HELP-SEEKING PATHWAYS FOLLOWED BY CAREGIVERS OF MENTALLY ILL PERSONS IN SINTHUMULE-KUTAMA, LIMPOPO PROVINCE

By

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DEDICATION

This work is dedicated to my late grandmother, Gavaza Grace Shiburi for believing in me; and encouraging me to pursue education since childhood. This dedication extends to my mother and husband for their continuous support and love.

DECLARATION

I declare that this dissertation, titled HELP-SEEKING PATHWAYS FOLLOWED BY CAREGIVERS OF MENTALLY ILL PERSONS AT SINTHUMULE-KUTAMA, LIMPOPO PROVINCE is hereby submitted to the University of Limpopo for the degree of Master of Arts in Clinical Psychology. It has never been submitted previously by me nor anyone else for a degree, at this or any other university. I hereby declare that it is my work in design and in execution; and that all material contained herein has been duly acknowledged.

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Surname and initials Date

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ABSTRACT

Mental illness is one of the major health challenges that significantly contribute to the global burden of diseases worldwide. Several studies reveal that mental illness often triggers or prompts people to embark on some help-seeking pathways in order to ameliorate their condition. These help-seeking pathways are often not linear routes, but rather recursive and complex. The aim of the study was to explore the pathways followed by caregivers of mentally ill persons seeking mental health care services in Sinthumule-Kutama area. The objectives of the study were: a) to examine the experiences of caregivers in caring for persons suffering from mental illness; b) to explore pathways that caregivers often engage in when they are seeking treatment options for mentally ill patients before and/or after they have been diagnosed with their condition; and, c) to find out whether or not caregivers make use of other forms of management in addition to the formal treatment interventions that they may receive from the health care facilities.

A qualitative approach was followed; and participants were selected through a snowball sampling method. The sample comprised twelve participants (female=11; Male=1) residing in and around the Sinthumule-Kutama District area, Limpopo Province. The participants' ages ranged from 24 to 88 years. The data was collected using in-depth, semi-structured individual interviews and analysed using interpretative phenomenological analysis (IPA). The following themes emerged from the study: a) the perceived causes of the mental illness; b) the pathways followed in the management of mental illness; and c) the use of alternative forms of management interventions.

The findings of this study revealed that the participants hold different perceptions and beliefs about the probable causes of mental illness. Secondly, the study further revealed that the participants visited a number of alternative management agencies to seek treatment for their mentally ill family members. Thirdly, the pathways that were followed were influenced by several factors such as the perceived cause of the illness, religious or cultural beliefs, severity of symptoms and/or advice from general practitioners and school teachers. This clearly suggests that participants have made use of more than one service provider to seek help for their family members. The path either started with the formal setting, then moved to the informal setting and vice versa. For instance, as soon as

individuals with mental illness are discharged from the hospital, the caregivers consulted with other alternative service providers mainly to enhance the treatment they have received for protection from evil forces. The results suggest that help-seeking behaviour and the pathways chosen in the management of mental illness are largely influenced by socio-cultural factors and beliefs about the causes of the disease.

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CHAPTER 1: INTRODUCTION

1.1 Background to the study

Mental illness is one of the major health challenges that significantly contributes to the global burden of diseases worldwide (World Health Organization, 2017). One in four individuals in the world is affected by some sort of mental illness at some point in their lives (Ritchie and Roser, 2019; Patel, Flisher, Hetrick and McGorry, 2007). Previous studies show that mental illnesses are quite common in both developed and developing countries (Patel, 2007; Kessler, Aguilar-Gaxiola, Alonso, Chatterji, Lee, Ormel…and Wang, 2009; O'Hara and Wisner, 2014). Mental illnesses account for 11.6 percent of the overall burden of diseases in low and middle income countries (Patel, 2007). Furthermore, about 450 million individuals currently suffer from mental illness, placing mental illness among the leading causes of ill-health and disability worldwide (World Health Organisation (WHO), 2017). A study conducted by Ritchie and Roser (2019) stated that it is estimated that over 1.1 billion people worldwide had a mental illness or substance use disorder in 2016. A study conducted by Patel (2007) suggested that most of the mental illnesses start in childhood or young adulthood. Furthermore, mental illness is regarded as the main cause of disease burden in the age group 15-44 years (Patel, 2007).

Mental illness is often accompanied by a stigma which is sometimes associated with under-reporting of its prevalence (Patel, 2007). A stigma does not only have an impact on individuals suffering from mental illness, but also affects families (Koschorke, Padmavati, Cohen, Weiss, Chatterjee…Balaji, 2017). A study conducted in India states that family members are closely involved in most of the aspects of individual suffering from schizophrenia's care and often make decisions in help seeking and treatment (Koschorke, et al, 2017). Furthermore, stigma increases the burden on caregivers and complicates the lives of family members in many ways. For example, people in the community may be discouraged to marry in the family where one member may be living with a mental illness, especially chronic psychosis (Koschorke, et al, 2017). Family

caregivers with individuals living with mental illness often experience emotional distress, stigma, financial burden, lack of support networks, and social exclusion (Ae-Ngibise, Doku, Asante and Owusu-Agyei (2015)

