

KNOWLEDGE AND ATTITUDES OF RURAL COMMUNITY MEMBERS' IN GA-DIKGALE  
TOWARDS MENTAL ILLNESS

by

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## DECLARATION

I declare that **KNOWLEDGE AND ATTITUDES OF RURAL COMMUNITY MEMBERS' IN GA-DIKGALE TOWARDS MENTAL ILLNESS**, hereby submitted to the University of Limpopo as fulfilment for Master of Arts Degree in Psychology has not been previously submitted by me for a degree at any other university, that it is my own work in design and execution, and that all the material contained therein have been duly acknowledged.

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**DATE**

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## **DEDICATION**

I would like to dedicate this work to my parents Mr and Mrs Tshoga for their admirable support, love, understanding and patience. All this would not have been possible without them. My older brother Itumeleng Tshoga and sisters Kgopotso, Koketso and Kopano Tshoga for being part and parcel of this process, you guys are the ultimate best.

## **ABSTRACT**

The aim of the present study was to investigate knowledge and attitudes of rural community members towards mental illness. A total of 249 participants were selected through simple random sampling from Dikgopeng community, Ga-Dikgale, through the Krejcie and Morgan's (1970) table. A simple random sampling method was employed in selecting the participants. A quantitative cross-sectional research study was administered using the Mental Attitude Knowledge Scale (MAKS) and Attitude Scale of Mental Illness (ASMI).

The MAKS and ASMI are structured 5-point Likert scale questionnaires translated from English into Sepedi. Demographic data were collected and administered using the demographic questionnaire. The Statistical Package for the Social Science (SPSS) software package for Windows (Version 24) was used to analyse data collected and to draw conclusions from this. Two hypotheses were drawn from the study to help understand the aim of the study.

Hypothesis one entailed that there is a significant difference in the level of knowledge towards mental illness by members of GaDikgale community, according to gender and age. According to the present study, there was a mean effect of gender with male participants being more knowledgeable about mental illness as compared to female participants. It was revealed that there was no effect of age on the knowledge scale. Hypothesis two detailed that there is a significant difference in attitudes on mental illness by members of GaDikgale community according to gender and age. From the study, there was a positive attitude towards people with mental illness by the older participants than there was with the younger participants. There was no effect of gender on attitudes towards mental illness.

It is shown from the present study that within rural communities, with the majority (57%) of the participants being lay people, mental illness is regarded as a burden for the family, contributing to isolation and poor access to adequate western treatment. Reintegration after treatment and positive recovery is difficult because of lack of knowledge and negative attitudes towards individuals diagnosed with mental illnesses. The burdensome existence of stigmatisation is the consequence of ignorance or misinformation, prejudiced attitudes and or exclusion from normal forms of social participation (Thornicroft, Rose, Kassam & Sartorius, 2007).

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## CHAPTER 1

### BACKGROUND AND ORIENTATION

#### 1.1 Background to the study

Mental illness remains a significant contributor to the global burden of diseases in many communities worldwide (Youssef et al., 2014), and affects people across all regions of the world (Steel et al., 2014). According to estimation by the World Health Organisation (2011), approximately 450 million people experience mental health challenges annually, and this is estimated to rise to 15% by 2020. The Royal College of Psychiatrists (2011) states that 68% of women and 57% of men, as parents suffer from mental illness resulting in early exposure of parental psychiatric illnesses to their children. However, Batchelor and Bochynska (2009) indicated a quarter of Australian children were exposed to mental illness through their parents which contributed to the high increased risk of poor mental health development (O'Connell, Boat & Warner, 2009) and emotional problems as adults (Dean, Stevens & Mortensen, 2010).

According to the World Health Organization (WHO), 4.6% of the South African population were revealed to have a mental illness (WHO, 2017). Flisher et al. (2012) pointed out that one in five children and adolescents from middle to low-income countries are likely to suffer from a mental disorder. Furthermore, one of the serious problems associated with mental illness is the stigma and the ensuing discrimination that people suffering from this morbid condition face. For example, a study by Uys and Middleton (2010) found that community members from Durban (Kwa-Zulu Natal, South Africa) would rather not be neighbours or live in the same block of flats with mentally ill individuals, alluding to Diefenbach and West's (2007) participants that do not support living next to persons with a mental illness or having mental health services in residential areas. Siu et al. (2012) remarked that stigmatisation and discrimination of persons with mental illness are largely attributable to cultural beliefs, negative attitudes and lack of knowledge regarding various forms of mental illness.

Cultural affiliations play a critical role in the conceptualisation of mental illness. It shapes and moulds beliefs, influences thinking processes and defines everyday activities of a specific group (Subudhi, 2014). In rural African communities, mental

illness has been regarded as punishment from ancestral gods or a self-inflicted illness. Idemudia (2015) affirms that mental illness within African communities is believed to be a stain or curse that has been passed on from one generation to the other. Furthermore, Madzhie, Mashamba and Takalani (2014) affirm mental illness as a serious problem that can affect anyone and has been recorded by the South African Stress and Health (2012) survey indicating that approximately 16.5% of adults in South Africa have reported suffering from symptoms of a common mental illness. Although much of the South African population consult with traditional healers for treatment, they too make use of Western forms of mental healthcare treatment (Simpson & Zambuko, 2012). To illustrate the above, a study by Mohamed-Kaloo and Laher (2014) found that religious and cultural beliefs consider mental illness to be caused by some form of spiritual punishment.

In some African communities, the cause of physical and mental illness is believed to be a result of disturbances in the harmony between an individual and the cosmos, which is understood to mean the family, society, peers, ancestors or a deity (Ngirababyeyi, 2012). Traditional healers understand mental illness to be some sort of madness and disturbance in the person's brain, memory and personality, which results in behaviours that are regarded as culturally unacceptable (Madzhie et al., 2014). Other studies have suggested that mental illness is a disorder caused by ancestors or witchcraft (Sorsdahl et al., 2009). Rankoana's (2014) study participants at Mogalakwena (Limpopo Province, South Africa) community labelled mental illness as *bogawsi* and believe that it is a heredity categorised as *leabela*. Within the above mentioned cultural context, consultation with a traditional healer is perceived to be an effective method of treatment of mental illness given the common cultural ideology shared by the traditional healer and the patient (Bulbulia & Laher, 2013).

Igbinomwanhia, James and Omoaregba (2013) found that 46, 8% of the people in Benin City (Nigeria) tended to perceive mental illness to be a result of supernatural or spiritual factors. Furthermore, Schomerus et al. (2012) found that people perceive mentally ill individuals as dangerous and unpredictable. Asserting to this are health caregivers from a study by Kapungwe et al. (2011), alluding to the idea of detaining and handcuffing those with a mental illness. Subsequently, treatment and care for those with mental illness is often obtained from priests or traditional healers. Similarly, causal explanations and the tendency to use non-western healing

practices to manage mental illness have been reported in other parts of the African continent (Mohamed-Kaloo & Laher, 2014; James, 2012).

## **1.2 Motivation for the study**

Studies previously conducted show that there is little information on knowledge regarding mental illness in rural communities (Longkumer & Borooah, 2013). For example, knowledge of mental illness was reported to be low and stigma high among the general population in South Africa (Kapungwe et al., 2011). Subsequently, lack of information serves as a means of stigmatisation, exclusion, discrimination and lack of motivation to seek treatment (Michaels & Corrigan, 2013). Evans-Lacko, Henderson and Thornicroft (2013) found that negative attitudes held by community members prompt a greater desire for the mentally ill to avoid contact because of being labelled and considered a societal burden.

Ganesh (2011) points out that improved attitudes towards people with mental illness are a result of being knowledgeable and being informed about mental illness. It is these attitudes towards mental illness that have motivated the researcher of the present study to investigate a rural community's knowledge and attitudes towards mental illness.

## **1.3 Aim of the study**

The aim of the present study was to determine the knowledge and attitudes of rural community members towards mental illness. The following hypotheses were used to better understand and outline the knowledge and attitudes held on different age and gender basis.

### *1.3.1 Hypothesis 1*

*Ho:* There is no significant difference in the level of knowledge of mental illness by members of GaDikgale community according to gender and age.

*H1:* There is a significant difference in the level of knowledge of mental illness by members of GaDikgale community according to gender and age.

### *1.3.2 Hypothesis 2*

*Ho:* There is no significant difference in attitudes towards mental illness by members of GaDikgale community according to gender and age.

There is a significant difference in attitudes towards mental illness by members of GaDikgale community according to gender and age.

#### 1.4 Operational definition of concepts

- **Attitude:** This can be defined as a learned disposition towards an object or situation which provides a tendency to respond favourably or unfavourably to the object or situation (Mohammed & Mohammed, 2008). In the present study, attitudes were understood to mean negative or positive behaviour held towards people with mental illness.
- **Knowledge:** This refers to the state of knowledge about a fact or situation (Hornby, 2010). In the context of the present study, knowledge was understood to mean perceptions held towards individuals with mental illness.
- **Mental illness:** It is a term used for a group of mental disorders that cause severe disturbances in thinking, feeling and relating and often resulting in an inability to cope with ordinary demands of everyday life (Rout, Dutta, Sengupta & Das, 2010). In the present study, mental illness is understood as any serious mental disorder that has led to functional impairments on an individual.

#### 1.5 Outline of chapters

In Chapter 1, the background to the study is outlined, followed by a brief presentation of the motivation of the study. The aim of the study and operational definitions of concepts is also given. In Chapter 2, relevant literature regarding the subject of this study is reviewed along with the theoretical background that guided the researcher in this study. Chapter 3 focuses on the methodology that was followed to conduct the study. Relevant topics such as the research design; description of the participants; the sampling procedure; instruments used; reliability and validity of the study; procedure followed; the method of data analysis that was followed; including ethical considerations that were followed in conducting the study are also highlighted. In the fourth chapter, the demographic characteristics of the participants are presented, followed by the detailed description of the findings, including the statistical analysis of the different variables under investigation. In Chapter 5, the results of the study are discussed in the context of existing literature. Conclusions are made, and recommendations are suggested in the last section of the chapter.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

In this chapter, the researcher considers the causes, knowledge and attitudes held, the prevalence and preferred methods of treatment of mental illness from both rural and western urban communities, specifically looking at Dikgopheng village, GaDikgale, Limpopo Province, South Africa. Furthermore, a theoretical framework of the study is presented in this section. In the process of reviewing the literature, the following search engines and databases were used: ebscohost, Sabinet, Google scholar, SA-epublication, BMJ Group, sciencedirect.com, Researchgate, Journal articles and books. A number of literature was published between 1958 and 2018. The following key words were used when searching for literature: mental illness in rural communities, mental illness and age, prevalence and treatment of mental illness in rural and urban communities and mental illness within the African context.

#### **2.2 The prevalence of mental illness in rural and urban communities**

A third of the world's population in developed countries suffer from mental health issues (Jack et al., 2014). The World Health Organization (2011) found that mental illness was ranked first and highest amongst disabilities in developed countries. For example, anxiety disorder, mood disorder, impulse-control or substance use disorders and major depressive disorder (Baxter, Scott, Vos & Whiteford, 2013) are regarded as those prevalent amongst mental health problems (MediaWiki, 2007).

A percentage of 35% and 50% of people in developed countries receive no treatment for their illness (World Health Organization, 2018). Unhealthy living conditions, social pressures and the lack of social support were revealed as contributors to the onset of mental illness (Kyei, Dueck, Indart & Nyarko, 2014). Over the years, attitudes within westernised communities have worsen towards individuals with schizophrenia, and there were recorded stable signs of attitudes towards individuals with depression (Angermeyer, Matschinger & Schomerus, 2013).

Mental illness is recognised to be a major contributor (14%) to the global burden of diseases (Ganesh, 2011). An estimated 450 million people suffer from mental or behavioural disorders worldwide (NguendoYongsi, 2015). From the global burden of the disease, 70% of the illness is high in low and middle-income countries (Lopez,

Mathers, Ezzati, Jamison & Murray, 2006). An estimated 58/1000 of adult Indians suffer from a mental illness (Kermode, Bowen, Arole, Joag & Jorm, 2010) with high prevalence in children because of behavioural and emotional disorders (Lakhan & Ekúndayò, 2015). Furthermore, 2/200 children from a village or a non-intact home in Africa develop a sort of mental illness at least once in their lifetime (Atindanbila & Thompson, 2011). A total of 3% of South Africans suffer from severe mental health problems that require hospitalisation (Madzhie et al., 2014). Thirty percent will suffer from depression and anxiety disorders as adults with a high rate of substance abuse (Schneider et al., 2016). Subsequently, alluding to Stein and Seedat (2007), most burdensome, prevalent and costly of all medical disorders is said to be mental illness.

The high prevalence, severity, long course and worsening outcome of mental illness is said to be the result of poverty (Lund et al., 2010), with studies suggesting a high prevalence of undiagnosed mental illness in Kenya (Ndetei et al., 2009). Poor mental health increases the risk of behavioural, social, emotional and educational problems amongst children with parents suffering from mental illness (Singleton, 2010). These children have a high chance of experiencing attachment problems and long-term mental health issues (Ola, Suren & Ani, 2015). This is constituted by a high percentage of women (68%) and a relatively high percentage (57%) of men as parents suffering from mental illness.

