And they were also discriminated against for their depression. However, I understand the uniqueness of this case and its intricacies and as an ethical researcher, I ensured that this is not generalised to the participants of the study who live in LMI communities. I ensured reflexivity, by consistently journaling my thoughts,

perceptions, and values throughout the data collection process to increase self-awareness. I also critically engaged with literature during the process to ensure that I analysed the data objectively. I also consistently consulted with my assigned supervisor which helped me to develop a more objective perspective when engaging with the data.

Guba and Lincoln (1981) provided four criteria by which trustworthiness can be ensured in qualitative research. This criterion which inquirers must consider when conducting their research includes truth value, applicability, consistency, and neutrality. To complement the quantitative terms 'internal validity, external validity, reliability and objectivity' they replaced them with similar terms namely, credibility, transferability, dependability, and confirmability.

Credibility is concerned with confidence in the data and the interpretations as provided by the researcher (Lincoln & Guba, 1982). It involves the extent to which the information provided can be undoubtedly perceived as the truth by the readers and fellow peer reviewers. As a researcher for this qualitative study, I ensured that I translated the responses word for word and directly as provided by the participants of the study. Moreover, each interview was given sufficient time (between 45-90 minutes) so that participants could feel comfortable sharing their experiences and perspectives on mental health. This also ensured that the engagement between the researcher (myself) and the participant was long-lasting so that a strong sense of trust and rapport could be developed. Furthermore, the study employed the use of seven different individuals (data triangulation) although coming from similar contexts, they each carry with them different backgrounds and experiences which can be relatable across a different group of people.

Transferability involves the potential for the research findings of the qualitative study to be applied in other similar contexts with similar characteristics (Lincoln & Guba, 1982). In this case, this would be whether the findings on perceptions of mental health in LMI communities can be applied in other similar LMI settings with the factors emphasised in this study such as environmental and socioeconomic challenges. One of the ways in which I ensured potential transferability is by providing descriptive information as reported by the participants of the study that details the important aspects that the research seeks to discover.

Dependability pertains to the stability of the research study over time, even in cases where unpredictable but logical changes are acknowledged (Lincoln & Guba, 1982). This means dependability in qualitative studies is concerned with maintaining the same/ similar findings amidst unforeseen or uncontrollable events in the process of conducting the research. As in quantitative studies where reliability precedes validity, in qualitative studies, dependability is the precondition for credibility (Lincoln & Guba, 1982) meaning, confidence in the truth value of the study can only be given if the findings are consistent over time. To establish stability for this study, I ensured that I clearly outlined the methodology of the research including data collection and data analysis. Secondly, I consistently maintained reflexivity during the entire course of the research by critically noting down my thoughts and views which should not contaminate the research findings. I also consulted with my supervisor to get an additional objective perspective.

Confirmability ensures that the data collected in research is a true representation of the findings (Lincoln & Guba, 1982). In this instance, that is, the data found in the research reflects the true responses provided by the participants of the study during the one-on-one interviews. To ensure confirmability, I shared the findings with my supervisor who was able to provide critical tracking feedback for the findings and analysis. This involved my supervisor making suggestions, posing important questions, and conducting an analysis for further refinement, upon receiving the feedback I would go through each point and integrate it into the data. And I practised reflexivity as well.

Ethical Considerations

Ethics are a way of conduct which researchers across disciplines should uphold (Gajjar, 2013). First and foremost, I ensured to apply for ethical clearance (please see Appendix E) from the Human Research Ethics Committee (non-medical) of the University of the Witwatersrand. The study commenced once the ethical clearance was granted. Research that is conducted ethically ensures that the process of consent informs potential participants of the full and clear details of the study including the perceived benefits and the risks and it also ensures that a participant is participating voluntarily (Smith, 2003). Therefore, prior to the start of every interview, every participant was given the participant information sheet (please see Appendix B) which comprises necessary details about the study and their expected

contribution to the study. I ensured that participants were asked if they understood everything stipulated on the sheet. Following that, I gave every participant an informed consent form (please see Appendix D) which they were required to read and sign as confirmation that they consensually agreed to be part of the study and that they agreed for the interview to be audio-recorded.

Participants of a study must be told their rights concerning their participation. An ethical researcher outlines those rights before the start of the participation (Schlenkeri, 1997). I informed participants about their rights in the study, including the right to withdraw from the research study at any point up until the end of data collection where they feel the need to without any negative consequences; their right to enquire about any part of the interview process or questions that they may find confusing or difficult to comprehend and may need further clarity; their right to refrain from answering any specific questions during the interview that participants feel are difficult to answer or feel uncomfortable to answer; their right to confidentiality meaning their interview transcripts will only be accessed by myself and the research supervisor; and their right to privacy.

Anonymity is one of the most important rights that participants are entitled to. It is the researcher's responsibility to ensure that participants are informed and further protected through the use of pseudonyms (Smith, 2003). I ensured that every one-on-one interview was held in a private setting with only the participant and myself present; and finally, their right to final anonymity such that their real identity was protected in the instance where I included direct references in the final research report. I gave each participant a pseudonym instead of using their real name and altered any obvious identifying data. Anonymised transcribed interviews are stored on a password-protected document on a password-protected computer. Original interview recordings are stored on a password-computer document only accessible to me.

As a researcher, it is best to inform the participants of the resources that are available to them to address any unexpected challenges (Gajjar, 2013). Following this guideline, towards the end of the interview, I provided a debrief session (please see Appendix C). The questions reflected on how participants felt about the interview, whether they encountered any discomfort, their favourite parts of the interview, their expectations and parts of the interview that they did not anticipate. The debrief also included an opportunity for the

participants to share any additional thoughts or opinions about mental health that they might have not gotten the chance to mention during the interview.

Although the intention was not to elicit any emotionally triggering responses in the participants. In the instance where this occurred, I ensured that potential participants were informed about the free counselling services available at the Counselling and Careers Development Unit (CCDU) at the University of the Witwatersrand when participants felt that the study was in any way emotionally/psychologically triggering. These details were on the participant information sheet (please see Appendix B). Participants were advised to consult with a professional from CCDU to ensure that there is no harm to the mental health of the individuals.

Findings Chapter

Interview Findings

During the one-on-one interviews conducted with the participants of the study, several factors and crucial information about mental health in LMI communities were revealed. These included the basic knowledge and understanding that individuals from LMI communities possess about mental health, the reported significance of mental health for them, the perceived causes of their mental health problems, and how they manage them. Importantly, the interviews uncovered the prevailing perceptions, beliefs, and stigmas about mental health within some of the LMI communities in Gauteng and one in Mpumalanga.

Diagram 1.1: Themes and sub-themes derived from the interview results through thematic analysis.