According to Marimbe-Dube (2013), caregivers of people suffering from mental illness carry a significant and often unrecognized burden as a result of their family members' condition. A study conducted by Dyck et al (cited in Marimbe-Dube, 2013) estimates that between one and two thirds of individuals with a long term psychiatric disabilities in the United States of America are taken care of by their family members. Most families of those with mental illness have been placed in an emotionally demanding situation and may feel psychologically burdened by taking care of their loved ones (Shamsaei, Cheraghi and Esmaeilli, 2015). Families of those with mental illness play a significant role in supporting their sick family members and are frequently affected financially, emotionally and socially by the condition of their loved ones. These demands may create substantial levels of stress and can affect their overall quality of life (Shamsaei et al, 2015). A study conducted by Shamsaei,et al (2015) reveal that caregivers experience a one-third increase in negative health symptoms after assuming caregiver responsibilities. Additionally, they suffer significant psychological distress and experience higher rates of mental ill health than the general population.

A study conducted by Chilale, Silungwe, Gondwe and Masulani-Mwale (2017) states that the beliefs that sufferers and family members hold about the causes of illnesses significantly shape the care giving process. The explanation that mental illness is caused by witchcraft and spirit possession has been linked to both the delay in seeking help and underutilization of modern health care systems (Chilale, et al, 2017 and Kar, 2008). The beliefs about the causes of mental illness can influence help-seeking, adherence to treatment, disease management and clinical outcomes (Chilale, et al, 2017).

Mental illness often triggers or prompts people to embark on some help-seeking pathways in order to ameliorate their condition. These help-seeking pathways are often not linear routes, but rather recursive and complex (Mbatha, Street, Ngcobo and Gqaleni, 2012). Many studies have found that help-seeking pathways followed by people suffering from mental illness are influenced by various factors. These include cultural or belief systems, socio-economic background, and social networks (Fridgen et al., 2013; Pandalangat, 2011; Zondo, 2008). Sometimes people seeking help for mental illness rely on alternative remedies such as traditional and religious healers (Mbatha et al., 2012). Previous studies have suggested that culture influences how health is viewed, how symptoms of illness are expressed, and when and how help is sought (Galdas, Cheater and Marshall, 2005; Zondo, 2008; Pandalangat, 2011; Peterson and Lund, 2011). A study conducted by Bjorck and Trice (2006) states that some people will seek help from mental health professionals, some will seek help from their religious leader and others may disregard seeking help at all. According to the study that was conducted in Northern Malawi, more than three quarters of patients and their families delay to access mental health services as they prefer alternative sources of care, although health services are well established (Chilale, et al, 2014).

The knowledge about mental illness plays a crucial role in making a decision to seek or not to seek professional help (Suka, Yamauchi and Sugimori, 2016). A number of studies illustrate the relationship between a person's knowledge and their health-seeking behaviour (Grundy and Annear, 2010; Van der Ham, Wright, Van, Doan and Broerse, 2011). Recognition of signs and symptoms for mental illness also determines the decision to seek or not to seek help. Knowing about the healing options, viable management facilities, etiology of illness and probable outcomes can also influence people's choice of care seeking (Grundy and Annear, 2010). A study conducted by Suka et al., (2016) suggested that knowledge of symptoms differs across countries and cultures. Reporting of symptoms may be influenced by sociocultural factors, more especially stigma surrounding mental illness (Suka et al, 2010). Society's beliefs about mental illness and the treatment options may also add to failure and/or delay in seeking help for some

people. According to Sorsdahl, Stein, Grimsrud, Seedat, Flisher, Williams and Myer (2009), education plays a significant role in help- seeking pathways that people follow in the context of mental illness in a specific family. The study reveals that people with little or no formal education are more likely to consult traditional healers as compared to people with more education (Sorsdahl et al, 2009).

A study conducted by Bifftu, Takele, Guracho and Yehualashet (2018) revealed that more than 340 million people are affected by mental illnesses. Mental illness is among the top ten leading causes of disability worldwide (Bifftu et al, 2018; WHO, 2001). Depression was found to be the most common mental illness with an estimation prevalence of 4.4 percent globally. Another study conducted by Kerebih, Abera and Soboka (2017) states that mental illnesses are highly prevalent and cause significant pain and disease burden. It is estimated that mental illnesses account for 12 percent of the global burden of diseases, and in 2020 the burden of these illnesses is predicted to increase by 15 percent. In South Africa, a study conducted by South African Depression and Anxiety Group (2016) reported that more than one-quarter of the respondents reported lifetime prevalence of a mental illness. It is estimated that 30% of the South African population will suffer from a mental illness of some sort in their lifetime (South African Depression and Anxiety Group, 2016).