### **2.3 The causes of mental illness in rural and urban communities**

In African communities, poverty plays a pivotal role in the wellbeing and access to service providers that can help in combating certain mental and physical disabilities (Aneshensel, 2009). Within rural communities, mental illness is believed to be caused by witches and sorcerers who use bad spirits to inflict those doing well in life as a sign of jealousy to stop them from progressing furthermore in life (Madzhie et al., 2014). Contrary to this is the held perception that mental illness emanates from demonic possession, resulting in fear of seeking help and secrecy of their illness, which contributes greatly in the lack of seeking medical attention (Okasha, 2002). Although the above are contributing factors to the development of mental illness, poverty, substance abuse and political violence also play a part in contributing to mental illness within the South African context.



In a community of predetermined norms, an individual behaving outside these norms is perceived as mentally unstable based on the predisposed knowledge that such an illness affects an individual's mind (Madzhe et al., 2014). For example, bone divination, use of herbs and steaming has been used as a tool for diagnosis on individuals, indicating that they see or talk to dead family members or community members (Madzhe et al., 2014).

Unhealthy social relationships which cause physical or mental illness (Sandlana & Mtetwa, 2008) and long-standing conflicts are believed to serve as contributing factors to the development of mental illness within African communities (Madzhe et al., 2014) and perceived notion that one is pretending to be mentally ill, are common within such communities (Egbe et al., 2014).

Preventative awareness programmes have been discovered as effective for children whose parents are mentally ill (Reupert, Maybery & Kowalenko, 2012). Western communities adopt and practise western medication, which contributes to society holding different views on the onset, treatment and prevalence of mental illness. Within the Buddhist context, mental illness is regarded as punishment directed to the individual who has been sinful in their past life (Lam et al., 2010), has experienced childhood, gender and/or substance abuse, has certain personalities, has a dependency on medication and there is access to guns (Corrigan & Bink, 2016; Flisher et al., 2012).

The held knowledge that mentally ill individuals are unpredictable and have violent behaviours (Swanson, McGinty, Fazel & Mays, 2015) contributes to the lack of conduct which emanates from psychosocial stress as a cause of mental illness (Dietrich, Heider, Matschinger & Angermeyer, 2006; Corrigan & Bink, 2016). Bhat and Rather (2012) indicated an increase in mental illness as result of increased exposure to urbanisation, feelings of worry and unhappiness. Supporting the above view, Murray (2012) admitted that living in the city can be a great contributor to the development of mental illness, thus the bigger the city the bigger the risk; for emotional distress, a high risk of development exists in industrialised and urbanised communities (James, 2008). With the coming of urbanisation comes the advancement of technology, which in turn contributes to the onset of mental illness (Iglowstein, Jenni, Molinari & Largo, 2003). This decrease sleeping hours, physical

activities (Nelson, Neumark-Stzainer, Hannan, Sirard & Story, 2006) and increases the high rate of obesity (Berg et al., 2006).

In an international study, the cause of depression was emphasised to occur from genetical and chemical imbalances, which in most cases are the causes of schizophrenia (Wang et al., 2007). Such beliefs have also been found within the South African context (Hugo, Boschhoff, Traut, Zungu-Dirwayi & Stein, 2003). There is complex knowledge held between the city and rural dwellers describing the development of mental illness as not being caused by supernatural causes (St. Louis & Roberts, 2013). Lam et al. (2010) emphasise that within the Taoism context, mental illness is a disharmony between the person's body, soul, economic deprivation, social isolation and pressures from family responsibilities (Klifton, 2012).

#### **2.4 Knowledge and attitudes held by lay people and urban community members**

According to Singh, Singh and Singh (2013), there tends to be a noticeable difference between knowledge and attitudes held towards mental illness in urban and rural areas; and planned and unplanned settings (NguendoYongsi, 2015). Adults in urban areas hold more favourable attitudes than adults in rural areas because of the low level of education and high level of unemployment (Lo & Cheng, 2014), affecting the urgency of seeking treatment (Ngab, Nyuntab, Chiamc & Kuaab, 2011).

##### **2.4.1 Knowledge by lay people and urban community members**

Lay people's opinion is not based on any pre-researched or scientific knowledge emerging from any academic sources; it is a perception sought by an individual's understanding and previous exposure to the topic at hand. The vast lack of knowledge on mental illness held by lay people contributes to stigmatisation, isolation and held negative attitudes (Gureje, Olley, Ephraim-Oluwanuga & Kola, 2006). The stigmatisation, isolation and negative attitudes held will lead to the reintegration of previously mentally ill individuals back into their communities (Corrigan, Edwards, Qreen, Thwart & Perm, 2001).

In the African context, religion serves as the biggest entity of forming perceptions and contributing to attitudes held regarding certain aspects. For example, individuals suffering from mental illness within the Pentecostal religion have been deemed as

Satan's servants (Mercer, 2013). On the other hand, mental illness is viewed as the consumption of dangerous herbs in Nigeria (Gureje, Lasebikan, Ephraim-Oluwanuga, Olleyand & Kola, 2005).

In addition to the above factors, Lund, Myer, Stein, Williams and Flisher (2013) indicate low financial income in rural areas as upsurging the risk of mental illness through increased risk of hostile life events. Although the above study supports the notion that knowledge of mental illness is scarce and vague in rural communities, Molaba, Mothiba and Kgole (2013) stipulate that study participants at Thabamooop Mental Healthcare Institution (Limpopo Province, South Africa) are well aware of the causes of mental illness. This was supported by one participant's statement, which says, "Pressure from my friends led to my behaviour of taking dagga, and the other thing is that I smoke petrol this led to my mental illness" (p. 248). Thus, emphasising those social factors (such as peer and media influences) serve as contributing factors to the development of mental health problems (Speller, 2005).

#### 2.4.2 Attitudes held by lay people and urban community members

Demographical backgrounds contribute towards attitudes held about mentally ill individuals. In support of this, St. Louis and Roberts (2013) in their study regarding mental illness found that individuals who earned less income held negative attitudes in comparison to those earning more.

Previous studies conducted proposed that it is more likely for people to demonstrate negative attitudes towards people afflicted with mental health problems when they possess little knowledge regarding mental illness (Kakuma et al., 2010). Drew et al. (2011) assert that people with mental illness are vulnerable to abuse, violence and neglect by their families and are often subject to high levels of stigma and discrimination. Though mental illness is regarded as a culturally bound illness, it can, in any instance, be experienced by any individual within any of the existing diverse socio-economic, cultural and religious backgrounds manifested within communities and families. Ndetei, Khasakhala, Mutiso and Mbwanyo (2011) found that 1.75% of participants from their study felt that mental illness was a problem for relatives, whereas 2.6% believed mental illness to be effectively treated by African traditional doctors.

Several families with a mentally ill person experience some feelings of vulnerability because of inhuman treatment and stigmatisation and the scarcity of resources (Engelbrecht & Kasiram, 2012). One of the commonly held stereotypes towards people with mental illness is the perceived knowledge that they are responsible for their condition, and the most damning is the perception that they are dangerous and unpredictable (Corrigan & Bink, 2016). This is evident in recent studies where 62% of the British population have experienced mental health problems (Together-UK, 2010) with an increased rate affecting younger people (Hyland, 2011). A staggering 62% experienced stigmatisation from their peers and 46% from their family members (Moses, 2010).

Most of the westernised communities believe individuals with a mental illness can attain educational qualifications, work, live independently, have relationships and spiritual goals (Corrigan et al., 2012) which encourage positive attitudes, while indicating a change in how mentally ill individuals are treated (Meier, Csiernik, Warner & Forchuk, 2015). However, Canadians considered depressed individuals as unpredictable and dangerous (Wan & Lai, 2008). Contrary to the above, participants in Meier et al. (2015) who have experienced some form of mental health problems were more understanding and accepting of people.

In a more western context, we expect a high level of education, which is associated with positive attitudes towards mental illness. However, most western participants stated that mentally ill persons pose a risk in the society (Barke, Nyarko & Klecha, 2011). In a study in Ghana (Barke et al., 2011), as compared to that in Germany (Angermeyer et al., 2003), it was observed that Ghanaians held less benevolent attitudes and more socially restrictive views towards mental illness than the Germans.

Adults in rural communities do not only hold negative attitudes towards mental illness, but they also exist and are held by primary health caregivers in Zambia (Kapungwe et al., 2011).

## **2.5 Treatment of mental illness in rural and western communities**

The method of treatment depends on the values and beliefs held by specific cultural groups, and if the origin of mental illness is not associated with their cultural beliefs, any sort of treatment that does not include their held beliefs will not be deemed helpful (Furnham, Ota, Tatsuro & Koyasu, 2000; Sehoana & Laher, 2015). Severe

mentally ill patients and Mental Health Care Users (MHCUs) frequently use western healing care treatment preferably from psychiatrists with understanding and hold similar cultural backgrounds (Lund, Petersen, Kleintjes & Bhana, 2012; Sodi & Bojuwoy, 2011).

One other form of treatment includes prayers as a form of treatment to depression based on their belief that mental illness is caused by social factors (Samouilhan & Seabi, 2010). In certain rural communities, mental illness is believed to be ancestral spirits that cannot flee the human body; as a result, a method of piercing both sides of the eardrums of a mentally ill individual is deployed as a form of creating an exit point for such spirits (Magnier, 2013). Furthermore, marriage, the infliction of physical punishment and personal guidance (Longkumer & Borooah, 2013) are sought as treatment options. For example, within the Malaysian culture, consultation of magico-religious therapy is done prior to consulting psychiatric treatment care (Sheri, 2015). Overall, culture plays a vital role in shaping the understanding of the causal and probable treatment of mental illness (Subudhi, 2014). Semanya, Potgieter and Erasmus (2012) report that Bapedi traditional healers closely observe one's condition and predominant symptoms before starting treatment. They further reported that diagnosis and treatment of diseases by such healers is done based on symptoms experienced by the patient.

Traditional healers and religious advisors are consulted by South Africans with no formal education (Sorsdahl et al., 2009) for the provision of proper mental health treatment (Sorsdahl & Stein, 2010). The above matter is supported by studies conducted by Mohamed-Kaloo and Laher (2014) and James (2012), who found traditional healers as sources and reliable providers of effective mental health treatment within the South African and Jamaican communities.

Western medical treatment is sought when the culturally preferred treatment and religious interventions fail to relieve mental illness (Drew et al., 2011; Ngab et al., 2011). However, religion consultation can play out as a negative impact on the outcome of mental illness; thus, supported by a study participant outlining that: "*I use tea from Zion Christian Church (ZCC) and I cannot mix it with the treatment as indicated by the priests, then I drink the tea when is finished is then that I can drink treatment*" (Molaba et al., 2013:249). This is done based on philosophies that

religious tea or treatment should not be mixed or drunk together with western medical treatment (Molaba et al., 2013).

Believers of the Pentecostal church revealed the notion of using traditional herbs while receiving interventions that have congruence with their Pentecostal beliefs (Mercer, 2013). The human species rely on both spiritual and cultural beliefs to help aid their existence and illness. Although such beliefs do not yield much support in recovery from mental illness, most individuals turn to them when they or their family members behave in unacceptable manners that are not of their societal norm. As a result, recovery is difficult, delayed and overlooked.

Williams et al. (2008) documented that 75% estimate of mentally ill South Africans do not receive suitable western treatment. Early identification and treatment of mental illness is crucial (Longkumer & Borooah, 2013) for effective outcomes of reintegration. However, societal barriers, lack of familial support, stigmatisation and embedded cultural beliefs and practices hinder the process of diagnosis and treatment (Strümpher, van Rooyen, Topper Andersson & Schierenback, 2014). The quality and urgency to seeking health care treatment is solely depended on the level of knowledge individuals hold towards mental illness (Ganesh, 2011).

The lack of psychiatrists, which ranges from 0.05 to 0.54 per 100,000 head of population in low and lower-middle-income countries is a prominent problem contributing to patients' lack of access to adequate mental health treatment (WHO, 2011). Within these countries (Kohn, Saxena, Levav & Saraceno, 2004) wherein schizophrenia is prevalent as the cause of disability that requires a combination of medicines and psychosocial interventions, family and community involvement (Patel, Farooq & Thara, 2007), the lack of adequate mental health treatment makes it difficult for treatment to be effective.

Treatment of mental illness in developed countries is centred on the belief that consultation with a counsellor, psychologist and engaging with family and friends about the illness will help with recovery (Wang et al., 2007). Although a large population of the above study are of the above belief, 15% of them were not sure of the best treatment for depression, while 30% were of the belief that mental illness can be resolved on its own (Wanget al., 2007). Within the western cultural context, mental illness is perceived to be a result of a biological causal, which can be treated

with psychiatric treatments (Wahl, Susin, Lax, Kaplan & Zatina, 2012). Contrary to this, 90% of people live in developing countries with the illness that do not receive the care they need to recover (Patel, 2012).

The causation and treatment of mental illness is dependent on cultural, traditional and religious beliefs held by the person suffering from it or their immediate family. As such, it differs widely in both the African and Western contexts. Within the Western communities, treatment is carried out holistically focusing on the individual's peers, parental pattern, fears, friendships and schooling (Sanders, Kirby, Tellegen & Day, 2014). The inclusion of both traditional medicine and Western biomedicine helps in treating the physically, mentally and spiritually ill (James & Peltzer, 2012). Even though research findings point out that cases reported at general hospitals are psychological, most people in South Africa avoid mental health professionals. They do not take advantage of the available mental health services (Trump & Hugo, 2006). A few of them go to the extent of going for a spa treatment instead of seeking Western professional treatment to combat their mental illness (Angermeyer, Breier, Dietrich, Kenzine & Matschinger, 2005).