Themes	*Sub-themes*
1. Understanding of mental health in LMI contexts.	1.1 Mental health perspectives in LMI communities 1.2 Factors that informed mental health understanding 1.3 Prevalent mental illnesses experienced in LMI contexts *1.4* Management of mental health in LMI contexts
2. Causes of mental illness in LMI contexts.	2.1 Unemployment and financial stress *2.2* Social context
3. Mental health stigma in LMI contexts.	3.1 Trivialising mental illness *3.2 "Mental health is abnormal"*

4. Mental health support and service in LMI contexts.	

1. Understanding of mental health in LMI contexts

1.1 Mental health as understood by people in LMI communities

Two outstanding perceptions of mental health were expressed by the participants when asked to describe their understanding of mental health, namely the ability to cope and consciousness of one's mental state.

1.1.1 Ability to cope

As per the study participants' remarks, the ability to face challenges is a positive indication of sound mental health. Coping with unfavourable events is considered to be paramount to one's mental well-being. The way one deals with challenges reflects one's mental state. Mental health is defined as any demonstration of strength and resilience in tough situations by the participants. For LMI communities, there seems to be an implicit relationship between mental health and distress. Mental health is highly valued in difficult times and is deemed a protective measure to anticipate problems. Challenges are seen as a test of perseverance, highlighting the importance of the relationship between context and mental health, particularly in LMI communities where socioeconomic issues such as unemployment can significantly impact the mental health of people, particularly the youth. The findings suggest that when people experience minimal or no distress, their mental health is likely to be in good condition. Some of the comments from the interviewees included:

Participant 2:

"…mental health for me is the ability to ***withstand those stressful situations****[1]…"*

Participant 5:

*"Yeah, it's a state of mind where … like **you can handle** a lot of things that are happening in your surrounding…"*

1.1.2 Consciousness

Mental health is also understood by the participants as the awareness of one's state of well-being at a given time and knowing how to distinguish between one's feelings. Furthermore, it is engaging with those feelings and recognising one's thoughts, such that positive and constructive decisions are made. Therefore, according to the interview findings, the type of decisions that one makes following the awareness of one's feelings is good for mental health. The decisions made expose the condition that one's mental health is in. The ability to make 'good' decisions reflects good mental health. Comments from the interviews included:

Participant 3:

*"Uhm mental health I won't say I understand it clearly but what I do know is the ability to be **conscious** in your mind and make positive decisions and understanding that uhm what you are thinking might affect your emotions and your physical health, so that's what I understand by mental health."*

Participant 1:

*"I think it's just that state of being of just I'm **understanding** that I'm either sad or I'm either angry or happy or in the state of mind"*

During the study, participants were asked to mention mental illnesses that they or people around them have experienced. The findings showed that depression was mentioned by six participants, anxiety and PTSD were each mentioned by three participants, bipolar disorder by two participants, and stress and body dysmorphia were mentioned by one participant.

1.2. Factors that informed mental health understanding

The interview findings also gave insight into the factors that are internal and external to the community which informed the abovementioned understanding of mental health that people from LMI communities have developed.

1.2.1 Education

A variety of factors were mentioned, the first one is education. It appears that education, especially tertiary education, plays a significant role in laying a foundation and in enhancing the understanding that individuals have about mental health, such that without it their understanding would be limited or less nuanced. School subjects such as Life Orientation (L.O) have played a role in providing knowledge, awareness, and information on mental health. Furthermore, the participants' tertiary education, including courses such as psychology, plays a significant role in providing well-founded information as well as eradicating the perpetuation of stigma and misconceptions around mental health:

Participant 5:

*"Honestly, it's **my education,** I only learnt about mental health when I got into university so before that it wasn't even like a concept that I know of."*

Participant 6:

*"Uh, I think my **studies** informed my understanding of well-being and mental health as a whole because without that then I don't think I would have much knowledge of what is mental health, what comes with mental health, what causes mental health."*

Participant 7:

*"I'd say **from school** yeah you understand that it's important to take care of your mental health"*

Participant 1:

*"…**school** has also like taught us about what mental health is: in our LO textbooks..."*

1.2.2 Personal experiences

Personal experiences can play an important role in understanding mental health. When people face events that impact their well-being, they get a chance to explore mental illnesses in depth and gain a holistic understanding of mental health. This understanding also helps them overcome their mental health problems.

Moreover, the experiences of people around them contribute to greater exposure, knowledge, and sometimes discovery of mental health. This highlights the importance of community projects that encourage conversations about mental health to make it relatable. Valuable insights can be gained from the experiences of others such as family, close friends, and neighbours. During the interviews, participants shared similar sentiments:

Participant 4:

*"…that's what informed me, just basically the **surrounding** of people, the things that happen and how that affects their mental health."*

Participant 1:

*"I think what informed my understanding is just my own **personal experiences.**"*

1.2.3 Media

The media plays a crucial role in educating people from LMI communities about mental health through books, television shows, and other forms of media exposure. The results of the interviews revealed that it is equally important for people to have access to credible sources of information about mental health:

Participant 3:

*"When it comes to mental health, probably **tv shows** I would see mostly on TV 'oh I have depression, I'm anxious' but not completely understanding what that entail if someone says I'm depressed or I'm anxious yah essentially it's a shallow understanding of mental health."*

Participant 2:

*"I'd say recently it's been the **exposure,** everyone is talking about mental health and uhm wellness uhm being self-aware so currently it's the conversations, the language of today that you can't, you're healthy by neglecting certain aspects of yourself, all of your aspects should be taken care of and your mind and your mental wellness is one of those aspects…"*

Unfortunately, not everyone has the privilege to access such media sources due to their socioeconomic status. Therefore, it is imperative that efforts are made to ensure equity in access to health education and the distribution of information across communities.

1.3 Prevalent mental illnesses experienced in LMI contexts.

According to the participants, depression is the most prevalent mental illness experienced by individuals in LMI contexts.

Participant 4:

*"…also **depression** affect a lot of us because when we go through a lot of stress and we ultimately do not achieve the desired outcome that could lead to depression. And we've seen with the high stats of people who commit suicide."*

Participant 1:

*"…just to kind of delve deep there was just a point in my life where life was not going the way that was supposed to go, to be going, or the thing that I envisioned for my life were not going according to plan and I just stood in a season of **depression** for like the whole year just drowning in my sorrows and just thinking that my life is not the way it's supposed to be."*

Participant 3:

*"Uhm I'd say **depression** and the feeling of being hopelessness…one of my older sisters committed suicide and it became very stressful for me because I was like 'what could I have done?'"*

1.4. Management of mental health in LMI contexts.

According to the participants in this study, religion proves to play a significant role in managing their, and those around them, mental health problems. The principles and values of religion help in stimulating hope and optimism. The practice of prayer and attending church seem to contribute immensely to creating a positive mindset and overall outlook on life:

Participant 2:

*"As a **Christian** right and I say that because that is my, my safe space, **church is my safe space** so I didn't stop going to church I didn't stop praying, I didn't stop doing uhm everything that I was doing before, reading the word and to some extent I do feel that because I had that, it did take me out of my perspective about life and why I still needed to live so having church and the church community I would say uhm helped me change my perspectives and start feeling uhm like I have purpose and start seeing why I need to be alive."*

Participant 1:

*"…equipping myself with **prayer,** 'cause I think I as well was equipping myself with prayer, 'cause I think having a belief system uhm you know kind of helps you to think of your problems just not as shallow, but think of them as bigger, you know religious problems that you can just go to your saviour and pray about…"*

2. Causes of mental illness in LMI contexts

According to the findings of the study, there is an evident interplay between socio-economic factors and mental health in LMI communities such that mental health becomes highly dependent on the ability of individuals to overcome their respective socio-economic challenges. Based on the participants of this study, unemployment, financial strain, and the social context were mentioned as the causes of mental health problems.