Equally concerning is that a large number of people with mental illness do not seek professional help and remain untreated despite the availability of effective treatment. For example, it is shown that only one third of adults with diagnosable mental illness seek professional help (Kerebih et al., 2017). Most individuals with mental illness in both developed and developing countries delay in seeking professional help and fail to receive effective treatment (Suka, et al, 2016). According to the WHO survey of mental health service use for anxiety, mood disorders and substance use disorders, the amount of seeking professional help within 12 months of beginning of mental illness was from 1.6 percent in Nigeria to 17.9 in the USA (Wang, Aguilar-Gaxiola, Alonso, Angermeyer, Borges, Bromet…, and Haro, 2007). Furthermore, from those who did seek professional

help, a minor amount of them did get specialised mental health care as indicated by 5.7 percent in South Africa, 7.7 percent in Mexico and 9.5 percent in Iran (Wang et al…, 2007). This study continues to reveal that in Ethiopia 22.9 percent of people with depression seek professional help. Moreover, some people seek alternative help such as traditional and religious help before the actual health care seeking for symptoms of mental illness, including depression is called for. It is found that 31 percent of patients with mental illness seek help from priests/holy water/churches, and the fear of stigma was highlighted to be the major reason for not seeking professional help (Menber et al,. 2018).

1.2 Research problem

In Africa, people who seek help for mental illness have been found to rely on a number of services that include alternative or informal sources of health care (Mbatha et al., 2012). Mabunda (1999) argues that many South Africans' first choice for mental health treatment is traditional healers. A study conducted by Shai (2012) revealed that help-seeking pathways are largely determined by the perceived causes of the illness, which are derived from cultural ideologies.

The study also illustrates that the pathways followed by individuals with mental illness vary according to the person's belief system and the nature of the symptoms. Hence, various agencies and providers of health care are visited by caregivers (Shai, 2012). According to Shai and Sodi (2015), when African patients and their families are confronted with chronic and/or mild mental health problems, traditional healers are usually the first point of consultation, if not the only source of care in some cases. A study conducted by Phethi (2014) found that patients in the rural communities of Limpopo Province (South Africa) tend to consult traditional healers and spiritualists before they can seek western health care services. Furthermore, the study found that help-seeking can start at the informal level and proceed to the formal sector and vice versa (Phethi, 2014).

Another study conducted by Lefley (1987) suggests that approximately 38 percent of severely mentally ill adults live with their families, and those who do not are in contact

with family members. Furthermore, 85 percent or more of known caregivers are parents, most in their late 50s or 60s. Moreover, most of these people depend on their family members for care and support throughout their lives (Marimbe-Dube, 2013). Family caregivers are frequently the people tasked with the responsibility of providing day-to-day caring for mentally ill patients within communities (Saunders, 2003). They often carry a significant burden in caring for their loved ones who are mentally ill (Marimbe-Dube, 2013). Additionally, caregivers are directly involved in decision making regarding the kind of intervention or treatment to seek for the mentally ill patients. According to Rogler, Dharma and Cortes (1993), people's help-seeking pathways are not based on a person who is distressed but include both formal and informal institutions such as family and health institutions. The family's view of illness and its causes, including any perceived stigma may often lead to a delay in help-seeking (Rogler et al., 1993). WHO (2010) states that irrespective of the type of illness, family members are often the first ones to be consulted before seeking any advice and/or treatment.

Whilst some previous studies (Shai, 2012; Phethi, 2014; Shai and Sodi, 2015) point to some form of help-seeking pathways that are followed by patients themselves, there is little information on the pathways that are followed by caregivers. The current study, therefore, seeks to explore help-seeking pathways followed by caregivers of persons who are mentally ill at the Sinthumule-Kutama area.

1.3. SIGNIFICANCE OF THE STUDY

Understanding the pathways that caregivers follow to care for mentally ill patients is crucial for the development of suitable or culturally appropriate interventions strategies. The study of pathways to mental health care is an important topic that may assist in the understanding of mental illness and can provide insight to mental health professionals who deal with mental illness in South Africa. Research indicates that families play a pivotal role in the health of people, including mental health. In most cases, when a person experiences changes in his/her health status, he or she informs family members who

become the first people to observe these changes. Thus, families have an influence on help-seeking pathways that a person may first observe or experience when they encounter a mental problem. The knowledge of options one has about the different help-seeking pathways that caregivers follow in the process of caring for their mentally ill family members is, therefore, an important area of research concern. The knowledge that will be gained from this study will help facilitate the identification and early detection of the first signs and symptoms of mental illness through psycho-education of families, patients and the community at large.

1.4 Aim of the study

The aim of the study was to explore the pathways followed by caregivers of mentally ill persons seeking mental health care services within the Sinthumule-Kutama District area.

1.5 Objectives of the study

- To determine the experiences of caregivers in caring for persons with mental illness;
- To explore pathways that caregivers engage in seeking treatment for mentally ill patients before and after they were diagnosed with their conditions; and,
- To establish whether or not caregivers make use of other forms of interventions in addition to the formal treatment they receive from the health care facilities.

1.6 Operational definition of concepts

1.6.1 Help-seeking pathways

Help-seeking pathways refer to remedial actions taken to treat perceived diseases (Zondo, 2008). These are viewed as routes that are taken or followed in achieving a specific outcome. In the context of the present study, help-seeking pathways are understood to mean routes that are taken by caregivers in an effort to seek help for a person with a mental disorder.

1.6.2 Caregiver

The concept caregiver refers to someone who takes the position of a family member or acquaintance to look after family members or acquaintances who require such attention with respect to their physical, psychological or developmental needs (Alliance, 2012). In the present study, a caregiver is understood to mean someone (family and friends) who takes care of a mentally ill person.