In certain families, mental illness is treated by relying on faith in God or practices of spiritual prayers for the individual to help manage the illness (Mokgothu, Du Plessis & Koen, 2015). Family involvement, as a form of intervention and treatment, reduces psychiatric symptoms and encourages healthy family relationships, and alleviate emotional stress. It gives provision of educating family members about the illness, offers emotional support, adequate communication skills and improves social support (Dixon et al., 2010). However, certain families where relationships have been affected, members suggested individual counselling and support (Simpson & Zambuko, 2012), while others preferred psychotherapy to talking to friends or family members (Mbuthia et al., 2018).

The government enforces segregation on those mentally ill by placing them in homes for treatment (Corrigan & Bink, 2016). Although psychological and psychiatric treatment are the leading interventions for mental illness, mental institutions provide limited care services that do not encourage self-reliance and self-dependency (Corrigan & Bink, 2016). Psychosocial rehabilitation (PSR) is one method of treatment that focuses on treating the patient in an environment where they work, live and learn (Farkas, Gagne, Anthony & Chamberlin, 2005). Valencia, Fresan,

Juarez, Escamilla and Saracco (2013) allude to this and accept that patients exposed to PSR have more favourable health outcomes.

It has been reported that hope is one element contributing as a positive outcome on mental health treatment, and is identified as a significant characteristic that can increase efficacy (Ociskova, Prasko, Latalova, Kamaradova & Grambal, 2016), which has since been implemented in psychotherapy and cognitive behavioural therapy (Shekarabi-Ahari, Younesi, Borjali & Ansari-Damavandi, 2012).

Speller (2005:26), in a study based on Caucasian students (77%) on mental health literacy, found that the use of selected therapy/support groups as another form of intervention on the treatment of mental illness and “talking with family/friends” was regarded as the leading treatment preference. Integrated therapeutic application across psychiatric rehabilitation and substance abuse domains, motivational interviewing, teachings on coping skills, relapse prevention and encouraging patients to take treatment were deemed beneficial for individuals diagnosed with comorbid substance abuse (Dixon et al., 2010). As a result, motivational interviewing has been proven to be a positive outcome relating to treatment compliance (Chanut, Brown & Dongier, 2005). Depression and anxiety within Western society has been treated with the use of psychotropic medication (Holmes, 2016).

## **2.6 Lay theories on mental illness**

The existence of lay perceptions asserts that mental illness can be personally controlled, unlike medical conditions based on studies informed by Attribution Theory (Corrigan et al., 2000; Opare-Henaku, 2013). However, one alarming aspect on the causes and onset of mental illness by lay people is the notion that most of them hold the belief that mental illness is a communicable disease (Marsh & Shanks, 2014). People behave and react towards any mentally ill individual based on consequences experienced previously (Kelley, 1967). They have no willingness to interact with them. This contributes to negative consequences towards these individuals (O’Driscoll, Heary, Hennessy & McKeague, 2012). Community members go to the extent of naming the illness as “madness” that represent and encourage psychotic disorders; with a causal of hallucinations, delusions, poor hygiene, aggression and nudity, and are perceived as unstable when portraying unusual behaviours, such as standing in one position for the whole day, eating from refuse bags, being



aggressive, incoherent speech, drooling and indiscriminating laughter (Yendork, Kpobi & Sarfo, 2016). The situation described above often leads to social distance.

Social distance occurs when mental illness is linked with psychological or environmental causal attributions than when it is linked with biological causal attributions (Dar-Nimrod & Heine, 2011). It is common and expected for people to stand aloof towards individuals with mental illness (Gur, Sener, Kucuk, Cetindag & Basar, 2012). Mental illness in African cultures is deemed to be caused by supernatural factors from individuals basing their perception on religious background (Bhui, Bhugra & Goldberg, 2002). Younger individuals in Nigeria hold such a perception. However, they also favour and mention biological and sociological factors as contributors to the onset of the illness (Furnham & Igboaka, 2007). Nonetheless, they prefer orthodox psychiatric medical options and supportive environments as treatment options for mental illness (Ikwuka, Galbraith & Nyatanga, 2013).

The lack of knowledge contributes to the stigmatisation of people with mental illness which, as a result places the ill person at increased chances and risks of abusing substances and engaging in criminal activities (Angermeyer, 2000). The difficulty in differentiating between mental illness and physical illness highlights the lack of information that exists within lay people's theories on mental illness (Yendork et al., 2016). Comparatively, those in western communities view the onset of mental illness as emanating from biological and social risk factors; for example, personal weakness and/ or stressful social conditions (Nakane et al., 2005).

## **2.7 African-centred theories on mental illness**

A number of scholars have put forward African-centred explanations of mental illness (Sodi & Bojuwoye, 2011; Gureje et al., 2006; Mkhize, 2003). According to Swartz (1997), indigenous African communities in South Africa perceive harmony between the individual and the ancestors as critical in maintaining good mental health. The individual and his/her family are supposed to have met their socio-spiritual obligations for this harmonious relationship to continue to exist. Consequently, some forms of mental illness may occur if this harmonious relationship between ancestors and the living is disturbed. According to Sodi and Bojuwoye (2011), such illness will require the intervention of a traditional healer who is believed to have the powers to

assist the affected family in restoring the balance between the family and the aggrieved ancestors.

In other parts of the continent of Africa, the idea of harmony in mental health is also noted. For example, among the Bambara of Mali, the fundamental concepts regarding health and illness are based on the idea of balances and imbalances between the components of the organism, and between those components and the elements of nature such as earth, water, fire, metal and heavenly bodies such as the sun, moon and stars (Koumare, 1983). All these elements are considered important, as each one of them can exert some influence on a particular organ in the body. According to Koumare (1983), even from birth, the newborn infant is under the control of the elements of nature. The infant's survival is thus dependent on its capacity to establish some form of balance in an environment containing both favourable and unfavourable elements. Koumare (1983) suggests that an illness is bound to result in cases where there is an imbalance or disharmony between the organism and elements of nature.

## **2.8 Theoretical framework: Attribution Theory**

In the present study, the researcher used attribution theory as a lens through which the knowledge of and attitudes held by members of a rural community towards people with mental illness is being understood.

Individuals naturally use attributional reasoning when a situation or outcome threatens their existing, held beliefs and expectations (Bougie, Pieters & Zeelenberg, 2003). Attribution theory sets out to explain the cause of a situation or a behaviour. Asserting to this is Confucianism, which originates from the Chinese population with the view that a person's destiny depends on moral effort (Lam et al., 2010). According to Weiner (2014), an individual's reaction to certain situations is led by emotions and behaviours held regarding the causation of the specific event or situation, emphasising the concept that knowledge of and attitudes held towards mental illness solely depend on the existence of available knowledge, cultural beliefs and social influences.

The attribution theory regards a person as the centre of action on how they perceive, attribute, act and attach the environment to the behaviours of those who inhibit it (Heider, 1958). They can choose to have beliefs that encourage their immediate

families and community members to seek help or shame them to an extent of stigmatisation contributing to self-stigmatisation and neglect (Heider, 1958). Consequently, this contributes negatively to the mediation of the need for help and seeking help behaviours (Chen & Chandrasekara, 2016).

Weiner, Perry and Magnusson (1988) identified three segments of causal attributions that include the following:

### *2.8.1 Locus of control.*

Locus of control can be understood as a lens through which a person sees life as resultant of fate or personal control (Mbutia, Kumar, Falkenström, Kuria & Othieno, 2018). Individuals start off by determining the cause, controllability and/or uncontrollability of a situation when exposed to mental illness as a means of trying to understand first-hand what or who is responsible (Weiner, 1995). They then base their causal perception of mental illness on onset – controllability; described as one having control over their illness; or onset –uncontrollability; described as an individual who does not have any control over their disability or illness; determining how they view and hold certain attitudes towards these individuals (Weiner et al., 1988). In comparison with the internal and external locus of control, those who show a high internal locus of control are more prone to coping with their problems than those with high external locus of control, and the development of psychological characteristics during adolescents are more likely to emerge as internal or external locus of control (Jain & Singh, 2015). Self-efficacy, which is understood to mean the regulation of emotional states (Bandura, 1997), is a contributor to a healthy mental state (Roddenberry & Renk, 2010).

The comparison of internal and external locus of control extends to the type of treatment sought for and behaviour of community members towards these individuals (Mnuthia et al., 2018). The causation of mental illness as emanating from internal locus of control contributes to community members having empathy and pity towards that mentally ill; while external locus of control on the onset of mental illness contributes to mentally ill patients seen as responsible for their illness (Mbutia et al., 2018). Little or no pity is given to them and they are most likely to be punished or neglected (Weiner et al., 1988).

Those who attribute the causes of their mental illness to self-inflicted emotions of anger develop to perceive that they could have avoided the illness (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003). Despite numerous traditional and advanced measures of awareness and governments moving away from institutionalisation to reintegrating the individual back within the community (Corrigan, 2000) and the vast cross-cultural and ethnic difference within African context, there is still a belief of external forces contributing to the onset of mental illness (Idemudia, 2003). Additionally, participants of Wang et al. (2007) are of the idea that people with depression can help themselves; the correlation between how an individual was raised and self-help as treatment contributes to negative beliefs regarding depression (Samouilhan & Seabi, 2010).

### *2.8.2 Stability and controllability.*

Stability is the longevity of the causes of an illness (Weiner, 1980). The causal attributions related to mental illness and the duration of the treatment as well as recovery depend on whether the causal is stable and unchanging or unstable and fluctuating (Försterling, 2001).

The stable the attribution towards mental illness, the harder it is for the attribution to be changed (Weiner, 1980). In Weiner's (1986) theory, failure attached to the lack of effort (unstable internal) and failure emanating from the lack of ability (stable internal) constitute to the stigma attached to the individual with mental illness.

Knowledge held on mental – behavioural or internal stigmas are perceived as unstable or reversible while on the other hand physical stigmas are concluded as stable or irreversible (Donaldson, Best, Langham, Browne & Oorloff, 2015). Additionally, individuals with an illness emanating from controllable causes are prone to negative attitudes as compared to individuals suffering illnesses from uncontrollable causes (Weiner, 1986). For example, an individual whose mental illness is attributed from a head injury during a car accident experiences sympathy, leading to help-seeking tendencies (Corrigan, 2000).

### *2.8.3 Controllable vs. Uncontrollable causes.*

This theory states that when an individual's illness is believed to be caused by forces within his/her control, the person is likely to be held responsible for their condition (Weiner, 1995; Corrigan et al., 2000); consequently, feelings of guilt will emerge from perceived personal control (Maymon, Hall, Goetz, Chiarella & Rahimi, 2018). Others

are of the idea that some people cause mental illness unto self and could absorb it to their system (Corrigan et al., 2013). A few individuals with mental illness mentioned negative thoughts and emotions as contributors to their illnesses (Mbutia et al., 2018). The view of mental illness and its onset differs according to gender differences.

A patient's conceptualisation that their illness is self-inflicted (internal attribution) affects their will to seek treatment because of community stigmatisation, shame and fear; resorting to family care in which it risks psychological problems and impaired quality of life (De Abreu Ramos-Cerqueira, Torres, Torresan, Negreiros & Vitorino, 2008). As such, there is a perception of future failures regarding recovery (Weiner et al., 1988).

Patients of mental illness tend not to seek help or visit medical institutions for treatment when experiencing feelings of shame, stigmatisation and exclusion, and are embarrassed to mention or let their friends find out about their illness (Jagdeo, Cox, Stein & Sareen, 2009), which contributes to late interventions and reintegration into their communities.

## **2.9 Concluding remarks**

It has been argued that lay people hold negative attitudes within rural settings, supporting the perception of mental illness emanating from witchcraft and attributed as self-inflicted illness. However, Western communities hold contrary knowledge and attitudes towards mental illness based on scientific knowledge indicating mental illness to be a chemical imbalance. Held negative attitudes contribute towards stigmatisation (self-stigmatisation and/or familial stigmatisation etc.), which hinders early diagnosis contributing to prolonged periods of seeking adequate psychiatric and Western medical treatment.

The attribution theory is considered the suitable theoretical framework for the present study as the aim of the study sets out to understand knowledge and attitudes held towards mental illness in a rural setting. Attribution and lay theories serve as major contributors to the formation of knowledge of both negative and positive attitudes towards mental illness.

The cause, prevalence and treatment of mental illness depend on various cultural beliefs, societal expectations, religious affiliation and the level of education that one

holds. How mental illness emanates contributes to the sort of treatment that the individual is most likely to seek for recovery. Within African communities, culture, religion, level of education and societal pressures push a mentally ill person living in rural communities to seek treatment from a traditional healer, prayers from church or even avoidance and denial of their sickness. However, in Western communities where there is a high level of educational achievement and employment, those with mental illness are most likely to seek treatment of a medical professional, and hold positive attitudes and better knowledge of mental illness and its treatment.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

The previous chapter focussed on the literature review and theoretical framework of the study. This chapter deliberates on the methodology of the study in which the research methodology strives to explain the logic behind research methods and their techniques (Welman, Kruger & Mitchell, 2005). This section will discuss the way in which research has been carried out, including: research design, sampling, research instrument, data collection, data analysis as well as ethical considerations.