2.1 Unemployment and financial stress

Participants mentioned that the economic climate in their communities affects the youth as they end up struggling to contribute towards supporting their families and themselves leading to intense distress and eventually mental illnesses such as depression:

Participant 2:

*"…I'd say most of the time especially in the township that I come from people that go through uhm the most stress or the stress that they will be comfortable enough to tell you about is **financially related issues** and that will make them uhm very stressed out to a point where they feel helpless and because they have a responsibility maybe to their family…"*

Participant 4:

*"I'd say uhm basically the sense of hopelessness of **not being able to get a job** not doing anything and just waking into this reality every day that you might begin to feel useless and feel like you're basically a waste of resources of space …"*

Participant 1:

*"I think **poverty** as well uhm it's, it's a very poverty-stricken community just to say the least"*

2.2 Social context

Participants also mentioned the social context that people are subjected to, such as family problems, school, and bullying, as other causes of mental illness. The conditions found in family, school, and the community in general play a role in an individual's mental health:

Participant 3:

*"…I'd say **external influences**, might be from family, school, bullying there's a lot of factors that go into someone going into a spiral of mental illness…"*

Participant 4:

*"…it could come from social, from the **social aspect** so this could be from within your family, the people, the people outside, so it comes from that…"*

Participant 5:

*"…I think it's your **environment** that plays like a heavy extreme big part of it…"*

Participant 6:

*"…I think the environment which one is in or yah the **social context** in which one is in can impact on one's mental health…"*

Participant 7:

*" I'd say its **life situations** you know sometimes I'd say death when you lose someone…and also having certain dreams and when things don't turn out the way you would've loved for them to happen, that also causes one's mental health not be okay…"*

The study also revealed other negative aspects of LMI communities that are detrimental, such as poor social development, poor health services, and poor infrastructure. Participants also expressed the implications of these issues, which reportedly lead to cyclical social challenges that can be difficult to overcome and unfortunately contribute to the prevalence of mental health issues such as crime, depression, suicide, substance abuse, educational setbacks, and reduced quality of life. The table below is a summary of the negative aspects and their implications expressed by the participants of the study.

Table 1.2: Negative aspects of LMI communities and their implications

Negative aspects	***Implications***
Youth unemployment	crime, depression, suicide
Lack of social development	substance abuse, unruliness, crime
Poor health services	reduced quality of life, educationalsetbacks, negligence of health (e.g., mental health)
Poor infrastructure	livelihood challenges

Furthermore, participants shared:

Participant 1:

"I think young people are sitting in spaces where they are not actually happy…the fact that I ***can't go to varsity****, for the fact that I* ***can't find a job*** *therefore* ***I think that is the reason that why young people in my community are depressed and like have anxiety or are committing suicide etcetera"***

Participant 5:

*"Because especially **the parks** part of it I think it also influences or impacts the safety of it because it's overgrown and **that's where you'd find a lot of like the nyaope boys and all of these dangerous people hanging out**"*

Participant 6:

*"I think **infrastructure** need improvement because uhm when infrastructure is improved it comes with the improvement of life so **for example if the robots are not working it makes it hard for people coming from work to get home early**"*

*"Yeah **it creates challenges** so that's why I'm saying that infrastructure **better infrastructure would improve lives** even with gym I think uh gym has a lot of effects on your health, physical, mental health so with that being in place it just improves your quality of life.*

3. Mental health stigma in LMI contexts

The stigma that is developed for mental health in the LMI context has a remarkable impact on various areas of the individual's behaviour. The study showed that this stigma is normalised in disadvantaged communities and transferred from generation to generation.

3.1 Trivialising mental health

Participants mentioned that people from the LMI context tend to underestimate and minimise the seriousness of mental illness through their attitudes and treatment towards those experiencing a mental health problem. It also appears that there is a generational misalignment between the young and old when it comes to understanding mental illness, the older generation appears to be misinformed and carry stigmatic perceptions about mental illness. For example:

Participant 3:

*"Some people will just think **you're whining and complaining** 'cause you have it easy, 'like why are you complaining? We've had it worse and we're fine,' 'cause it's that situation…"*

Participant 1:

*"it's **seeking attention** as well uhm it's just you being rebellious right 'cause they say 'we never did that 'we just suck it in' like if we mad it's fine, if I'm angry I'm just gonna keep it in and keep moving forward. And also that like **young people want to always be comforted,** young people always want things to be soft for them that's why they always complain about stuff. I think those are the type of ideologies that we have here."*

Participant 4:

*"…okay this is a very ignorant one, but I do think that in our communities we often [have] the belief that when someone goes through a certain thing it's because **they brought it upon themselves**… not actually uhm realising that there are certain things that were actually affecting you to actually behave in that way and to actually commit such an action that you did…"*

3.2 *"Mental illness is abnormal"*

According to participants, mental illness in their LMI contexts is often perceived as an evil sickness or an abnormality, caused by bad or dark spirits. It is not necessarily perceived as a diagnosable illness. Comments included in this regard:

Participant 1:

*"Uhm one, that it's very uhm **devil-like, it's a sin**…"*

Participant 5:

*"It's that if you show a form of psychosis **you're a witch**, that is the dominant like understanding"*

Participant 2:

"So it's a township right, so in the township there's a language and now that I'm here and I understand what mental health is, once you present certain characteristics right they start calling you names and it's because they don't understand. One of them would be 'sowuyahlanya' [lunatic] and to some extent yes because you're not in your normal self, right, but they shame you for that instead of providing you a direction…"

4. Mental health support and service in LMI contexts

According to the participants of this study, the South African government is not adequately providing and maintaining mental health services for those in LMI contexts. Communities in these areas lack access to mental health institutions, psychologists, and programs that cater to mental health. Reportedly, the only assistance they receive is the availability of a mental health professional, social worker, or psychologist once a week at their local public health clinics. This creates a challenge because there are many patients in need of help and not enough professionals to attend to their needs. Furthermore, this lack of adequate mental health services exacerbates the negligence of mental health by community members, leading them to believe it is not important. Comments from interviews support this issue, showing an experience of a pattern of inadequate mental health resources in LMI contexts:

Participant 1:

"…there's a clinic right just here at Goba, Goba Clinic, it provides young people with social workers, and I think a therapist comes once or twice a week that can kind of interact with people who have mental health issues but that's like the only organisation that I can think of. There is no like tangible organisation that I can think of."

Participant 2:

"…the local clinic provides uh on Tuesdays therapy and group therapy sessions for the community and I do know that uhm one of the government hospitals actually in our area does that as well just that people are not utilising those resources."