1.6.3 Mentally ill persons

A mentally ill person is a person who has a mental or emotional condition that has significant opposing effects on his or her ability to function and who requires care and treatment (Durand and Barlow, 2012). In the context of the present study, mentally ill persons are understood to mean persons who require care, treatment or control for their condition.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter will discuss help-seeking pathways for mental illness. Covered among the issues to discuss here include, the factors that influence help-seeking behaviour, the role of culture, and the role of family belief systems. Furthermore, the theories that are relevant to help-seeking pathways to health care will be discussed. These include Theory of Reasoned Action, the Health Belief Model, Theory of Planned Behaviour and the biomedical model. Lastly, the chapter will discuss the theoretical framework of the present study, namely, the pathway model.

2.2 Help-seeking pathways for mental illness

People use different pathways and strategies to manage diseases of different kinds. Several studies on help-seeking pathways worldwide indicate that attitudes to and beliefs about mental illness determine help-seeking pathways to be followed (Aghukwa, 2012; Anderson, Fuhrer and Malla, 2013; Sorketti, 2013; Ikwuka, 2016). These studies suggest that lack of knowledge about mental illness and available treatment options are some of reported obstacles to care. Patients suffering from mental illness and their families frequently use help-seeking pathways that are consistent with their cultural belief systems. A study conducted by Adeosun, Adegbohun, Adewumi and Jeje (2013) found that patients with mental illness prefer to consult traditional and spiritual healers in their pathway to care.

A study conducted by Pescosolido (1992) noted that help-seeking has often been defined as an individual's rational decision about whether or not to seek out the assistance of a mental health professional. The study further postulated that the action toward help-seeking is rooted in the social network; and that network interactions influence identification of a problem as well as what should be done about it (the problem). People with mental illness seek advice regarding which pathways to follow from a range of

informal sources of support, for example, family, friends, and co-workers. They further seek advice from ethnic/ traditional healers, collateral service providers such as teachers, doctors and mental health professionals until a resolution is found or all options are exhausted (Pescosolido, 1992).

Trivedi and Jilani (2011) conducted a study that reveals that even though there is considerable progress with regard to mental health care facility in India, faith healers are the first to be consulted by many people suffering from mental illnesses. The authors also state that many care seekers simultaneously seek help from Western as well as traditional methods of therapy. Often, the process of seeking help involves some interaction between the person concerned and their entire family. For example, family or caregivers may be involved in the decision-making process on the path to follow in seeking treatment for mental illness (Shai, 2012). Girio-Herrera, Owens and Langberg (2013) indicate that socio-cultural factors affect the decision to seek help by the family, especially in the rural communities. Shai and Sodi (2015) conducted a study that suggests that help-seeking pathways include several entry points**.** These points include the utilisation of western medicine when experiencing acute symptoms, and traditional medicine when confronted with chronic yet manageable symptoms (Shai and Sodi, 2015). The findings of this study also suggest that help-seeking pathways do not always start at mental health systems to end up at the western mental health care system. Some people may start with western health care system and end up with traditional medicine (Shai and Sodi, 2015). A study conducted by Hess (1998) found that traditional and spiritual healers have been treating mental illnesses for centuries by the majority of South Africans. Literature has highlighted an estimation of 45 to 60 percent of people with psychosocial problems in developing countries who first consult traditional healers as their primary agents (Sorketti, 2008; Shai and Sodi, 2015). Furthermore, these practitioners or frontline service provider of health services are the first to be consulted because they live within the community.

In most developing countries, traditional medicine plays a significant part in the promotional, preventative and curative aspects of health for a great number of residents

(Sorketti, 2008). A study in Sudan reveals that due to lack of economic resources, inaccessibility of medical services and lack of awareness among the population and high values of psychiatric services, traditional healing is the greatest predominant way for treating mental ill people (Sorketti, 2008). Furthermore, most of the patients suffering from mental illness and their families rely more on traditional healers and their healing processes to treat mental illness as the most accessible and less demanding in terms of financial obligations (Sorketti, 2008).

A study conducted in Bangladesh, India, Japan, Mongolia and Nepal by Hashimoto, Fujisawa, Giasuddin, Kenchaiah, Narmandakh, Dugerragchaa and Sartorius (2015) shows that a substantial percentage of people with mental illness choose traditional or religious healers as their initial caregivers. Furthermore, due to medical resources not spread throughout most of these countries, traditional or religious healers naturally play an important role in helping people with mental illnesses. According to a study from India, faith healers are frequent care providers for majority of psychiatric patients, and in some cases, caregivers may revert back to faith healers or simultaneously seek help from modern as well as traditional methods of therapy (Naik, Pattanavak, Gupta and Pattanavak, 2012). Furthermore, some caregivers reported an intention to continue seeking help from faith healers alongside the medical treatment. This diverse approach to medical treatment has been indicated from India as well as from other developing countries (Naik et al., 2012).