#### **3.2 Research design**

This is a cross-sectional quantitative study conducted at Dikgopheng village, GaDikgale, and explores knowledge and attitudes of community members towards mental illness. According to Christensen, Johnson and Turner (2011), a cross-sectional survey seeks to collect data from research participants during a single and brief time to draw conclusions from it.

#### **3.3 Description of the study's population**

The participants were adults from GaDikgale with a mean age of 18 to 92 years; out of which 187 were females and 62 males. The participants were either working or unemployed, pensioners or self-employed, with a large (n=77) number having not completed their high school education.

#### **3.4 Sampling procedure**

The participants of the study were selected from the Dikgopheng community at GaDikgale using a simple random sampling method. A sample size of 249 individuals participated and were selected using Krejcie and Morgan's (1970) table to determine the sample size from the given population. The targeted participants include residences aged from 18+ living at GaDikgale, and were either male or female. The use of a simple random sampling method allows each member of the community equal chance of participating in the study (Babbie & Mouton, 2012). The researcher assigned a single number to each community member in which a table of random numbers were used to select the sample without skipping any number (Thompson, 2012). Furthermore, data collection was done using structured questionnaires that helped obtain information regarding knowledge and attitudes

held towards mental illness in Dikgopheng community. A total of 249 participants completed the questionnaires voluntarily.



Figure 1. Map of South Africa and Limpopo Province, GaDikgale

### 3.5 Instruments

The study used three scales to measure the demographic data, knowledge and attitudes held towards mental illness in a rural setting, namely: the Demographic scale, the Mental Health Knowledge Schedule (MAKS) and the Attitude Scale for Mental Illness (ASMI).

#### 3.5.1 Demographic data scale

Demographic data was collected using a self-report instrument for the following variables: gender, age, educational level, religion and work status (See **Appendix 1a**- English version; and **Appendix 1b**- Sepedi version) which was a back-to-back translation. The original language of both the MAKS and ASMI is English. As a result, a back-to-back translation was done by an experienced translator. Sepedi is the national language of the participants. The questionnaire items were read out to participants who could not read. They were assisted to complete the questionnaires.

#### 3.5.2 The Mental Health Knowledge Schedule (MAKS)

The adapted version of the Mental Health Knowledge Schedule (MAKS) (see **Appendix 2a**- English version and; **Appendix 2b** - Sepedi version) was used as a tool to gather data on the level of knowledge towards mental illness. It comprised 11 research questions on a 5-point Likert scale with the following ranges and corresponding meanings: 1 - "Strongly disagree", 2 – "Disagree", 3 – "Uncertain", 4 – "Agree" and 5 – "Strongly agree". This scale was used based on the fact that it is a



brief and feasible instrument of collecting stigma related mental health knowledge. However, it is not sufficient to be used alone in determining stigmatisation on mental illness; it is required to be coupled with attitude related measures (Evans-Lacko, et al. 2010).

### 3.5.3 *The Attitude Scale for Mental Illness (ASMI)*

The ASMI questionnaire consisted of six subscales presented into 34 items namely: separatism, which included 10 items from the questionnaire (1- 9 and 24), and emphasised the community needing patients of mental illness to be treated in institutions away from the community (Pelzang, 2010). Stereotyping included 4 items (10 – 13) defining people with mental illness based on certain behavioural patterns and mental ability, labelling them as dangerous and unpredictable (Corrigan & Bink, 2016). Restrictiveness consisted of 4 items (14 - 17) that held an uncertain view on the rights of people with mental illness (Hahn, 2002).

One of the subscales includes benevolence that consisted of 8 items (18 -23, 25 and 26), which set out to measure the kindness that people have towards people with mental illness (Salve, Goswami, Sagar, Nongkynrih & Sreenivas, 2013), which can be described as paternalistic and sympathetic views associated with religious and humanistic values (Hinkelman & Granello, 2003). Pessimistic prediction subscale comprised of 4 items (27 – 30) that are identified as the view that people with mental illness are unlikely to improve, and included items indicating views held towards mental illness, and if such views are likely to improve (Salve et al., 2013). The stigmatisation subscale set out to measure negative and shameful attitudes towards mental illness (Salve et al., 2013), and included 4 items (31 – 34) that people perceive mental illness as shameful, and that it should be hidden from society.

The Attitude Scale for Mental illness (ASMI) (see **Appendix 3a** English version, and **Appendix 3b-** Sepedi version), which was used by the researcher is also a 5-point Likert scale with similar meanings, and ranges as MAKES. The ASMI is the modified version of opinions about mental illness in Chinese community (OMCC) questionnaire (Ng & Chan, 2000). The ASMI questionnaire was developed by Basson, Julie and Adejum (2012), who sought to study a group of professional nurses' attitudes and perceptions towards the mentally ill in a psychiatric hospital setting. The scale used yielded satisfactory psychometric properties based on the

notion that it has been used on numerous and different populations (Cohen & Struening, 1962).

### 3.6 Reliability and validity of the study

A survey pilot study was administered to a sample like that of the selected sample to ensure the accuracy and non-bias of the questionnaire before being administered to the specific sample population (Gumucio, 2011). The pilot study was administered to ten participants who were also included in the final sample of the study. The MAKES and ASMI with a total of 45 items from both scales yielded a high internal consistency of .695. The researcher, along with other experienced and professional personnel, reviewed and assessed the scales to ensure the validity of the questionnaires.

#### 3.6.1 Reliability statistics

*Table 1: Reliability statistics of the MAKES scale (Cronbach A)*

A	N	$\alpha$ on standardised items
0.71	45	.695

*Note:* Subscales ranged from average to good

Cronbach alpha computation indicated a score of 0.71, which indicates an acceptable internal consistency for the MAKES scale showing that the test is reliable.

*Table 2: Individual Cronbach A reliability statistics of the ASMI subscales*

Subscales	N	A
Separatism	10	0.77
Stereotyping	4	0.78
Restrictiveness	4	0.80
Benevolence	8	0.40
Pessimistic Prediction	4	0.57
Stigmatisation	4	0.70

The Cronbach's Alpha of the ASMI questionnaire along with the questionnaire's subscales is ranged from average to good. Cronbach alpha sets out to estimate and test an instrument's reliability (Gliem & Gliem, 2003), and according to DeVellis

(2003), a scale's Cronbach's Alpha must be above .7 to be regarded as a valid measurement.

### *3.6.2 Validity*

The accuracy of validity on the ASMI scale was concluded on the basis of face validity, which indicates that the instrument is set to measure the appropriate construct (Polit & Beck, 2004).

### **3.7 Procedure**

The questionnaires were administered in either English or Sepedi depending on the participants' preference of face-to-face, read aloud, or the participants completed them on their own. The researcher made a brief introduction, indicating the procedure of completing the questionnaire, ensuring anonymity of each participant and that participation is voluntary, and that they were welcome to stop the procedure should they feel a need to do so during any time of completing the questionnaire with no consequences. The covering letter in English which was translated to Sepedi clarified the intention and purpose of the study. A consent form which required to be completed by every participant before answering the questions was attached to each questionnaire. Furthermore, demographic data was collected for every participant.

Participants were asked to rate each statement about knowledge held and attitudes towards mental illness on a 5-point Likert scale ranging from "totally disagree" to "totally agree" of the MAKES questionnaire. Thereafter, the scales were broken down into subscales of each to make sense of the data. Subscale one from the MAKES questionnaire comprised of stigma-related knowledge and the conceptualisation of mental illness namely: help-seeking, recognition, support, employment, treatment and recovery (Evans-Lacko et al., 2010). The ASMI had 34 questions that are scored on a 5-point Likert scale set out to determine attitudes held by GaDikgale community members towards mental illness. The questionnaire was administered face to face to all 249 participants.

### **3.8 Data analysis**

The Statistical Package for the Social Science (SPSS) software package for Windows (Version 24) was used to analyse the data collected. The SPSS was used to generate percentages to indicate the nature of knowledge and attitudes of rural community members. The ASMI scale was grouped into six subscales, namely; separatism, stereotyping, restrictiveness, benevolence, pessimistic prediction and

stigmatisation. MANOVA'S was used to test levels of differences in the knowledge and attitudes towards mental illness according to gender and age.

### **3.9 Ethical considerations**

This study is part of a bigger investigation supported by Vlaamse Interuniversitaire Raad – institutional University Cooperation (VLIR – IUC). The bigger study, which is entitled “Human wellness in the context of global change – finding solutions for rural Africa”, aims to develop and introduce an intervention programme for prevention, control and management of chronic diseases in rural communities. Though ethical clearance has been sought and obtained for the bigger study, the researcher in the present study obtained ethical clearance from the University of Limpopo's Research Ethics Committee before commencing with her study.

#### *3.9.1 Confidentiality.*

Participants were assured that the researcher would practise anonymity and confidentiality during and after information gathering. It was thoroughly clarified to them that data collected will not be divulged outside the content of the study, and their real names will not be revealed. Furthermore, participants were made aware that should at any moment the need arises, the researcher would make use of codes or pseudo names to identify the participants.

#### *3.9.2 Voluntary participation.*

The participants were informed that participation is voluntary and that they can withdraw at any stage during completion of the questionnaires should they wish to do so, and that there would not be consequences.

#### *3.9.3 Anonymity.*

Anonymity and confidentiality was assured to each participant by ensuring that their identity will not be revealed. Participants were identified by using codes or pseudo names should the need arise.

#### *3.9.4 Informed consent.*

According to Christensen et al. (2011), research participants are entitled to be fully informed about the reason, aims, and purpose of an investigation. In line with this ethical principle, the participants were informed about the purpose of the study (see **Appendix 2a**), why it was being done, and how it can, directly and indirectly, affect

them. They were also given a consent form to sign before they could participate in the study (see **Appendix 2a**- Informed consent letter and form – English version, and **Appendix 2b**- Informed consent letter and form – Sepedi version), which were attached to the questionnaires. Furthermore, they were informed that participation is voluntary and that they can withdraw at any stage should they wish to do so.

### **3.10 Conclusion**

In this chapter, research methodological features were considered and discussed with relevant stakeholders before the commencement of the study. Permission to collect the data was granted, and data collection and analysis methods were discussed and agreed upon.

## CHAPTER 4

### RESULTS

#### 4.1 Introduction

The previous chapter addressed the issue of research methodology, research design and data collection. The present chapter presents the findings of this study, which include the demographic information of participants, and information about knowledge and attitudes of rural community members towards mental illness. The demographic information of participants is presented in the form of tables with narratives that describe their pertinent characteristics.

Members of Ga Dikgale community, which is depicted on tables, used the Mental Health Knowledge Schedule (MAKS) to measure their level of knowledge of mental illness. Furthermore, the kind of attitudes these members have towards mental illness were measured using the Attitudes Scale for Mental Illness (ASMI). This chapter is concluded by a summary of the findings.

#### 4.2 Hypothesis

According to Babbie (2013), a hypothesis is a testable reality that can be or might not be supported by research. In the current study, the researcher set out to test the following hypothesis.

##### *4.2.1 Hypothesis 1.*

There is a significant difference in the level of knowledge of mental illness by members of GaDikgale community according to gender and age.

##### *4.2.2 Hypothesis 2.*

There is a significant difference in attitudes towards mental illness by members of GaDikgale community according to gender and age.

### 4.3 Demographic characteristics of participants

*Table 3: Demographic characteristics of participants*

Demographic data		<i>n</i> = 249	%
Age	<30	60	23%
	30+	189	77%
Gender	Male	62	27%
	Female	187	144%
Religion	Christianity	55	24%
	Indigenous African religion	2	.4%
	Islamic religion	0	.4%
	Jewish	5	.4%
	Other:	187	74%
Education	No formal education	36	15%
	Primary school	38	15%
	Completed primary school	23	8%
	High school	77	31%
	Completed high school	46	19%
	Tertiary level	29	11%
Employment	Not employed	140	57%
	Employed	19	7%
	Self- employed	13	6%
	Pensioner	62	25%
	Student	15	6%

The demographic characteristics in Table 3 include the participants' age, gender, religious background, education level and employment statuses. According to the data gathered, as many as 189 (77%) participants were aged below 30, while only 60 (23%) of the participants were between the ages of 31 to 95 years old. Of the 249

participants, 187 were female and 27% (62) were male. Additionally, a large number (187) of them belonged to a religious entity apart from Christianity, Jewish, Islamic or Indigenous African religion, with the second largest religious affiliation being Christianity at 24% (55).

The demographic data indicated that a large number (77) of the participants having not completed their high school studies, 46 of them only completed high school, 38 did not complete primary school, 36 had no formal education, while 29 had tertiary education and only 23 completed primary education. From the 249 participants, 140 were not employed, while 62 of them were pensioners, with 19 of the participants being employed at the time of the study. Of all these, only 13 were self-employed and 15 were tertiary students. The questionnaires used were written in English. However, all the participants were Sepedi speaking, which resulted in the questionnaires being translated from English into Sepedi to enable the respondents to partake in the study.