Participant 3:

"Unfortunately, we do not have institutions, but what they do is that within our clinics they do have professionals who can assist with that which is also not enough because already clinics are short staffed so if you gonna come there and say you need therapy they could tell you that maybe the doctor is helping other patients or the doctor is not available so that is not enough. We do need institutions that deal with that specifically…"

Participant 7:

"I'm not sure if I know of any…I wouldn't say they provide anything…but I also know of LoveLife…[however] for instance, the last time I heard of Lovelife was during my high school days"

In conclusion, participants from LMI communities seem to have a basic understanding of mental health which they yielded from their personal experiences, through media and education. However, the living conditions found in these contexts create an illusion that it is normal to experience distress which should not be distinguished as serious mental illness. In addition to this, the poor mental health care within LMI communities do not stimulate or promote mental health care, hence individuals hardly know when they are depressed or not. Together these issues perpetuate stigma around mental health. Culture and tradition also play a negative and instrumental role in solidifying mental health stigma. With the generational gap among LMI communities, misconceptions and stigma are easily passed down across generations. Collectively, the interviews shed light on the significant impact that socioeconomic issues have on the mental health of people living in LMI contexts, citing them as the founding reasons for prevalent mental illnesses and other detrimental social issues.

[1] Bold in all quotations is the author's emphasis.

DISCUSSION CHAPTER

This study aimed to explore and discover the various perceptions of mental health in LMI communities in the South African context and understand the factors that inform those perceptions. Additionally, the study aimed to establish information on the role of perceptions of mental health. Finally, the study aimed to contribute to the current scope of knowledge on perceptions of mental health and improve the academic research attention given to perceptions of mental health in the South African context.

The study's main research question is: What are the perceptions of mental health in South African LMI communities? This is followed by three secondary research questions: How do individuals in South African LMI communities understand mental health? What role do perceptions of mental health play in LMI communities? How can an understanding of mental health perceptions inform community mental health interventions?

Through thematic analysis, this study has uncovered four fundamental themes that effectively address the research questions and accomplish the study's objectives. These themes comprise, (theme 1) the understanding of mental health in LMI communities, (theme 2) the causes of mental illness in LMI contexts, (theme 3) the mental health stigma in LMI context, and (theme 4) the mental health support and service issues in LMI communities as reported and suggested by the participants of the study.

Understanding of mental health in LMI communities

The first theme, 'Understanding of mental health in LMI communities', consisted of the diverse and common perspectives held by individuals in the study from LMI communities. This theme is crucial in answering the main research question, as it delved into the participants' fundamental understandings of the concept of mental health, the factors that they believe informed their mental health understanding, the prevalent mental illnesses experienced in LMI contexts, according to them, and the participants' management of their mental health problems. Together, these sub-themes directly reflected their holistic perception of mental health, which is the central focus of the study.

As per the data analysis, mental health is perceived as the ability to cope with unpleasant situations, and according to the participants, the unpleasant situations referred to, include unemployment, access to education, and poverty. Therefore, the capacity for one to learn how to cope, adapt, and overcome these adverse circumstances is their understanding of mental health. Additionally, according to the interview findings, mental health is also understood as the awareness of one's mental state.

Similarly, according to the World Health Organisation (WHO) 2004, mental health involves the condition of one's mental well-being which allows one to cope with various stressful events. It is the ability for one to be aware of one's capacities and to be productive in one's respective environments. The DSM-5 maintains that mental disorders are typically linked to distress experienced in essential aspects of life such as within occupational or social environments (DSM-5, 2013; Thyer, 2015). Given that the participants' descriptions of mental health complement the definition provided by the WHO and include the role of distress caused by contextual factors under varying environments (similar to the DSM-5), it shows that participants do have a basic comprehension of mental health. This may suggest that although there is a gap in clinical knowledge about mental health in LMI communities (Corrigan, 2004) at the least, some people in LMI communities know that mental health is concerned with their psychological state and mental well-being. However, this would not be enough to conclude that they are adequately informed about other key aspects of mental health, such as other mental illnesses, the importance of early intervention and various treatment options.

The participants' description of mental health also adds a significant contribution to showing the magnitude to which socioeconomic status affects those who live in LMI communities. The saturation of socioeconomic issues in their responses may suggest that there is a potential interplay between mental health and socioeconomic status. Studies suggest that the attributes found in an environment may cause variations in mental health (Hill & Maimon, 2013). Although this may not be unique to LMI communities only, the findings of the study suggest that this may be the dominating factor for LMI contexts. Literature also supports this potential relationship, as poverty proves to be the leading factor affecting LMI communities and a leading cause of their mental health problems i.e., chronic stress (Phadi & Ceruti, 2011). Financial stress such as unemployment was mentioned by the participants of the study as one of the fundamental causes of mental health problems in LMI contexts. The social causation

theory postulates that the burden and distress resulting from socioeconomic status increases mental health vulnerability (Srijan, 2012). Fulfilment with life is another way in which socioeconomic issues affect those living under disadvantaged circumstances (Schierenbeck et al., 2013). Although not enough studies go beyond the surface level on how socioeconomic issues affect individuals' overall happiness and psychological well-being this study highlights how much socioeconomic issues can overlap across many areas of individuals' lives. The participants' happiness seems to be deeply connected and drawn to how they stand socioeconomically, hence many of the responses incorporated financial or social support needs as a reason for most of their and those around them stress and mental health. In conjunction with literature (e.g., Docrat et al., 2019), this study continues to highlight the significant role that socioeconomic disparities play among communities with low levels of income toward their psychological well-being.

The findings of the study also reveal the value that is placed on resilience for socioeconomic burden within LMI contexts. Resilience emerges as the pillar to the diverse challenges present in LMI contexts (Alameldeen & Cakan, 2021). This study also alludes to how resilience fosters resourcefulness in a marginalised context. Learning how to adapt to financial instability and poverty is highly commended by the participants, hence they describe mental health as the exercise of perseverance amidst adversity. Vulnerable communities often develop high resilience as they continuously learn how to prepare for Disaster Risk Reduction (DRR) (Alameldeen & Cakan, 2021). These findings play a significant role in enhancing the intricacies and dynamics of mental health in LMI contexts, such as how mental health and individual characters can be shaped by the development in their respective communities. Issues such as crime, according to the participants, were described as outcomes or consequences of unemployment or failure to develop social development facilities such as libraries, parks, centres etc. According to the data analysis, the quality of community services affects not only individuals' socioeconomic standards but their behaviour as well, and the choices they end up making such as resorting to substance abuse or crime because of no access to either higher education or jobs. These findings may also serve as a foundation for how interventions for mental health in LMI context should be tailored. According to Sun (2023), governments should ensure the provision of social assistance for those who live under poor conditions and invest more in public mental health services. In support of this stance, the findings of this study also

indicate the need for community interventions, such as mental health outreach programs, sufficient mental health specialists within hospitals and clinics and in-school campaigns to improve mental health education. These will help engage the existing disparities in LMI communities while improving communities' mental health.