The choice to seek help from the diverse methods of treatment is often influenced by an individual's mental illness and the family's beliefs on the cause of the illness (Ibrahim, Hor, Bahar, Dwomoh, McKay, Esena and Agyepong, 2016). Generally, in Africa, a mental illness is often believed to be caused by spiritual factors, and for this reason, some people with mental illness would usually seek help from traditional/ religious healers before they consider mental health care services (Ibrahim et al, 2016). In Ghana, faith based and traditional healers are usually the ideal and viable avenues for mental health treatment (Ibrahim et al., 2016). The beliefs that mental illness is caused by evil spirits and lack of

inadequate formal mental health treating facilities in African countries, including Ghana, play a role in influencing people to seek help from their churches, prayer camps and shrines. Therefore, some amount of time is often lost before the initiation of treatment at formal public mental health facilities, which sometimes results in poor response to psychiatric treatment and consequently, lowers the quality of life (Ibrahim et al., 2016).

In recent years, experiences and challenges of caregivers of patients with mental illnesses have received attention (Schene, 1990). Mentally ill patients' relatives and caregivers may be confronted with uncertainty, and sometimes emotions of shame, guilt and anger (Schene, 1990). Almost similar to people with mental illness, they (relatives or families) may feel stigmatised and socially isolated. Sometimes the process of seeking help may involve an interaction between the patient concerned and the caregivers. According to Zondo (2008), the family often decides which type of help will be suitable for the symptoms presented by their family members. Significant others, for example, the family and friends play a role in decision-making processes of seeking treatment, and are frequently the ones who manage the treatment of the individual in terms of illness, negotiation and management (Good, 1987; Janzen 1978).

2.3 Factors influencing help seeking behaviour

According to Pandalangat (2011), an important factor that influences how health is perceived, how individuals express symptoms of illness and when and how they seek help is culture. Other factors that may influence help-seeking behaviour include health knowledge, socio-cultural, socio-economic and demographic characteristics (Shai, 2012; Sorketti, 2013; Dung, Thang, Van Thang, Cat, Lê Đình Dương, Võ Văn Thắng, et al, 2015). A study conducted in India shows that lay public are largely not knowledgeable of the numerous aspects of mental health and the available facilities that treat mental illness (Chadda, Agarwal and Singh, 2001). Stigma and social network also play a role in deciding on the treatment modality required (Clement et al., 2015). The degree of interconnectedness of social networks has an influence on help-seeking behaviour. If the

network is strong, it leads to acceptance of beliefs prevalent in communities, leading to culturally accepted ways of help-seeking (Chadda et al., 2001; Clement et al., 2015).

Another barrier that influences individuals not to seek professional psychological help is negative attitudes towards professional help-seeking (Clement et al., 2015). A study conducted by Rickwood, Deane, Wilson and Ciarrochi (2005) states that most people tend to believe that their family can help more than professional sources of help for many personal and emotional problems. Therefore, these beliefs may influence help-seeking behaviour. A study conducted by Bronfenbrenner (1979) indicates that the societal environment involves several spheres of influence which are defined by the closeness to an individual. It further states that most proximal influence is the family, followed by neighbours, schools and community at large. These play significant role in the lives of youth.

2.4. Role of the family

Families also carry a significant burden of taking care of their loved ones with mental illness. According to Mkize and Uys (2004), the financial status of a patient and their family members also plays a major role in determining the seeking of relevant help and the availability of the desired mental health service. The decision to consult either a western-trained doctor or a traditional/ spiritual healer is often influenced by factors such as the seriousness of the illness, availability of health services, financial implications and the person responsible for the decision (Mkize and Uys, 2004).

Families are intimately involved in the mental health care of members (WHO, 2010). Thus, significant others are often the ones who become actively involved in the decision-making process around the intervention that the individual will follow (Shai and Sodi, 2015). A study by Suka, et al (2016) reported that perceptions of family and friends concerning help-seeking were significantly related to help-seeking intention from mental health care services.

Many people tend to first seek help from family and friends because they consider them more favourable as helping advisers (Rickwood, Deane, and Wilson, 2007; Suka et al, 2016). The challenge, however, may be that the family option may spark both positive and negative influence. For example, if they have inadequate knowledge about mental illness, their support could be unhelpful or even harmful (Suka et al., 2016). Families that have inadequate knowledge about mental illness are likely to feel reluctant to seek help for mental illness, and this may exacerbate the illness of their family member. Those who have had some exposure to mental illnesses are less likely to be hesitant to seek help and apply their knowledge to resolve their health problems (Suka et al., 2016). Family knowledge about mental illness, its causes and perceived stigma may lead to delay in seeking help.

Lack of sufficient knowledge about mental illness may contribute to families hiding a mentally ill individual due to feelings of embarrassment, and that may delay seeking help for their loved ones. Families can also contribute to non-adherence to treatment regimens and default from treatment. For example, those that perceive mental illness to be caused by supernatural powers may discourage taking treatment from health care services, and follow the prescription from traditional or faith healers. A study conducted by Lin, Inui, Kleinman and Womack (1982) found that a help-seeking process was found to associate powerfully with ethnicity. The study further showed that Asians and blacks involve extended families in making decisions for their mental health treatment. According to Angermeyer, Matschinger and Riedel-Heller (2001), individuals closer to the person with a mental illness have a powerful role in determining whether to seek mental health services or not when faced with distressing symptoms. Furthermore, it is shown that those who sought help had friends or family suggesting and recommending that they seek help as compared to those who never sought mental health services.