#### 4.4 Descriptive statistics on knowledge and attitudes towards mental illness based on participants' educational level

Table 4: MANOVA: Education Level

	Level of Education						Group comparison			<i>post-hoc</i>	
	<i>No Formal</i>	<i>In primary</i>	<i>Primary completed</i>	<i>In High School</i>	<i>High School Completed</i>	<i>Tertiary</i>	<i>Wilks <math>\Lambda</math></i>	<i>F</i>	<i>P</i>	$\eta_p^2$	<i>p</i>
<b>N</b>	36 (14%)	38 (15%)	23 (9%)	77 (31%)	46 (19%)	29 (12%)	0.703	1.92	< 0.001	.08	
	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>	<i>M (SD)</i>					
<b>Knowledge</b>	18.72 (1.63)	18.53 (2.09)	19.09 (1.47)	18.38 (1.72)	18.15 (1.74)	18.00 (2.04)					n/s
<b>Concept</b>	17.83 (4.22)	17.97 (4.81)	18.52 (4.95)	18.13 (4.35)	17.52 (4.55)	17.38 (5.68)					n/s
<b>Knowl&amp; Concept</b>	36.33 (3.33)	36.56 (4.81)	36.50 (5.76)	37.61 (5.63)	36.51 (5.01)	35.67 (5.47)					n/s
<b>Attitude</b>	104.53 (8.00)	104.18 (8.17)	104.61 (7.12)	104.25 (9.00)	101.72 (6.10)	98.10 (5.51)					< 0.05*
<b>Separatism</b>	29.39 (15.37)	29.21 (3.47)	29.09 (2.43)	29.42 (3.29)	28.22 (3.07)	27.45 (2.31)					n/s
<b>Stereotype</b>	14.28 (1.61)	14.00 (1.85)	15.00 (1.76)	13.86 (2.17)	13.70 (1.85)	12.90 (2.24)					< 0.01**
<b>Restrictive</b>	12.53 (2.41)	12.47 (2.53)	12.43 (2.56)	11.75 (2.66)	10.46 (2.24)	10.21 (2.19)					< 0.05***
<b>Benevolence</b>	27.11 (2.67)	27.00 (2.37)	27.22 (3.58)	27.22 (2.66)	27.74 (2.63)	27.55 (2.44)					n/s
<b>Pessimistic</b>	10.25 (2.10)	11.00 (2.59)	11.26 (2.22)	11.44 (2.85)	11.80 (1.85)	11.24 (2.25)					n/s
<b>Stigmatise</b>	9.89 (1.80)	10.50 (2.11)	10.04 (2.14)	10.32 (2.76)	9.72 (2.01)	8.55 (2.08)					< 0.01****

\* The tertiary educated group scored significantly lower than the other groups ( $p < 0.05$ ), except than those who completed High School (n/s).

\*\*The tertiary educated group scored significantly lower than the group that completed primary school ( $p = 0.002$ ). Other groups: no significant differences.

\*\*\* The tertiary and high school completed groups scored significantly lower than the groups with no formal and primary education and those still in high school ( $p < 0.05$ ).

\*\*\*\* The tertiary educated group scored significantly lower than the groups who were still in primary ( $p = 0.009$ ) and high school ( $p = 0.006$ ). Other groups: no significant differences.

The MANOVA findings in Table 4 indicate the educational level (comprising those with no formal education, no primary school education, those who completed primary school, those with no high school education, those who completed high school and those with a tertiary qualification) of the study participants. The findings reveal that 77(31%) of the participants have not completed their high school studies, 46(19%) of them only completed high school, 38(15%) did not complete primary school, 36(14%) had no formal education, 29(12%) had tertiary education and only 23(9%) completed their primary education.

The MANOVA results on attitude revealed that there were no negative, stereotypic and stigmatised attitudes towards people with mental illness from the current participants. Furthermore, there was no statistical significance in separatism, benevolence and pessimistic on knowledge and attitudes of mental illness in GaDikgale in relation to the level of education. This suggests that the level of education contributes to knowledge and attitudes held.

#### 4.5 Descriptive statistics on knowledge and conceptualisation towards mental illness using MAKs

*Table 5: Descriptive statistics: Knowledge and conceptualisation*

Gender	Age	<i>N</i>	$\pm SD$
Male	<30	17	38.41 $\pm$ 4.57
Male	30+	45	38.13 $\pm$ 4.91
Female	<30	43	33.60 $\pm$ 5.25
Female	30+	144	36.33 $\pm$ 5.38

Table 5 shows descriptive statistics for the knowledge and conceptualisation scale. It is apparent that 17 males who were less than 30 years of age obtained an average score of 38.41 (4.57); 45 males who were over the age of 30 obtained an average

score of 38.13 (4.91); 43 females aged less than 30 had a mean score of 33.60 (5.25); and 144 females who were over 30 in age scored on average 36.33 (5.38). Thus, these descriptive scores suggest that females obtained a lower mean score than males.

#### 4.5.1 MANOVA: Knowledge and conceptualisation

Table 6: MANOVA: Knowledge and conceptualisation

	<i>DF</i>	<i>F</i>	<i>P</i>	Partial eta-squared
Gender	1, 245	14.380	<0.001	0.06
Age	1, 245	1.978	0.16	0.01
Gender*Age	1, 245	2.98	0.09	0.01

The Manova findings in Table 6 reveal the main effect of gender ( $F(1, 245) = 14.38$ ,  $p < 0.001$ ,  $\eta_p^2 = 0.06$ ). Additionally, it showed no effect of age, neither main nor interacting. As reflected in Figure 2, the males scored significantly higher on the knowledge and conceptualisation scale than the females.

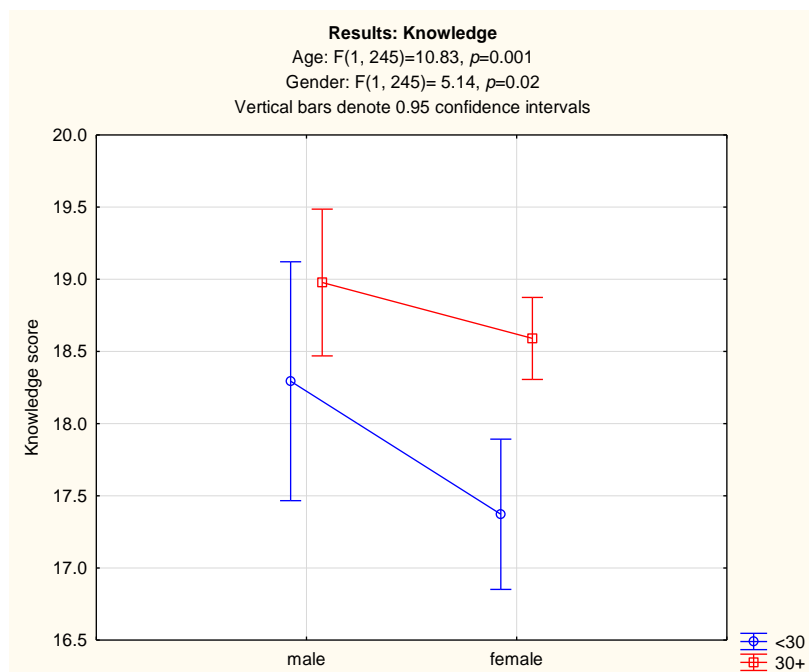


Figure 2: Knowledge conceptualisation according to gender

#### 4.6 Descriptive statistics on attitudes ASMI scale

The ASMI questionnaire comprised of six subscales used to determine attitudes towards mental illness, namely; separatism, stereotyping, restrictiveness, benevolence, pessimistic prediction and stigmatisation.

##### 4.6.1 Separatism

Table 7: Descriptive statistics: Separatism

Gender	Age	<i>N</i>	± SD
Male	<30	17	25.88±3.52
	30+	45	28.87 ±2.96
Female	<30	43	28.23±3.18
	30+	144	29.47 ±2.95

Table 7 shows the descriptive statistics for one of the subscales of ASMI, separatism. It seems that 17 males who were below the age of 30 years obtained an average score of 25.88 (3.52); 45 males who were over the age of 30 years obtained an average score of 28.87 (2.96); 43 females below the age of 30 years old had a mean score of 28.23 (3.18); and 144 females who were above 30 years scored an average of 29.47 (2.95). Thus, the descriptive scores suggest that the males scored lower mean score than the females.

Table 8: MANOVA: Separatism

	Degree of – Freedom	<i>F</i>	<i>P</i>	Partial eta-squared
Gender	1, 245	8.49	0.004	0.03
Age	1, 245	17.37	<0.001	0.07
Gender*Age	1, 245	3.00	0.08	0.01

The Manova findings in Table 8 point out the main effects of gender ( $F(1, 245) = 8.49, p= 0.004, \eta_p^2 = 0.03$ ) and of age ( $F(1, 245) = 17.37, p < 0.001, \eta_p^2 = 0.07$ ). Furthermore, it shows no interacting effect of age and gender. As reflected in Figure

3, females scored significantly higher than male participants on the separatism subscale of the ASMI.

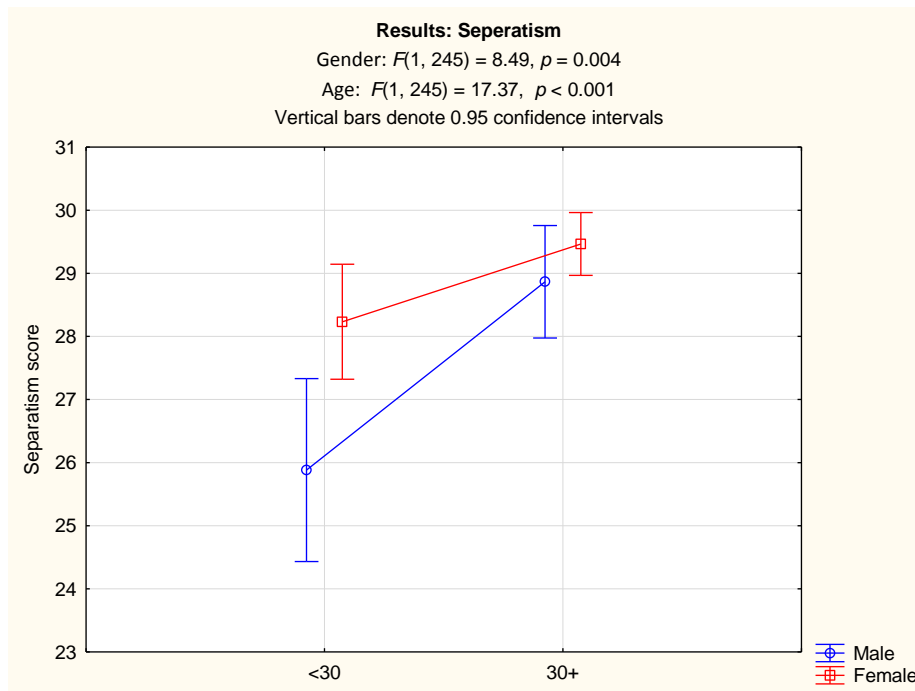


Figure 3: Performance on the Separatism scale of the ASMI according to gender effects

#### 4.6.2 Stereotyping

Table 9: Descriptive Statistics: Stereotyping

Gender	Age	N	± SD
Male	<30	17	13.65 ±2.26
	30+	45	14.31±2.13
Female	<30	43	12.98 ±1.91
	30+	144	14.08±1.91

Table 9 shows the descriptive statistics of the stereotyping subscale of ASMI. It indicates that 17 male participants aged below 30 obtained an average score 13.65 (2.26), 45 male participants above the age of 30 obtained an average score of 14.31 (2.13), 43 females of the age below 30 scored a mean score 12.98 (1.91) and 144 female participants above the age of 30 scored average score 14.08 (1.31).

Meaning, the descriptive scores suggest that both the younger age group obtained a lower mean score than the older age group.

Table 10: MANOVA: Stereotyping

	<i>DF</i>	<i>F</i>	<i>P</i>	Partial eta-squared
Gender	1, 245	1.86	0.17	0.01
Age	1, 245	7.24	0.01	0.03
Gender*Age	1, 245	0.45	0.50	0.01

The Manova findings in Table 10 suggest that there was a main effect of age ( $F(1, 245) = 7.24, p = 0.01, \eta_p^2 = 0.03$ ), and that there was no effect of gender, neither main nor interacting. The older age group (30+) scored significantly higher on the stereotyping variable than the younger (<30) group. This is reflected in Figure 4 below.

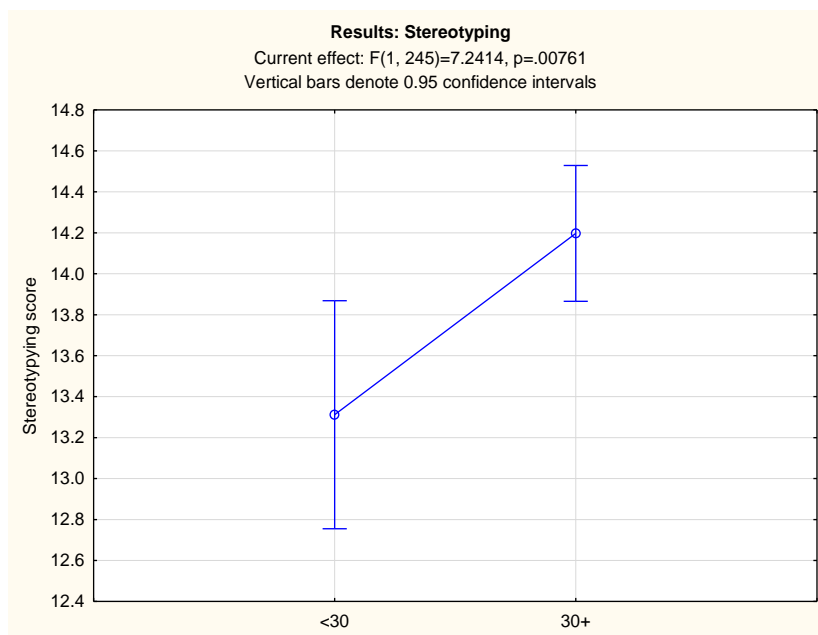


Figure 4. Performance on the Stereotyping scale of the ASMI according to age group effects

### 4.6.3 Restrictiveness

Table 11: Descriptive statistics: Restrictiveness

Gender	Age	<i>N</i>	± SD
Male	<30	17	10.18 ±2.46
	30+	45	12.02±2.88
Female	<30	43	10.56 ±2.42
	30+	144	11.98 ±2.45

Table 11 shows descriptive statistics for restrictiveness of the subscales of the ASMI scale. It is apparent that 17 of the male participants who were less than 30 years of age obtained an average score of 10.18 (2.46); 45 males who were above the age of 30 obtained an average score of 12.02 (2.88); 43 females aged less than 30 had a mean score of 10.56 (2.42); and 144 females who were of the age of over 30 scored an average score of 11.98 (2.45). Thus, these descriptive scores suggest that the younger group obtained a lower mean score than the older group.