Another sub-theme that was found under theme 1 was the factors that inform the mental health perspectives in LMI communities, which details the specific issues that contributed to how participants of the study came to understand mental health. Exploring the factors that inform mental health perceptions is important in answering the research questions, particularly the one question concerned with how people in LMI communities understand mental health. Participants mentioned that education, personal experiences, and media played a major role in informing and advancing their knowledge of mental health. While all of these factors contributed to improving the participants' knowledge, education particularly proved to be the most effective and impactful factor based on the data analysis. The participants expressed how media, and personal experiences, only provided them with limited information and did not provide deeper insight into mental health. However, with education, participants mentioned how their studies were a highly informative platform to learn more about mental illness such as what it is, how it affects people, and the causes. Furthermore, they mentioned that before their studies they were illiterate regarding the concept of mental health and that university was the beginning of learning about mental health.

These findings play a significant role in indicating how impactful formal education is, especially in communities where mental health is not sufficiently promoted. While there is insufficient literature on the integration of mental health education into formal school curriculum, this study unveils the compelling need for this transformation, to ignite the awareness of mental health from an early age. The WHO also recommends that schools must function as a support base for mental health and may focus on promotion, prevention, management and destigmatisation (Cavioni et al., 2020; WHO, 2000). The setting and structure of schools allow for effective educational interventions as learners spend much of their time on the school premises. Moreover, the way content is delivered and taught in schools is also a key factor in enhancing comprehension for mental health (Humphrey, 2018).

Mental health as a topic should not only be taught informally through campaigns, outreaches, and media but it should also be adequately included in the curriculum of education.

Management of mental health problems in LMI contexts

Mental health is an aspect of health that needs to be confronted in almost every phase of life (Sun, 2023). According to Muhammed (2013), attitude is the choice one makes to interpret a situation, which can be positive or negative. For example, people who have a positive mindset choose to view bad events as isolated, out of their control, and temporary (Muhammed, 2013). Pais-Ribeiro et al. (2007) found that epileptic patients who were optimists had an improved quality of life because of their positive attitudes towards their illness. From Wrosch and Scheier's (2003) study, quality of life appears to be affected by two factors, namely, optimism and adaptation of purpose. Hence, developing a positive mindset is crucial in approaching adversity (Coversano et al., 2010).

In line with this position above, the findings from the current study suggest the important role that religion plays in instilling individuals with faith and optimism as well as in developing perspectives that give them courage. Despite the existing literature not delving deep into religion and how it nurtures faith, these findings add a significant understanding of the positive interaction between religion and mental health, demonstrating that religion gives individuals an opportunity to develop a perspective that helps them view their challenges from a position of strength that they can overcome them. Hence, Fusar-Poli (2020) posits that a multitude of factors contribute to the state of one's mental health, including their culture. Participants expressed how their faith which is drawn from their religions, helped them survive the most turbulent times of their lives, and that is how they managed their mental health problems. While the root problem for most of the mental health problems would not be eliminated by religion, it does grant them strength by giving them hope amid their problems. Therefore, religion can be perceived as a crucial resource for communities whose mental health is constantly negatively affected by their uncomfortable circumstances.

Causes of mental illness and the prevalent mental illness in LMI contexts

The World Bank (2017) reported that the poverty rate was at a threshold of R18,69 daily in terms of purchasing power parity (PPP) within LMI areas of SA. Most families in these contexts suffer from unemployment, poor education, lack of social support, etc. (Gumede, 2021).

Similarly, based on the current study's findings, mental illnesses, especially depression, are reportedly understood to be caused by unemployment and financial stress. The study found that, according to this group of participants, depression is the most prevalent mental illness experienced in their LMI communities. This is an important finding as it unfolds the interconnectedness between depression and unemployment, particularly in LMI contexts. Unemployment is reported to be associated with decreased life satisfaction, poor psychosocial well-being, and increased susceptibility to affective disorders (Zuelke et al., 2018)

A variety of other aspects also shape and affect an individual's behaviour and mental health. Social aspects are one of the attributes in an environment that can affect one's mental health (Meyer et al., 2019). Such as the type of conditions present in a household/family. Issues such as unemployment create tension within families and affect their relationships. Subsequently, such family problems lead to poor mental health, leading to illnesses such as depression (Srijan, 2012). Participants from the study shared how unemployment leads to intense feelings of hopelessness. Furthermore, they shared how being unemployed can make someone feel helpless as they have the responsibility to take care of their families but are unable to because of financial lack, leading to depression for some. Importantly, these findings reveal how the root problem in LMI communities may be socioeconomic gaps and all the other challenges are by-products of this socioeconomic status.

Mental health stigma in LMI contexts

Participants shared the common misconceptions of mental health within their communities such as strong beliefs that dismiss mental illness and deem it as insignificant. They also elaborated on the various ways in which their mental health has been affected by those misconceptions and how they imposed those beliefs onto themselves. This theme plays a major role in adding key information on the ideologies that need to be addressed and unlearned within LMI contexts to improve community members' help-seeking behaviour. Most importantly, this theme also answers the main research question in unfolding not only the perceptions of mental health but also misconceptions that form part of the stigma that is attached to mental health in LMI communities.

From the participants' reports, one of the ways in which mental health is stigmatised is through trivialisation. According to the findings, mental illness is made to seem unimportant and a non-health priority. Examples from the data include, how mental health is viewed as an attention-seeking tactic or seen as whining, or that people brought the suffering onto themselves. These types of attitudes and mindsets reveal the amount of work that needs to be done in educating communities about mental health (Ford, 2020). It appears mental illness is treated as typical distress that does not call for urgency. People can view mental illness lightly because they have become used to the challenges they are exposed to (Al-Rawashdah et al., 2021) hence mental illness would not call for urgency. Taking from the findings of the study, stagnant challenges such as unemployment, poor service delivery, crime and poverty can overwhelm and overshadow individuals' outlook on life such that they can no longer differentiate between mental illness that calls for professional psychological care and general/ everyday worry. Consequently, it becomes customary for them to neglect their mental health because their circumstances are unlikely to change.

The role of tradition and culture across communities is one of the key factors that should be taken into consideration when studying perceptions of mental health (Ogundare, 2019). From the current study, it is important to note that every participant was black and African, thus their responses should be analysed holistically, including from a cultural background. Therefore issues such as gender roles, the role of family, and traditional practices can shape how people experience and understand mental health. Their perceptions can be drawn from the cultural and traditional norms that are incorporated into their self concept. Another perception expressed by participants of the study was that mental illness is often associated with evil, some of the examples include being perceived as a witch should one show any sign of mental illness. Another example from the participants is labelling mental illness as a sin as it is associated with the devil or that someone is a lunatic. There may be underlying traditional beliefs that shape and further influence the stigma they have developed. Such a realisation can make the task of dismantling stigma difficult, as mental health interventions are more inclined to Western approaches and contrary to African beliefs (Vukic et al., 2011). African approaches are often rooted in spirituality, rituals and African medicine contrary to this, Western interventions often involve biomedical forms of treatment such as, diagnoses, therapy, and medication (Vukic et al., 2011). This clash might also be a factor that makes the

effort of curbing mental health stigma difficult as these two forms of intervention continue to be isolated and tailored for different groups of people. However, this realisation will also ensure that these perceptions are addressed with much awareness regarding the nuances involved. Understanding black communities, their values, beliefs, and cultures is useful in designing interventions that will resonate with their approaches. For example, most African communities believe in consulting reputable elders in the community when there is a concerning issues affecting them (Okpalaenwe, 2017). Therefore, educating those trusted elders about mental illness would be one of the ways to integrate African approaches into mental health interventions. In this way, stigma will progressively be dismantled.