Despite family influence in help-seeking, social influence may also play a role in influencing individuals with mental illness in the decision making to seek professional help (Vogel, Wade, Wester, Larson and Hackler, 2007). For example, one within the

community may have fear of what neighbours will think, and attitudes about exposing personal or family problems to strangers (Wong, Hou and Wong-Kim, 2015). According to Vogel (2007), acceptance and encouragements from one's social network plays an important role for an individual to seek help when faced with mental health problems. If significant people around a person's life perceive seeking help from health professionals as negative, then the person may not seek help due to the fear of exposure and loss of societal approval. Furthermore, peer judgment also has a significant influence on how individuals evaluate their symptoms and whether the person would seek professional treatment. A study conducted by Wong et al. (2015) found that people are reluctant to seek help because they view a mental illness as character weakness where communicating their personal problems may be seen as disgracing their family. They may also have the fear of being judged as failures.

2.5. The role of religion

Understanding the role of religion in help-seeking and services utilization varies, as does the function of religion as a source of support (Pandalangat, 2011). According to a quantitative study conducted in Toronto, 1 % of people suffering from mental illness or stress related issues seek help from religious leaders (Beiser et al., 2006). Furthermore, other sources of problem relief that were identified were astrologers (5.5%), rituals (30 %), wearing religious stones and bracelets (10%) and use of herbal or traditional medicine (Beiser et al., 2006). Religious leaders, are therefore, mostly consulted in times of emotional difficulty; and they seem to function as front-line mental health workers. Furthermore, research has shown that community priests are often considered to be the first contact to be consulted for mental illness as compared to health care professionals (Leavey, Loewenthal and King, 2007). According to Allay and Laher (2008), religious beliefs have a role to play in how people perceive mental illnesses.

Witchcraft and possession by spirits are seen as causal factors of mental illness in many religions (Razali, khan and Hasanah, 1996). The methods used by religious leaders to

treat mental illness are mainly influenced by the views held by that specific denomination. A study conducted by Razali, et al… (1996) revealed that the belief that mental illness is caused by supernatural agents is firmly held by traditional healers, who emphasize that mental illness is caused by being witched or possessed by evil forces in those who seek their advice. Furthermore, patients who hold the belief that mental illness was caused by supernatural forces were also found to show poor drug compliance as compared to those who did not believe in supernatural causes. Therefore, the perceived causes of mental illness influence the help- seeking behaviour. This study showed that the level of education does not influence cultural beliefs about the causes of mental illness. Even university graduates visited traditional healers at some stage when faced with mental illnesses. Furthermore, the pattern of illness and help-seeking behaviour is often influenced by cultural beliefs, and this is related to the perceived etiology of mental illness (Razali et al., 1996).

Alley and Laher (2008) conducted a study to explore Muslim Faith Healers' perceptions of mental illness which focused on etiology and treatment methods. Their findings concluded that mental illness was seen to be caused by a diversity of factors which include medical and religious factors. It was also indicated that these faith healers were aware of the distinction between mental and spiritual illness. The treatment methods used for mental illness include natural products which originated from the Islamic medicine as prescribed in the teachings of the Prophet Mohammed (Allay and Laher, 2008).

Religion is a prominent part of people's culture. Therefore, it is essential for mental health professionals to take into cognizance issues that are relevant to religion and religious diversity in their practices (Darroch, 2011). Research suggests that religiosity plays a role in influencing people's perceptions towards mental illness and the preferences of mental health services they will choose to follow (Moreno and Cardemil, 2013). Furthermore, these preferences include an increased sense of trust and comfort with their provider, their expectation of the same beliefs and values, having existing relationships with

providers and increased accessibility. People practicing religion may feel that they should consult their religious leaders for treatment (Bjorck and Trice, 2006).

Highly religious Christians do not seek professional psychiatric help for mental illness because they believe that psychotherapy will mismatch the practices of their faith (Darroch, 2011). Furthermore, the fear of this mismatch is that many Christian's stress that faith in God is proved strong when they face difficulties, and rely on prayers and praise during these difficult times (Darroch, 2011; Keating and Fretz, 1990). Seeking help from mental health professionals may be interpreted as lacking faith in God (Bjorck and Trice, 2006). On the contrary, a study conducted by Kgwatalala (2003) found that religion has a positive influence on health matters and determines the utilization of health services.

2.6. The role of culture

Culture affects all aspects of health and illness, including the perception of illness, the explanations for an illness and the behavioural options to promote health or relieve suffering (Saint Arnault, 2009). Culture can also influence people's attitudes about mental illness which may impact help-seeking behaviours and the readiness to seek treatment (Bjorck and Trice, 2006). Research on professional help-seeking indicates that there is a methodical change between individuals from one cultural context in frequency of help-seeking. Hwang (2006) states that individuals from Asian and Asian American cultural contexts are not keen to seek professional help as compared to those from European American context. It is therefore, crucial to understand underlying reasons why people decide whether to seek professional help or not (Mojaverian, Hashimoto and Kim, 2013).

Cultural customs might be an influential aspect in shaping attitudes towards seeking professional help. According to Cause, et al. (2002), culture determines numerous factors of professional help-seeking, which include recognition and attribution of problems,

decision making for help-seeking, and evaluation of various coping resources. Culture has an influence on the perceptions of health, illness and disease. Furthermore, it plays a role in the selection of health related behaviours such as beliefs that cause the utilization of sources of help (Pillay 1996). How an individual perceives the cause of an illness determines the pathway that they will take to seek help for that illness. A study conducted by Arnault (2009) states that culture affects all facets of health and illness, including the perception of it, the explanations for it and the behavioural options to promote health or relieve suffering.