Table 12: MANOVA: Restrictiveness

	<i>DF</i>	<i>F</i>	<i>P</i>	Partial eta-squared
Gender	1, 245	0.16	0.69	<0.001
Age	1, 245	15.02	<0.001	0.06
Gender*Age	1, 245	0.25	0.61	0.001

The Manova findings in Table 11 shows that as reflected in Figure 5, there was a main effect of age ( $F(1, 245) = 15.02, p < 0.001, \eta_p^2 = 0.06$ ). However, there was no effect of gender, neither main nor interacting.

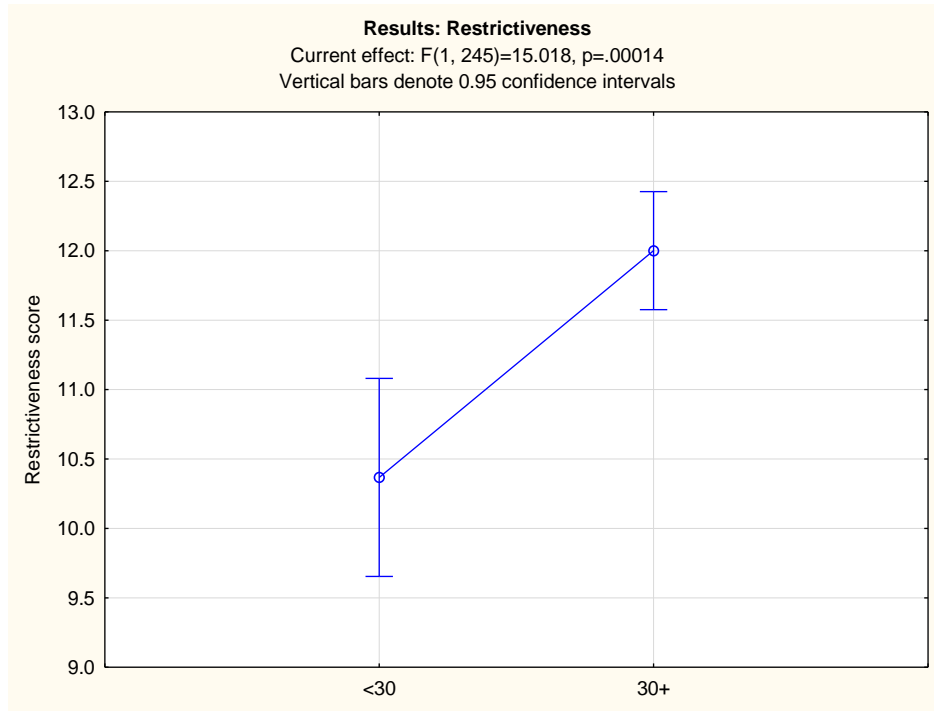


Figure 5. Performance on the Restrictiveness scale of the ASMI according to age effects

#### 4.6.4 Benevolence

Table 13: Descriptive Statistics: Benevolence

Gender	Age	<i>n</i>	± SD
Male	<30	17	27.35±3.00
	30+	45	27.38 ±3.02
Female	<30	43	27.74±2.31
	30+	144	27.15 ±2.62

Table 13 indicates descriptive statistics of benevolence subscale of the ASMI. It suggests that 17 male participants aged below the age of 30 years obtained an average score of 27.35 (3.00); 45 of the male participants obtained an average score of 27.38 (3.02); 43 females of the age below 30 years obtained a mean score of 27.74 (2.31); and 144 females aged above 30 years of age obtained an average score of 27.15 (2.62). Thus, the descriptive scores suggest that the benevolence variable was not statistically significant.



Table 14: MANOVA: Benevolence

	<i>DF</i>	<i>F</i>	<i>P</i>	Partial eta-squared
Gender	1, 245	0.03	0.86	<0.001
Age	1, 245	0.41	0.52	0.002
Gender*Age	1, 245	0.49	0.49	0.002

The Manova findings in Table 14 suggests that there were no effects of gender and age, neither main nor interacting.

#### 4.6.5 Pessimistic prediction.

Table 15: Descriptive statistics: Pessimistic prediction

Gender	Age	<i>n</i>	$\pm$ SD
Male	<30	17	11.76 $\pm$ 2.25
	30+	45	11.33 $\pm$ 3.08
Female	<30	43	11.56 $\pm$ 2.17
	30+	144	11.03 $\pm$ 2.32

Table 15 indicates the descriptive statistics of the pessimistic prediction subscale of the ASMI. From the 249 participants 17 males below the age of 30 years obtained an average score of 11.76 (2.25); 45 males aged above 30 years of age obtained an average score of 11.33 (3.08); 43 females aged below the age of 30 years obtained an average score of 11.56 (2.17) and 144 female aged above the age of 30 year obtained a mean score of 11.03 (2.32).

Table 16: MANOVA: Pessimistic prediction

	<i>DF</i>	<i>F</i>	<i>P</i>	Partial eta-squared
Gender	1, 245	0.38	0.54	0.002
Age	1, 245	1.37	0.24	0.006
Gender*Age	1, 245	0.01	0.91	<0.001

There were no effects of gender and age, neither main nor interacting; therefore, the results of the variable pessimistic prediction were not statistically significant.

#### 4.6.6 Stigmatisation

Table 17: Descriptive Statistics: Stigmatisation

Gender	Age	<i>n</i>	± SD
Male	<30	17	10.00±3.12
	30+	45	10.40±2.56
Female	<30	43	9.79±2.32
	30+	144	9.84±2.15

Table 17 shows descriptive statistics for stigmatisation subscale of the ASMI scale. It is apparent that 17 males who were less than 30 years of age obtained an average score of 10.00 (3.12); 45 males who were over the age of 30 years obtained an average score of 10.40 (2.56); 43 females aged less than 30 had a mean score of 9.79 (2.32); and 144 females who were of the age of over 30 scored on average 9.84 (2.15).

Table 18: MANOVA: Stigmatisation

	<i>DF</i>	<i>F</i>	<i>P</i>	Partial eta-squared
Gender	1, 245	0.98	0.32	0.004
Age	1, 245	0.33	0.56	0.001
Gender*Age	1, 245	0.20	0.65	<0.001

The Manova findings in Table 18 suggest that variables stigmatisation were not statistically significant because there were no effects of gender and age, neither main nor interacting.

#### 4.6.7 Overall attitudes.

Table 19: Descriptive statistics: Overall attitudes

Gender	Age	<i>N</i>	$\pm$ SD
Male	<30	17	98.82 $\pm$ 7.38
	30+	45	104.58 $\pm$ 8.26
Female	<30	43	100.95 $\pm$ 6.69
	30+	144	103.58 $\pm$ 8.09

Table 19 indicates the overall descriptive statistics of the ASMI scale. It is apparent that 17 males who were aged below 30 obtained an average score of 98.82 (7.37); 45 males aged above 30 obtained an average score of 104.58 (8.26); 43 females who were aged below the age of 30 obtained an average score of 100.95 (6.69); and 144 females who were aged above 30 obtained an average score of 103.58 (8.09).

Table 20: MANOVA: Attitudes overall

	<i>DF</i>	<i>F</i>	<i>P</i>	Partial eta-squared
Gender	1, 245	0.19	0.67	<0.001
Age	1, 245	10.24	0.002	0.04
Gender*Age	1, 245	1.42	0.23	0.01

The Manova findings in Table 20 suggests that there was a main effect of age ( $F(1, 245) = 10.24, p= 0.04, \eta_p^2 = 0.04$ ) and no effect of gender, neither main nor interacting. The older age group (30+) scored significantly higher on the overall attitudes variable than the younger (<30) group of participants.

## 4.7 Summary of findings

Table 21: Summary of results

Variable	Gender effect			Age effect		
		P	$\eta_p^2$		P	$\eta_p^2$
Knowledge	M > F	0.02	0.02	Y > O	0.001	0.04
Conceptualisation	M > F	< 0.001	0.05	-	Ns	-
Knowledge and Concept	M > F	< 0.001	0.06	-	Ns	-
Overall Attitudes	-	Ns	-	O > Y	0.002	0.04
Separatism	F > M	0.004	0.03	O > Y	<0.001	0.07
Stereotyping	-	Ns	-	O > Y	0.01	0.03
Restrictiveness	-	Ns	-	O > Y	< 0.001	0.06
Benevolence	-	Ns	-	-	Ns	-
Pessimistic prediction	-	Ns	-	-	Ns	-
Stigmatisation	-	Ns	-	-	Ns	-

*Notes'* = Male, F = Female, Y = Younger age group (<30), O = Older age group (30+), ns = not significant

There exists a statistical significance on the knowledge and the conceptualisation of mental illness on both gender and age. It was revealed that social distance is prevalent in females than it is in male participants. However, there was no statistical significance in age and gender on the stereotyping, restrictiveness, benevolence, pessimistic prediction and stigmatisation scales.

## CHAPTER 5

### DISCUSSION OF FINDINGS AND CONCLUSIONS

#### 5.1 Introduction

This chapter presents and discusses the study findings in relation to the literature. The researcher will discuss the level of knowledge and attitudes held by community members in GaDikgale towards mental illness determined by their demographic backgrounds, MAKS and ASMI scales.

#### 5.2 Findings of the study

The present study was conducted at Dikgopheng community, GaDikgale, to 249 participants (27% male and 144% female participants). Amongst the participants, 23% were below the age of 30 years, and 77% were above the age of 30. The study set out to find if there are any differences in gender and age on knowledge and attitudes towards mental illness in a rural setting.

The overall findings of the knowledge scale (MAKS) indicate differences in age towards mental illness and no difference in gender towards the illness. The attribution theory applied in this study explains that a person is responsible for their illness. Mental illness is regarded and understood in various aspects depending on a person's surroundings, perspectives and attitudes, including beliefs that those with a mental illness are playing into assumed roles, impersonated roles or are genuinely ill (Hyland, 2011). The ASMI scale revealed significant difference in age on mental illness and no difference in gender. Negative attributes on self and people of mental illness is supported by Jagdeo et al. (2009), who revealed the avoidance of patients with mental illness to friends. Gateshill, Kucharska-Pietura and Wattis (2011) revealed positive knowledge and attitudes towards mental illness from professional healthcare workers.

#### 5.3 The level of knowledge on mental illness by members of GaDikgale community according to gender and age

Negative attitudes towards mental illness constitute the community's level of knowledge towards the illness. This is supported by findings from Nxumalo and Mchunu (2017), who revealed that community members would blame patients for unjust acts. This will consequently require family members to pay for the damage claimed to have been caused by mentally ill individuals. Amugune and Verster

(2016) state that the violations of human rights against the mentally ill, lack of respect and inadequate emotional support are challenges that undermine efforts to address unmet poor mental ill needs.

In Somalia, patients with mental illness are restrained by chains as cultural practices and medical interventions of participating in the process of treatment (WHO, 2010). The prevalence of mental illness in South Africa was found to be at 36% (Sorsdahl & Stein, 2010), supporting facts that one in three South Africans will have a mental illness at some point in their lives (Jack et al., 2014). This will result in mental health facilities and services requiring extensive amounts of money for treatment (Madzhe et al., 2014). Traditional healers in Mpumalanga revealed using forceful tactics such as tying the patient with ropes and chains to ensure the patient adheres to treatment (Sorsdahl, Flisher, Wilson & Stein, 2010).

In the present study, male participants (38.41%) held more knowledge towards mental illness as compared to the study's female participants (36.33%). The barriers indicated lack of knowledge of mental health services perceived by young individuals. Moreover, they do not consider general practitioners as relevant options in the treatment and distress of mental illness (Gulliver, Griffiths & Christensen, 2010).

Both ages represented in the current study have shown no significant difference on mental illness. However, young adults who perceive those with a mental illness as being dangerous are most likely to suggest help of a psychiatrist (Yap, Wright & Jorm, 2011). Even so, 44.7% of male participants who were knowledgeable of mental illness were of the idea that supernatural causes are the onset of the illness, while a quarter (females) of that study attributed it to natural causes (Olawande, Jegede, Edewor & Fasasi, 2018). Although religious and cultural beliefs hold the onset to mental illness as supernatural causes, ancestral or God's punishment, Lerobane, Ngoveni, Mahlangu and Matjekana (2017) hold the knowledge that mental illness emanates from biological, psychological, social and environmental factors.