Mental health support and service in LMI contexts.

Theme 4 focussed on the mental health service issues faced by LMI communities. This theme is important for providing insights into the gaps that need redress and how they can inform possible community interventions that the study aimed to explore. The participants of the study shared important information about the inadequate effort put into the mental health services of LMI communities. “A study in SA found that the expenditure towards public mental health care during 2016/17 was USD615.3 million, which is 5.0% of the total public health budget” (Docrat et al., 2019, p. 706). Given the prevalence of mental health illness in SA, investing only 5,0% is a clear indication of how undervalued mental health is in budget planning by the government. To effectively transform the poor state of mental health services in most LMI areas, there needs to be an integration of the different bodies and industries that are responsible for contributing to the improvement of mental health care. These include the government, researchers, policymakers, health workers, and the communities (Meyer et al., 2019)

According to the findings of the study, there are several challenges faced by residents of LMI communities. Firstly, it was reported that there are not enough psychologists/social workers in the various public hospitals and clinics, participants mentioned that they can only access a social worker once a week, which creates an influx of patients in hospitals making it difficult to cater for every patient. Secondly, it was reported that there are no other psychiatric institutions available. Finally, participants mentioned that there have been little to no community outreaches or campaigns that promote mental health.

In 2014, 33% of South Africans were diagnosed with a mental illness, but only 25% had access to treatment (Pillay, 2019). On the basis of these inadequacies, in a scenario where all individuals seek mental health care, not all of them would be accommodated. Service delivery is confronted by challenges in the dissemination of resources and communication channels from national-provincial levels (Docrat et al., 2019). Mental health in SA continues to be poor because of limited/lack of information and interventions that are engaging at the community level (Burns, 2011). The 'White Paper for the Transformation of the Health System in South Africa' outlines the need for a comprehensive and community-based mental health service that should be planned, coordinated, and integrated with other health services at the national, provincial, district, and community levels (Lund, 2004).

Given this information, it is crucial for all the relevant bodies to prioritise infrastructure development, to ensure there are enough centres that can cater to mental health. Infrastructure improves quality service, awareness, and help-seeking behaviour (Radhika, 2020). The resource allocation also needs to prioritise mental health such as funding. Most importantly, when programs are being developed, they must maintain consistent community engagement by allowing community members to have an active role during campaigns, activities, events, workshops, etc.

Collectively, all the themes discussed illuminate the complexity and interconnectedness of diverse aspects affecting the mental health of people living in LMI communities and give a detailed lens into the world of disadvantaged communities, highlighting the importance of contextual understanding regarding well-being. Furthermore, the data reveal the strong implications of poor living conditions in LMI contexts. The revelations in this have also helped in providing a clear understanding of how community interventions can be effectively coordinated and implemented. Most importantly, this study has been able to accomplish the discovery of the perceptions of mental health by people in LMI communities.

CONCLUSION CHAPTER

This research study aimed to discover the perceptions of mental health in LMI communities in the South African context. Based on the thematic analysis, it can be concluded that mental health is a phenomenon that is fairly understood within LMI communities, however, it is often stigmatised. The stigma surrounding mental health/illness includes trivialising it, treating it as insignificant, and labelling it as abnormal eg., as demonic/sinful. Based on the analysis, there is evidence of a generational gap in LMI contexts regarding knowledge of mental health. Misconceptions informed by cultural and religious influences are passed down to the younger/ emerging generations. While the younger generation is more exposed to sources of information such as media and education, by virtue of being born into LMI contexts and into families that have been affected by the consequences of socioeconomic and political disparities they also adapt some of the perceptions and attitudes that their elders have. Subsequently, they also impose those beliefs onto themselves. According to the analysis, the role of culture and religion have a great impact on the perceptions of mental health that are circulated and validated by families and communities.

According to the findings, mental health is understood as the ability to cope amidst adversity and is the awareness of one's psychological state. The distress experienced in LMI communities can be linked to socioeconomic challenges that those in these circumstances face daily. Issues such as unemployment make individuals feel hopeless and can lead to mental illnesses such as depression. However, because of the stagnation of their socioeconomic challenges individuals in LMI communities trivialise mental illness. Because of this trivialisation individuals rarely consult with mental health professionals for diagnoses and treatment, rather they deem their mental illness as normal day-to-day stress. As a result of poor community interventions, the communities also lack the encouragement to learn and take care of their mental health.

The context of LMI communities includes poor education, unemployment, poor health care which for mental health involves inaccessible mental health services, inadequacy in mental

health professionals in hospitals and clinics, and a lack of community engagement toward mental health development.

The use of a qualitative, exploratory research approach was suitable and effective for this study as this research design enabled the researcher to discover the underlying perceptions of mental health in LMI communities and factors that informed them. This approach also enabled the researcher to learn of potential interventions that could be effective in curbing mental health stigma in LMI communities and improving the mental health care of those living in LMI communities.

While this research study explored the perceptions of mental health in LMI communities in the South African context, it also highlighted the role of social and economic factors in perpetuating mental health stigma and mental illness. It also highlighted the crucial role that government incompetence has in affecting the well-being and quality of life for those whom they are responsible for.

Limitations

The use of seven participants and convenience sampling may limit the generalisability of the findings as this may not be representative of a larger population, therefore, conclusions from the study should be drawn with caution, which is a limit to only the study's participants. However, saying this, generalisability is not an aim of qualitative research. Furthermore, the study comprised of individuals between the ages of 21-26 years, the majority of them being university students. Therefore, they may not reflect the true perceptions of those older individuals in LMI communities and may have had the privilege to leave their childhood environments. Therefore, the knowledge carried by participants of the study may be altered by their exposure to further education and opportunities.

The study's reliance on the participants' views and opinions means the majority of the participants' responses are subjective and limited to their own understanding and personal experiences which may not reflect the broader population.

Mental health perceptions are perhaps one of the most sensitive topics and participants may have provided answers to interview questions that are socially desirable in order not to

appear stigmatic or discriminatory, which could have led to biased data. However, on the whole, it was felt that participants shared quite candidly.

Recommendations

Based on the findings of this research study on perceptions of mental health in LMI communities, there should be more studies conducted on socioeconomic depression among LMI communities. This is extremely important as socioeconomic development is something that may take years to transform, which means people living in such contexts will need to learn how to live with that reality for a longer time without allowing their circumstances to get them depressed.