2.7 The role of the community

The community's attitudes about mental illness may impact on help-seeking behaviour (Angermeyer et al., 1999). Public opinions may often shape the attitudes of those in direct contact with individuals suffering from mental illness. These include a network of possible advisors from the close and informal concerns of the nuclear family. Social networks can also influence help-seeking behaviour of individuals suffering from mental illness as a communication system giving information, keeping normative and as a support system (Gottlieb and Hall, 1980) as cited in Angermeyer et al. (1999).

The role of the community in the prevention and care of mentally ill individuals has now been acknowledged and is regarded significant in the development of mental health programs in communities (Kabir, Lliyasu, Abubakar and Aliyu, 2004). Community attitude and beliefs about mental illness play a role in determining help-seeking behaviour and the successful treatment of the mentally ill individuals. Moreover, ignorance and stigma prevent the mentally ill from seeking appropriate help. Attitudes and beliefs concerning mental illness are influenced by lack of knowledge. A study conducted by Van der Ham, Wright, van, Doanand, Broerse (2011) revealed that many respondents identified stress and nerve problems as mental illnesses, and were unable to define mental illness and pointed out the causes of mental illness when asked about them. Therefore, this calls for

mental health awareness programs in communities to assist community members in understanding mental illness. This may improve good help-seeking behaviour.

2.8 Theoretical perspectives on help-seeking pathways

The term help-seeking originates from the medical sociology literature examining illness behaviour within the health context (Rickwood and Thomas, 2012). The establishment of the study of illness behaviour followed the recognition that people do not always consult health care professionals whenever they experience symptoms (Rickwood and Thomas, 2012). One of the challenges of help-seeking process to effective intervention for prevention and treatment of mental illness is the reluctance by people to seek professional help. The study of help-seeking pathways is essential because many people who are suffering from mental illness do not access professional service for mental health problems. Furthermore, even in countries with good access to health care, people are reluctant to access mental health professionals (Rickwood and Thomas, 2012).

According to Rickwood and Thomas (2012), help-seeking was conceptualized as an active and adaptive process of attempting to cope with problems or symptoms by using external resources for assistance. Health care seeking behaviour is a specific aspect of help-seeking behaviour. Individuals vary in their readiness to seek help from health care services. Some people seek help when their symptoms worsen, while others openly show willingness to go for treatment (Chandrika, 2019).

2.8.1 Theory of Reasoned Action (TRA)

The Theory of Reasoned Action was developed by Fishbein in exertion towards recognizing the relationship between attitude and behaviour (Ajzen and Fishbein, 1980). The theory finds its origins in the field of psychology. The theory defines the relations between beliefs, attitudes, norms, intentions and behaviours of the individual. It is believed that an individual's behaviour is determined by his behavioural intention to

accomplish it. The intention is itself determined by the person's attitudes and his subjective norms towards the behaviour (Ajzen and Fishbein, 1980).

The theory of reasoned action suggests that to envisage an individual's intention, the person's attitudes, subjective norms and perceived control play a key role in help-seeking behaviour (Demyan and Anderson, 2012). Furthermore, the theory proposes that help-seeking behaviour for mental illness will happen after a person overpowers beliefs and obstacles to seek help. When this change occurs, it will increase positive attitudes, which will impact on the intention to take treatment and adherence to treatment.

2.8.2. The Health Belief Model

The Health Belief Model (HBM) was developed in the early 1950s by a group of social psychologists as a model that attempts to explain and predict health behaviours (Janz and Becker, 1984). The focus of this model is to understand the widespread failure of people to accept disease preventatives or early detention of asymptomatic disease (Janz and Becker, 1084). The HBM was based on the understanding that a person will take a health related action if that person feels that a negative health condition can be avoided; has a positive expectation that by taking a recommended action, he will avoid negative a health condition and believes than recommended health action can be successful (Rosenstock, 1974).

The model explains three main aspects related to health behaviour, which are an individual's perceptions regarding the illness, modifying factors and the likelihood of taking action (Becker, 1974). An individual perception' covers the perceived susceptibility of an illness and its perceived seriousness or severity (Becker, 1974). According to the HBM, health behaviour is explained by an individual decision to take action. It suggests that in order for an individual to take action to avoid an illness, that person would need to believe that he/she was personally susceptible to the illness, that the occurrence of the

illness would have at least moderate-severity on some component of life, and that taking action would benefit him/her by reducing the susceptibility to the condition (Rosenstock, 1974). It further highlights that the likelihood of a person to take action is extremely reliant on an individual's perception of an illness, perceived threat to their health and the benefit of preventative action. In addition, a stimulus, or cue to action must also be present in order to trigger the health promoting behaviour. These cues can be internal or external. They include pain, symptoms, social influence and information from health care providers.