The treatment gap of mental illness remains very high (90%) in low resourced countries (Patel et al., 2010). Poverty is a risk factor in the development of depression that occurs from social exclusion, violence, trauma and high levels of stress (Lund et al., 2011). Within the South African context, few of its population

seek treatment for their mental illness (Lerobane et al., 2017). This is associated with low knowledge and high stigmatisation that is prevalent in South Africa (Hugo et al., 2003). However, it has been revealed that one in four South Africans who have a common mental illness receives treatment (Petersen et al., 2016).

Given the high rate of maternal depression (Hartley et al., 2011), this is alarming as it serves as a contributor to the wellbeing and growth development of the child (Walker et al., 2007). However, possible early interventions of information sharing, and awareness can combat the risk of mental ill health development later in life (Grove, Riebschleger, Bosch, Cavanaugh & van der Ende, 2017).

Mental illness can be defined as cognitive, emotional and behavioural difficulties that interfere with interpersonal relationships, work, home and/or school (Uys & Middleton, 2010). Although the participants hold different and contradicting facts of the cause of mental illness, 72% of male participants from Nigeria and 91% of female participants of the same study support the statement that mental illness is curable (Olawande et al., 2018), suggesting and alluding that more knowledge on mental health encourages openness and the possibility of pursuing and sticking to treatment (Schomerus et al., 2012).

#### **5.4 Attitudes towards mental illness by members of GaDikgale community according to gender and age**

There was a statistical significant difference on age on the attitudes towards mental illness in the current study. Older participants scored significantly higher than younger participants. The older participants held more positive attitudes towards mental illness, with both genders showing no significant difference in their attitudes towards mental illness within the community. Upadhyay, Srivastava, Singh and Poddar (2016) revealed that females were socially restrictive and discriminative as compared to males.

##### *5.4.1 Separatism*

The high score by females on separatism suggests that they are most likely to distance themselves from mentally ill patients than males, which then contributes to avoidance and abandoning these individuals (Mann & Himelein, 2004). For some, they attribute their separatism as a mechanism to keep a safe distance from these patients (Ng & Chan, 2000). On the other hand, this shows absence of knowledge on

Western medical treatment on mental illness (Kermode, Bowen, Arole, Pathare & Jorm, 2009) and the illness's onset.

Social isolation prolongs mental illness because humans rely on social surroundings, relationships and engagement with family members, friends and colleagues for self-identity, and the will to achieve social standards (WHO, 2013). Only community members, friends and family of the ill person who do not practise separatism. It can extend to the patient distancing themselves from the social world by avoiding going out, parting from friendships and not being interested in romantic relationships (Rose et al., 2011).

#### *5.4.2 Stereotyping*

The assumptions held by lay people regarding people of mental ill health contribute to stereotypic (Ayazi, Lien, Eide, Shadar & Hauff, 2014) and discriminative behaviours (Corrigan, 2000). In most cases, their rights are violated against (Thorncroft et al., 2009). Participants aged above 30 years held more stereotypic attitudes towards mental illness than those below the age of 30. This is because of low educational attainment and misinformation.

#### *5.4.3 Restrictiveness*

Restrictiveness holds an uncertain view on the rights of people with mental illness (Hahn, 2002). There is a high level of social restrictiveness within communities in Ghana, wherein there exists beliefs that mentally ill individuals are inferior and should be socially isolated (Barke et al., 2011). Older participants held more restrictive attitudes towards patients with mental illness than the younger participants. As a result, community members ignore or do not visit the patient's home (Salve, Goswami, Sagar, Nongkynrih & Sreenivas, 2013). WHO (2013) revealed possible restrictions for these individuals in practising their political and civil rights, which included the right to make decisions on issues that affected them and restriction in participating in public affairs.

Magadla and Magadla (2015) acclaimed that mental illness is a problem of the family, solely because it affects everybody in the family. Furthermore, they indicated that only 34% of MHCU were visited during rehabilitation in hospital, due to relationship problems that suffice. As a result, fear, helplessness, rage and despair is felt by these family members.



A study suggested that young participants held less favourable attitudes (Hogberg, Magnusson, Lutzen & Ewalds-Kvist, 2012) and were prone to distancing themselves from peers diagnosed with mental illness (Dogra et al., 2011), which contributes towards them growing as adults holding negative attitudes (Ndetei et al., 2016), and increases the large number of older individuals with negative and restrictive attitudes (Tinker, 2002). This will furthermore contribute to the high rate of suicide amongst adults (Reynders, Kerkhof, Molenberghs & Audenhove, 2014).

#### *5.4.4 Benevolence*

Benevolence items set out to measure kindness that may exist as held by individuals towards those with a mental illness (Salve et al., 2013). The participants of the current study did not show any sign of benevolence by both genders and age difference. Contrary to this, individuals (24.2%) with serious psychological distress agreed that people are generally caring and sympathetic towards them (Kobau & Zack, 2013). However, younger participants have shown signs of negative attitudes towards mentally ill individuals (Jagdeo et al., 2009).

There are still experiences of personal harassment, social isolation and economic exclusion from society (Kapungwe et al., 2010), which contribute to chronic unemployment and diminishing self-worth that hinders recovery (Mak, Tsang & Cheung, 2006). The above experiences ultimately reduce earnings that perpetuate the circle of poverty, low educational attainment, poor physical health and depression (Ardington & Case, 2010).

The civil rights associated with schizophrenia held by the general public consist of benevolent opinions (Loch et al., 2013). Contrary to this is the perception by lay people, professionals (Magliano, Fiorillo, De Rosa, Malangone & Maj, 2004), well-educated and religiously affiliated individuals that schizophrenia is caused by spirit, magic and spells (Ikwuka et al., 2013).

#### *5.4.5 Pessimistic prediction*

Pessimistic prediction includes items indicating the view towards mental illness, and if such views are likely to improve (Salve et al., 2013). The current study did not give any indication of change in attitudes and knowledge towards mental illness. Positive attitudes towards mental illness have been discovered to have increased in the past years amongst older individuals as compared to younger individuals (Mackenzie, Erickson, Deane & Wright, 2014). This will then contribute to the likelihood of using

Western medication (for example; pharmacotherapy) as a means of treatment from increased knowledge on the onset, prevalence and possible treatment to mental illness (Mackenzie et al., 2014).

#### *5.4.6 Stigmatisation*

There is high prevalence of stigmatisation regarding mental illness in African communities (Kakuma et al., 2010), creating fear and resistance to the use of mental healthcare services and facilities for treatment (Kakuma et al., 2010). In these [African] communities, the cause of mental illness has been regarded as self-inflicted one. As such, they are perceived as responsible for their illness (Weiner, 1995). Stigmatisation towards mentally ill patients is characterised by disgrace (Thornicroft, Rose, Kassam & Sartorius, 2007); negative attitudes, shameful behaviour, secrecy about the illness (Salve et al., 2013); labelling, separation and dominant cultural and social beliefs (Phelan & Basow, 2007), thus contributing towards access to service delivery (WHO, 2013). Within African communities, there is little to no integration of western medicines and indigenous resources (Mkhize, 2003). Contrary to this is Afrocentricity, which calls for the foregrounding of African interests, values and perspectives in understanding and defining our immediate surroundings (Asante, 2003).

Based on the participants of the current study, there was no indication of differences between both genders and age towards mental illness and stigmatisation. However, Winkler et al. (2016) indicated less stigmatisation from females as compared to males and stigma in young people due to confidentiality issues, low knowledge, feelings of fear/stress and lack of accessibility (Gulliver et al., 2010). Stigma in young people has been revealed to be acute from stresses of the preferred self and social identity clash (Clement et al., 2015).

There is a heightened association of mental illness and danger emanating from negative stigmatisation (Jorm, Reavley & Ross, 2012) on individuals suffering from schizophrenia (Loch et al., 2013), substance abuse and addiction (Livingston, Milne, Fang & Amari, 2012). Although external stigmatisation exists, anticipated discrimination, which is closely associated with self-stigmatisation (Lasalvia et al., 2013), contributes to the continuous limiting circle of life opportunities, withdrawal from social activities and walking away from life goals (Lasalvia, 2015).

## **5.5 Conclusion**

The World Health Organization (2011) stipulated mental illness as a major contributor to the global burden of diseases, with the treatment gap reaching 90% in low resourced countries (Patel et al., 2010). While most of these individuals do not know their diagnosis, their traditional healers diagnose them with ancestral issues that will be treated through induced vomiting and/or steaming (Chipps et al., 2015).

It is evident that negative attitudes still constitute and contribute to the urgency and the form of treatment administered to individuals suspected of having a mental illness. Within rural areas, mental illness is a burden to the individual and their family members, contributing to stigmatisation, isolation and poor access to adequate treatment, resulting in difficulty of reintegration. The burdensome existence of stigmatisation is the consequences of ignorance or misinformation, prejudice, attitudes and or exclusion from normal forms of social participation (Thornicroft et al., 2007).

## **5.6 Limitations of the study**

The quantitative research study undertaken had limitations in terms of providing in-depth knowledge and comprehensive explanations from the participants. Given the fact that the questionnaires were structured, and analysis used SPSS, the participants were only allowed to give structured and set out responses.

## **5.7 Recommendations**

High stigmatisation towards mental illness is encouraged by lack of awareness and false beliefs (Phasha, 2014). Based on the findings of the study, it is recommended that awareness of the onset, treatment and reintegration of people with mental illness after treatment and interventions will lower the high level of stigma and stereotypic behaviours.

A qualitative research study needs to be undertaken to find in-depth information of the non-existing difference of stereotypic behaviours, restrictiveness, benevolence, pessimistic prediction and stigmatisation between gender and age towards mental illness.

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## APPENDICES

### Appendix 1(a): Demographic characteristics

Please fill in and tick the appropriate information

1. Age (in numbers): .....
2. Gender
  - a. Male
  - b. Female
  - c. Other: .....
3. Religion
  - a. Christianity
  - b. Indigenous African Religion
  - c. Islamic religion
  - d. Jewish
  - e. Other.....
4. Current highest level of education
  - a. No formal schooling
  - b. In Primary school
  - c. Primary school completed
  - d. In High school
  - e. High school completed
  - f. Tertiary education (Post Grade 12)
5. Current employment status
  - a. Not employed
  - b. Employed
  - c. Self-employed
  - d. Pensioner
  - e. Student

## **Semamaretšwa sa 1(b): Temokerafi**

Hle tlatša o be o swaye tshedimošo ya maleba

1. Mengwaga (ka dinomoro):

a. Monna

2. Bong

b. Mosadi

3. Tumelo

a. BoKeresete

b. Tumelo ya setloso ya SeAforika

c. Kopanyo ya 1 le 2 ka godimo

d. Tše dingwe (Hlalosa):.....

4. Maemo a godimo a thuto

a. Ga ke a tsena sekolo

b. Phoraemare

c. Feditše phoraemare

d. Sekolo se phagamego

e. Ke feditše sekolo se phagamego

f. Dithuto tša godimo (Ka godimo ga kereiti ya 12)

5. Maemo a tša mošomo

a. Ga ke šome

b. Ke a šoma

c. Ke a ipereka

d. Modulagae

e. Moithuti

**Appendix 2(a): Mental health knowledge schedule (MAKS)**

Instructions: For each of statements 1– 6 below respond by ticking one box only.	
<b>(1) Strongly Disagree      (2) Disagree      (3) Uncertain      (4) Agree      (5) Strongly Agree</b>	
1. If a friend had a mental health problem, I know what advice to give them to get professional help.	1   2   3   4   5
2. Medication can be an effective treatment for people with mental health problems.	1   2   3   4   5
3. Psychotherapy (for example, therapy or counselling) can be an effective treatment for people with mental health problems.	1   2   3   4   5
4. People with severe mental health problems can fully recover.	1   2   3   4   5
5. Most people with mental health problems go to a healthcare professional to get help.	1   2   3   4   5
<b>Instructions:</b> Say whether you think each condition is a type of mental illness by ticking one box only	
6. Depression	1   2   3   4   5
7. Stress	1   2   3   4   5
8. Schizophrenia	1   2   3   4   5
9. Bipolar disorder (manic-depression)	1   2   3   4   5
10. Drug addiction	1   2   3   4   5
11. Grief	1   2   3   4   5

**Semamaretšwa sa 2(b): Šetulo ya tsebo ya maphelo a bolwetši bja monagano (MAKS)**

Taelo: Go setatamente sengwe le sengwe 1– 6 ka tlase arabela ka go swaya lepokisi le tee feela.

**(1) Gana kudu      (2) Gana      (3) Ga ke na nnete      (4) Dumela      (5) Dumela kudu**

1. Ge mokgotse a na le bothata bja monagano, ke a tseba gore nka ba fa keletšo efe gore ba humane thušo ya sephorofešenale.	1	2	3	4	5
2. Dihlare e ka ba kalafi ya maleba go bao ba tshwenywago ke bolwetši bja monagano	1	2	3	4	5
3. Saekhothraphi (mohlala, theraphi/khanseling) e ka ba kalafi ye e atlegago go batho ba go tshwenywa ke bolwetši bja monagano.	1	2	3	4	5
4. Batho ba go ba le bolwetši bja godimo bja monagano ba ka folela ruri.	1	2	3	4	5
5. Batho ba bantši ba go tshwenywa ke bolwetši bja monagano ba etela mopporofešenale wa maphelo go humana thušo.	1	2	3	4	5

**Taelo:** Bolela ge eba o gopola okare seka sengwe le sengwe ke mohuta wa bolwetši bja monagano ka go swaya lepokisi le tee

7.Kgatelelo	1	2	3	4	5
8.Seterese	1	2	3	4	5
9.Šizoforenia	1	2	3	4	5
10.Tšharakano ya maikutlo/mekgwa	1	2	3	4	5
11.Bokgoba bja ditagi	1	2	3	4	5
12.Pefelo	1	2	3	4	5

**Appendix 3(a): Attitudes Scale for Mental Illness (ASMI)**

Please indicate how much you agree or disagree with each of the following statements. The position of the number you choose to encircle will depend on how strongly you feel about the statement.