Seemingly, religion plays an instrumental role in helping individuals cope with adversity. More critical investigations on how community mental health interventions can respond to religion and culture must be conducted. And it could be transformative for the field of psychology to be inclusive of non-western yet seemingly effective measures to address mental health issues within poor communities.

The health, research, and social development sectors should be in constant collaboration and engagement to prevent gaps and exclusion in policies, programs, and interventions related to mental health. This will allow for interventions to be diverse and inclusive, such as having family, social, and educational interventions for different communities. The constant communication between these domains is important in serving communities and implementing effective strategies.

Community interventions should also design different interventions for different age groups to address the generational gap between LMI populations. This will also ensure that the generational stigma about mental health is no longer passed on.

Conclusion

Through thematic analysis the study was able to rigorously gather four key themes that answered the research question - “What are the perceptions of mental health in LMI communities?” Each theme was able to contribute a different perception through varying details. The understanding of mental health in LMI communities (theme 1) delved into how participants comprehend mental health. The participants shared their perspectives on the

concept of mental health such as defining/explaining mental health and the factors that informed their perspectives or understanding, they also shared the prevalent mental illnesses in their communities (according to their knowledge), and how they manage mental health. This theme significantly contributed in answering the research question as it provided a clear foundation of how much knowledge participants have gathered on mental health and thus how they perceive it.

Causes of mental illness in LMI contexts (theme 2), added further information by providing insight into the social, political and economic factors that exist in LMI communities that reportedly lead to mental illness. Exploring the contextual causes created a deeper understanding of LMI communities which created a seamless understanding of the connection between their environment, mental health and perceptions of mental health.

Mental health stigma in LMI contexts (theme 3) delved into the prevalent stigma surrounding mental health in their respective LMI communities. The participants narrated the beliefs that are held regarding those who experience mental illness and mental health holistically. They also shared how they have been affected by the stigma. This theme played a formidable role in highlighting the knowledge gap evident in LMI communities and the harmful perspectives that are preserved in LMI communities regarding mental health. Moreover, this theme revealed the significant role of culture and religion in perpetuating mental health stigma as well as the generational gap in knowledge among black LMI communities and families that needs to be addressed.

Mental health support and service in LMI contexts (theme 4) focussed on the challenges that people in LMI communities face regarding mental health aid. The participants shed light on the unattended matters by the government that affect their quality of their mental health such as access to mental health care, mental health promotion, insufficiency of mental health professionals and lack of interventions tailored to their context and problems. This theme also played an instrumental role in expanding the information gathered on what affects the perceptions of mental health by people living in LMI communities.

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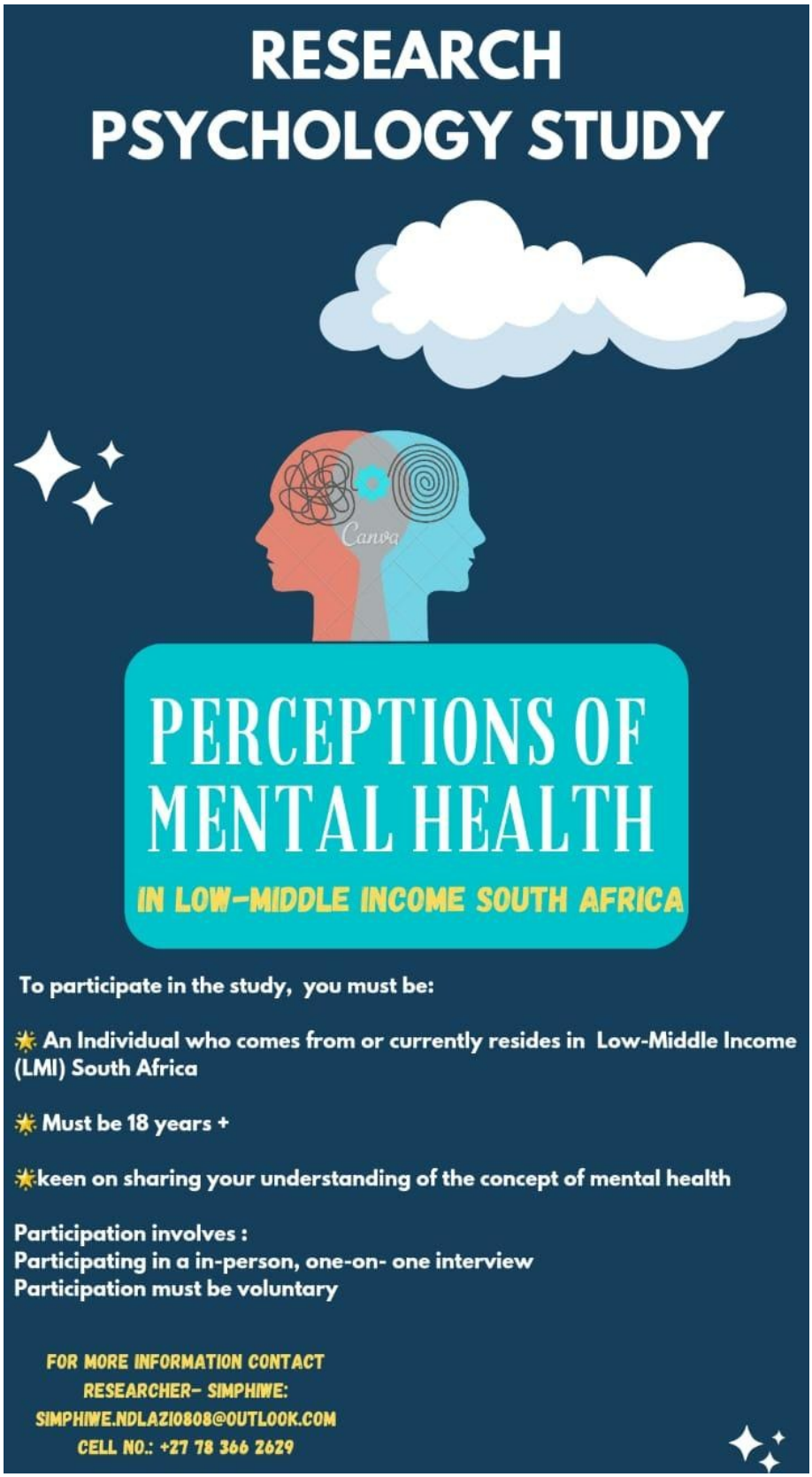
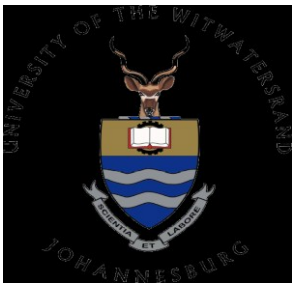
APPENDICES:

Appendix A: Letter of invitation



Appendix B: Participation information sheet



School of Human and Community Development

Private Bag 3, Wits 2050,

Johannesburg,

South Africa

TEL: 011 717 4500 **FAX:** 011 717 4559

Participant Information Sheet

Perceptions of mental health in low- middle income South Africa

Dear Sir/Madam,

My name is Simphiwe Ndlazi, and I am a master's student in Research Psychology at the University of the Witwatersrand. As part of my academic year, I am conducting a research project under the supervision of Dr Clare Harvey that is exploring perceptions of mental health in low-middle income (LMI) communities in the South African context.