**(1) Strongly disagree (2) Disagree (3) Uncertain (4) Agree (5) Strongly Agree**

1. People with mental illness have unpredictable behaviour.	1	2	3	4	5
2. If people become mentally ill once, they will easily become ill again.	1	2	3	4	5
3. If a mental health facility is set up in my street or community, I will move out of the community.	1	2	3	4	5
4. Even after a person with mental illness is treated, I would still be afraid to be around them.	1	2	3	4	5
5. Mental patients and other patients should not be treated in the same hospital.	1	2	3	4	5
6. When a spouse is mentally ill, the law should allow for the other spouse to file for divorce.	1	2	3	4	5
7. People with mental illness tend to be violent.	1	2	3	4	5
8. People with mental illness are dangerous.	1	2	3	4	5
9. People with mental illness should be feared.	1	2	3	4	5
10. It is easy to identify those who have a mental illness.	1	2	3	4	5
11. You can easily tell who has a mental illness by the characteristics of their behaviour.	1	2	3	4	5
12. People with mental illness have a lower I.Q	1	2	3	4	5
13. All people with mental illness have some strange behaviour.	1	2	3	4	5

14. It is not appropriate for a person with mental illness to get married.	1	2	3	4	5
15. Those who have mental illness cannot fully recover	1	2	3	4	5
16. Those who are mentally ill should not have children.	1	2	3	4	5
17. There is no future for people with mental illness.	1	2	3	4	5
18. People with mental illness can hold a job.	1	2	3	4	5
19. The care and support of family and friends can help people with mental illness to get rehabilitated	1	2	3	4	5
20. Corporations and the community (including the government) should offer jobs to people with mental illness.	1	2	3	4	5
21. After a person is treated for mental illness, they can return to their former job position	1	2	3	4	5
22. The best way to help those with a mental illness to recover is to let them stay in the community and live a normal life	1	2	3	4	5
23. After people with mental illness are treated and rehabilitated, we still should not make friends with them.	1	2	3	4	5
24. After people with mental illness are treated, they are still more dangerous than normal people.	1	2	3	4	5
25. It is possible for everyone to have a mental illness.	1	2	3	4	5
26. We should not laugh at the mentally ill even though they act strangely.	1	2	3	4	5
27. It is harder for those who have a mental illness to receive the same pay for the same job as those with no mental	1	2	3	4	5

illness.	
28. After treatment, it will be difficult for the mentally ill to return to the community.	1 2 3 4 5
29. People are prejudiced towards those with mental illness.	1 2 3 4 5
30. It is hard to have good friends if you have a mental illness.	1 2 3 4 5
31. It is seldom for people who are successful at work to have a mental illness.	1 2 3 4 5
32. It is shameful to have a mental illness.	1 2 3 4 5
33. Mental illness is a punishment for doing some bad things.	1 2 3 4 5
34. I suggest that those who have mental illness do not tell anyone about their illness.	1 2 3 4 5



**Semamaretšwa sa (3b): Sekala sa mekgwa sa Malwetši a Monagano (ASMI)**

Laetša gore o dumela/gana gakaakang ditatamente tše di latelago. Maemo a nomoro ye o e kgethago e tla laolwa ke gore o rata bjang setatamente seo.

**(1) Gana kudu (2) Gana (3) Ga ke na nnete (4) Dumela (5) Dumela kudu**

1. Batho ba bolwetši bja monagano ba na le maitshwaro a go se akanyege.	1	2	3	4	5
2. Ge motho a ka lwala monagano ga tee, ba tla lwala gape gabonolo.	1	2	3	4	5
3. Ge senolofatši sa bolwetši bja monagano se agilwe seterateg/setšhabebg sa gešo, ke tla huduga.	1	2	3	4	5
4. Le ka morago ga ge molwetši wa monagano a alafilwe, ke tla no tšhoga go ba nabo.	1	2	3	4	5
5. Balwetši ba monagano le ba go se be ba monagano ga se ba swanela go alafiwa bookelong bo tee.	1	2	3	4	5
6. Ge molekani a lwala ka hlogong, molao o swanetše go dumelela molekani yo mongwe go hlala.	1	2	3	4	5
7. Balwetši ba monagano ba na le go tshwenya.	1	2	3	4	5
8. Balwetši ba monagano ba kotsi.	1	2	3	4	5
9. Balwetši ba monagano ba swanetše go tšhabiwa	1	2	3	4	5
10. Go bonolo go tseba bao ba lwalago monagano.	1	2	3	4	5
11. o ka tseba yo a lwalago monaganong ka dika tša maitshwaro a bona.	1	2	3	4	5
12. Balwetši ba monagano ba na le IQ ya tlase.	1	2	3	4	5
13. Bohle balwetši ba monagano ba na le maitshwaro a go makatša.	1	2	3	4	5

14. Ga se tshwanelo gore molwetši wa monagano a nyale/nyalwe.	1	2	3	4	5
15. Ba go lwala monagano ba ka se folele ruri	1	2	3	4	5
16. Balwetši ba monagano ga se ba swanela go ba le bana.	1	2	3	4	5
17. Ga go na bokamoso go balwetši ba monagano.	1	2	3	4	5
18. Balwetši ba monagano ba ka swara mošomo.	1	2	3	4	5
19. Tlhokomelo ya lapa le bagwera e ka thuša balwetši bja monagano go boela sekeng	1	2	3	4	5
20. Dikoporase le ditšhaba (go akaretšwa le mmušo di swanetše go fa balwetši ba monagano mešomo.	1	2	3	4	5
21. Ge motho a alafilwe bolwetši bja monagano a ka boela maemong a mošomo wa gagwe wa pele	1	2	3	4	5
22. Mokgwa o mo kaone go thuša bao ba lwalago monagano go fola ke go ba dumelela go dula mosetšhabeng ba phele bophelo bja tlwaelo.	1	2	3	4	5
23. Morago ga ge balwetši ba monagano ba alafilwe mme ba boetše sekeng, ga re a swanela go gwerana nabo.	1	2	3	4	5
24. Morago ga ge balwetši ba ba alafilwe, ba sa le kotsi go feta batho ba ba bangwe.	1	2	3	4	5
25. Go a kgonega gore motho mang le mang a ka lwala monagano.	1	2	3	4	5
26. Ga re a swanela go sega balwetši ba monagano le ge ba dira dilo di šele.	1	2	3	4	5
27. Go bothata gore balwetši ba monagano ba humane tefelo ya go lekana le ya ba go se lwale bjalo mošomong wa go	1	2	3	4	5

swana.	
28. Morago ga kalafo go tla ba thata gore balwetši ba gomele setšhabeng.	1 2 3 4 5
29. Batho ba kgetholla balwetši ba monagano.	1 2 3 4 5
30. Go bothata go humana bakgotse ge o na le bolwetši bja monagano.	1 2 3 4 5
31. Ga se gantši batho ba go atlege mošomong ba lwala ka monaganong.	1 2 3 4 5
32. Go a swabiša go lwala monaganong.	1 2 3 4 5
33. Bolwetši bja monagano ke kotlo ya bobbe bjo bo dirilwego.	1 2 3 4 5
34. Ke šišinya gore balwetši ba monagano ba se botše motho ka bolwetši bja bona.	1 2 3 4 5

**Appendix (4a): Informed consent letter and form**

Department of Psychology  
University of Limpopo (Turfloop Campus)  
Private Bag X1106  
Sovenga,  
0727

Date: \_\_\_\_\_

Dear participant

Thank you for demonstrating interest in this study, which focuses on knowledge towards and attitudes of people at GaDikgale community towards mental illness. The purpose of this study is to investigate knowledge of and attitudes towards people with mental illness.

Your responses to this individual interview will remain strictly confidential. The researcher will not attempt to identify you with your responses to the interview questions or to disclose your name as a participant in the study. Please be advised that participating in this study is voluntary and that you have the right to withdraw your participation at any time.

Kindly answer all the questions and reflect your true reaction. Your participation in this research is very important.

Thank you for your time.

Sincerely

\_\_\_\_\_

Mashoto Tshoga (Masters' student)

\_\_\_\_\_

Date

\_\_\_\_\_

Prof T. Sodi (Supervisor)

\_\_\_\_\_

Date

**Appendix 4(b): Informed consent letter and form - Sepedi version**

Dephatemente ya Psychology

Yunibesithiya Limpopo (Turfloop campus)

Private Bag X1106

Sovenga

0727

Letšatšikgwedi: \_\_\_\_\_

Dumela motšeakarolo nyakišišong

Kelebogage o bontšhitše kgahlego go tšea karolo nyakišišong ye e legomabapi le go nyakišiša tsebo le maitswaro go batho bao banang le bolwetši bja mogopolomo GaDikgale.

Diphetolo tša gago mo nyakišišong ye di bolokegile. Monyakišiši a kaseleke go golebanya le diphetolo tša gago le dipotšišo tša nyakišišo goba a tšwetša leina la gago nyanyeng bjalo ka motšeakaralo monyakišišong ye. Le lemošwa gore go tšea karolo monyakišišong ye ke boikgethelo ebile le nale tokelo ya go tlogela go tšea karolo nako efe go ba efe.

Araba dipotšišo kannete yeo e phatlaletšego. Dikarabo tša gago di bohlokwa ebile di bolokegile.

Ke leboga nako ya gago

Wa gago ka mehla

\_\_\_\_\_

Mashoto Tshoga (Morutwana wa Masetase)

\_\_\_\_\_

Prof. T. Sodi (Mohlali)

\_\_\_\_\_

Letšatši kgwedi

\_\_\_\_\_

Letšatši kgwedi

**Appendix 5(a): Consent form to be signed by participant**

I \_\_\_\_\_ hereby agree to participate in a Masters' research project (which is a part of a larger VLIR-IUC research project), which focuses on knowledge towards and attitudes of people in GaDikgale community towards mental illness.

The purpose of the study has been fully explained to me. I furthermore understand that I participate willingly and without being forced in any way. I also understand that I can withdraw my participation in this study at any point, and that this decision will not in any way affect me negatively.

I understand that this is a research project whose purpose is not necessarily to benefit me personally. I understand that my details as they appear in this consent form will not be linked to the interview schedule, and that my answers will remain confidential.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Appendix 5(b): Consent form to be signed by participant - Sepedi version

Nna \_\_\_\_\_ kedumela go tšea karolo porotšekeng ya nyakišišo ya Masetase (ye e lego ye nngweya di Porotšeke tša VLIR-IUC) ka ga nyakišišo ya tsebo le maitshwaro go batho bao banang le bolwetši bja mogopolo GaDikgale.

Ke hlaloseditšwe go tlala seatla ka ga maikemišetšo magolo a nyakišišo ye. Go tšea karolo ga ka ke boithaopo nyakišišong ye, kafa o nka tlogela nako efe goba efe. Ke kwešiša gore se ke nyakišišo dithutong, ebile gago seo ke se humanago go tšea karolo nyakišišong ye. Ke kwešiša gape gore seoke se bolelagomo, se tla šomišwa fela kebao ba dirago nyakišišo ye fela, ebile tsebo yaka e bohlokwa. Nyakišišo ye e tloga e bolokegile.

\_\_\_\_\_  
Mosaeni

\_\_\_\_\_  
Letšatši kgwedi



**University of Limpopo**  
Department of Research Administration and Development  
Private Bag X1106, Sovenga, 0727, South Africa  
Tel: (015) 268 2212, Fax: (015) 268 2306, Email:noko.monene@ul.ac.za

**TURFLOOP RESEARCH ETHICS  
COMMITTEE CLEARANCE CERTIFICATE**

**MEETING:** 03 March 2017

**PROJECT NUMBER:** TREC/22/2017: PG

**PROJECT:**

**Title:** Knowledge and attitudes of rural community members' in  
Ga-Dikgale towards mental illness  
**Researchers:** Ms MP Tshoga  
**Supervisor:** Prof T Sodi  
**Co-Supervisor:** Dr SL Govender  
**School:** Social Sciences  
**Degree:** Masters in Psychology

  
**PROF TAB MASHEGO**  
**CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE**

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

**Note:**

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol.  
**PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**





**University of Limpopo**  
**School of Languages and Communication Studies**  
**Department of Linguistics, Translation and Interpreting**  
**Private Bag x1106, Sovenga, 0727, South Africa**  
**Tel: (015) 268 3707, Fax: (015) 268 2868, email:kubayij@yahoo.com**

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**13 August 2019**

**Dear Sir/Madam**

**SUBJECT: EDITING OF DISSERTATION**

This is to certify that the dissertation entitled 'Knowledge and attitudes of rural community members in Ga-Dikgale towards mental illness' by Mashoto Pheladi Tshoga (201530171) has been proofread and edited, and that unless further tampered with, I am content with the quality of the dissertation in terms of cohesion, clarity of thought and precision.

Kind regards

Prof. SJ Kubayi (DLitt et Phil - Unisa)

Associate Professor

SATI Membership No. 1002606