This letter serves as a formal invitation to be a part of the research study as a research participant. All participants will be required to be part of an in-person, one-on-one interview with the researcher which will be held at a place and time convenient for you. Each interview will last for a period of 45 to 90 minute. The content of the interview will be based solely on the area of interest for the research study. As a participant, you will have the right to withdraw from participation at any point up to the end of the interview if you feel the need to. You will also be allowed to refrain from answering questions that you do not feel comfortable with,

without any negative consequences. Furthermore, you will be allowed to ask for clarity any time during the interview. It is important to note that participation in the study has no intended negative nor positive implications on you as a student. The purpose of the interview is only for the fulfilment of the research project.

As part of the research process, the interview will have to be analysed and transcribed thus the interview will be audio recorded. Participant's details as well as the interview recording will be kept anonymous and should direct participant references in the final thesis be made, pseudonyms will be given to the participants to ensure final anonymity. Any obvious identifying data will also be disguised or altered. Confidentiality will also be maintained as the interview recording will only be accessible to the researcher and the supervisor. With your permission, other researchers may use the data collected from this research study, but your name and any personal information will not be used or passed on.

The study is qualitative, meaning the participant's experiences will be shared during the interview, therefore there is a possibility that sensitive information may be elicited. Should this occur and the participant feels the need to further speak to a mental health professional, they can contact the Counselling and Careers Development Unit (CCDU)

- CCDU: 011 717 1000

Finally, prior to the start of the interview, it is important that you carefully read the consent form and sign it. This will serve as confirmation that you fully understand everything stipulated with regards to participating in the study.

The University Human Research Ethics Committee (Non-Medical) can be contacted should you have any concerns or complaints arise regarding the study:

Telephone +27(0) 11 717 1408,

Email: hrecnon-medical@wits.ac.za

If you have any further questions regarding the study, please do not hesitate to contact me via email (simphiwe.ndlazi0808@outlook.com) or phone number (0783662629) or my supervisor Dr Clare Harvey (clare.harvey@wits.ac.za / 011 717 9999).

Appendix C: Interview Schedule

Interview Schedule

Demographic questions

What is your name?

How old are you?

What is your gender?

Where do you currently live?

How long have you been residing in this context?

How long did you live in a LMI context? (If relevant)

Interview questions

1. Tell me about your favourite aspects of your community?

2. Can you list aspects of your community that you think need improvement?

   Follow up: a. Why do you think these areas need improvement?

   b. How do you think these areas can be improved?

3. What is your understanding of mental health?

   Follow up: a. What do you think informed your understanding/knowledge regarding mental health?

   Follow up: b. How important is mental health to you?

4. Can you name any mental illnesses?

   Elaborate: a. Can you briefly explain this/these mental illness/eses?

5. What do you think causes mental illness?

6. Can you tell me about any mental health problem/s you have encountered before in others around you?

7. How did you manage with these mental health problems?

8. What would you say are the main causes of those in your community experiencing a mental health problem/s?

9. How do you think these causes could have been treated/prevented?

10. Are there any mental health institutions (private or public) in your community and were there any then?

11. Are there psychologists/therapy accessible in your LMI context?

    Follow-up: a. Why is that?

12. Were there any mental health projects/campaigns in your community or at school?
13. What beliefs are dominant regarding mental health in your community?
14. From these beliefs which one/s did you adapt as an individual?

    Follow-up: a. Do you think these beliefs or attitudes are positive or negative?

    Follow-up: b. What factors do you think influence these beliefs in your community

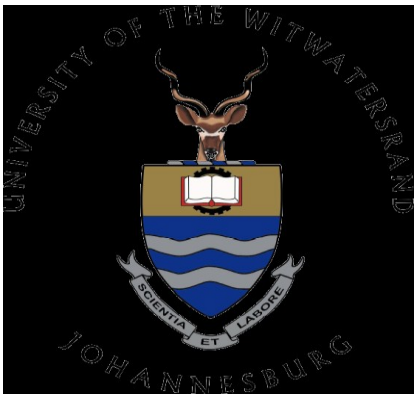
15. Is there anything else you would like to mention or discuss with regards to your experience or opinions on mental health?

Debrief Questions

1. How was the interview experience for you?
2. What did you like the most about the interview?
3. Is there any part of the interview that made you feel uncomfortable? And would you like to discuss that?
4. Are there any parts of the interview you did not expect?
5. Do you feel okay to officially end the interview now?

(Thank you for sharing your thoughts and experiences with me and for your time. I hope this was insightful for you as it was to me.)

Appendix D: Consent Form



School of Human and Community Development

Private Bag 3, Wits 2050,

Johannesburg,

South Africa

TEL: 011 717 4500 **FAX:** 011 717 4559

Consent Form

Perceptions of mental health in low-middle income South Africa

I..... consent to taking part in the interview conducted by Simphiwe Ndlazi, for her master's degree in research psychology study, that will be exploring perceptions of mental health in the South African context. The research has been clearly explained to me and I understand what my participation will require from me.

As a participant in her study, I understand that:

- My participation is completely voluntary.
- I can withdraw my participation any time during the study and prior to data analysis.
- I have the right to refrain from providing a response for a question I do not feel comfortable with.
- All my personal details and information will remain confidential and anonymous, although I may be quoted in the final report. However, if I am quoted, it will be under a pseudonym.
- My interview with the researcher will be audio recorded.
- The recordings and transcripts from the interview discussion will remain confidential and stored in a password-protected file accessible to only Simphiwe and her supervisor.
- The research report will make use of the results from the interview for the final research report that is required for the completion of the master's in research psychology (Coursework) Degree. The data may also be used in publications and/or conference

proceedings.

- I agree that other researchers may use the information I provide in my interview (depending on their own ethics clearance being obtained) but my name and any personal information will not be used or passed on.

Signed..... Date.....

Appendix E: Ethics clearance certificate

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE

PROTOCOL NUMBER: MAPSYC/23/08

PROJECT TITLE:	Perceptions of mental health in low-middle income South Africa.
INVESTIGATOR	Ndlazi Simphiwe (2106710)
SCHOOL/DEPARTMENT OF INVESTIGATOR	SHCD/Psychology
DATE CONSIDERED	20 June 2023
DECISION OF THE COMMITTEE	Conditionally Approved **Conditional Clearance: Data collection cannot commence until the permission letter is submitted to the school/dept HREC Non-Medical Committee**
RISK LEVEL	Low Risk
EXPIRY DATE	31 December 2025

ISSUE DATE OF CERTIFICATE 05 July 2023 **CHAIRPERSON**

_____

(Dr Aline Ferreira Correia)

cc: Dr Clare Harvey (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

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

_____ ___06___/___07___/____23___.

Signature **Date**