2.8.3. Theory of Planned Behaviour (TPB)

According to Ajzen (1991), the theory of planned behaviour links a person's beliefs and their behaviour. He further proposes that an individual's behaviour is predicted by his /her intentions. In turn, intentions are predicted by attitudes about the behaviour, the subjective norms and the individual's perception of their control over the behaviour. Thus, an individual's attitude towards behaviour, his or her subjective norms and perceived behavioural control, together shape his or her behavioural intentions and behaviours (Ajzen, 1991).

A study conducted by Schomerus, Matschinger and Angermeyer (2009) suggests that behavioural beliefs produce a favourable or unfavourable attitude towards the behaviour, normative beliefs result in perceived social pressure and subjective norm and control beliefs give rise to behavioural control, the perceived ease or difficulty of performing the behaviour. An individual's beliefs determine whether a person will seek help or not when faced with a mental illness. The theory highlights that behaviour is also influenced by what significant others think about the behaviour that should be performed. For example, if they approve the behaviour, it is likely that an individual will perform the behaviour.

Based on the theory of planned behaviour, it can be suggested that an individual's beliefs towards mental illness will determine the pathways that a person's beliefs will result in a positive outcome. Moreover, significant others have an influence on the pathway to follow

when seeking help for mental illness. Attitudes towards help-seeking, perceived social norms about help-seeking, and perceived behavioural control influence behavioural intentions to seek help. Equally, attitudes and perceived norms are influenced by individual beliefs about behaviour (Mills, 2010).

2.8.4 The biomedical model

According to Beckett (2017), the biomedical model first advanced by Wilhelm Greisinger, proposes that just as diseases cause physical illness, they are thought to underlie mental health problems. This is based on the notion that illnesses are caused by a specific disease. Furthermore, there are a range of known biomedical explanations for the causation of mental health issues, which include genetics, neurological problems, or substance misuse. A person who is suffering from depression, for example, may present signs and symptoms such as lowered mood, unusual eating habits, and alteration in sleeping patterns and so forth, just as a physical illness has signs and symptoms (Beckett, 2017). The central tenet of the biomedical model is that psychological problems are literal diseases of the brain (Deacon and McKay, 2015).

This model holds that all illnesses can be explained biologically, and assumes that psychological and social processes are independent of the disease process. Though it is effective in diagnosing and treating illnesses, the model has ignored a large component of Biopsychosocial aspect of illnesses. Furthermore, it has neglected treatment processes, inhibited treatment innovation and distribution (Deacon and McKay, 2015). People often experience unusual sensations, which will influence whether a person or their health advisors interpret a change in their state as indicating disease (Wade and Halligan, 2004). Symptoms that people experience lead to involvement with health care. Moreover, interpreting abnormal sensations as symptoms by people and their significant others will have an influence on the use of health care systems.

2.9. Theoretical framework of the study: The Pathway Model of help-seeking

The present study employed the Pathway Model to develop a model on help-seeking pathways followed by caregivers of mentally ill persons. Suchman (1965) was the first to use the pathway model to describe the steps of the process from identification of symptoms to the use of particular health care providing facilities. The model aims at identifying a logical sequence of steps in help-seeking and analyses how social and cultural factors influence this sequence. This model is based on the path that people follow until they use different health facilities such as faith advisors, traditional healers and mental health services. The pathway model was developed by Febraga (1972). The model seeks to determine factors that influence health care choices that assist in understanding why people prefer certain mental health treatment over others (Febraga, 1972).

The hypothesis of the pathway model is that a path that people follow in reacting to the illness may be influenced by a number of factors. These factors include the perception of the illness, and the significant others that are involved in the decision about the help-seeking pathway choice to be followed (Good, 1987).

This theoretical framework outline above guided the researcher in the present study. This was achieved by understanding factors that influence pathways that caregivers follow in order to seek help for their loved ones suffering from mental illness. This model was found relevant to this study because it highlights factors that influence help-seeking behaviour as it helps understand how and why one would seek care earlier than others. More importantly, this model emphasizes the role of significant others in decision making for seeking help for mental illness (Good, 1987). The significant others (family members or members of the local community) play a role in health-seeking as they form part of a therapy managing group (Janzen, 1978). This emphasizes the essential role of relatives and friends in illness negotiation and management.

The pathway model gives an explanation on why people prefer certain help-seeking pathways over others. The following factors influence help-seeking behaviour:

- Beliefs about the significance of illness and its outcomes, which depends on how the illness is perceived and its severity.
- The readiness and eagerness to be worried about mental health related issues.
- Beliefs that a certain treatment practice will be helpful to treat mental illness.
- Perceived barriers, a perception of the difficulties to help-seeking behaviour.

Understanding of pathways that caregivers take prior to seeking help for mental illness is an important factor. This may be very crucial in planning to reduce any delays in seeking treatment. The decision to seek help from either the mental health care services or a traditional/spiritual healer may be influenced by issues such as the seriousness of the illness, the availability of the health services, financial implications and the person who is responsible for making that decision (Mkize and Uys, 2004). Other factors that may influence the pathway to seeking help includes perception of the illness, significant others and result in the decision about the health-seeking pathways choice that will be followed (Good, 1987).

According to Trivedi and Jilani (2011), sociocultural outline; educational background; the attitude of family; community concerning mental illness; perceptions about mental illness; myths that people believe in about mental illness; belief systems; stigma attached to mental illness; availability and accessibility of mental health institutions cause delay in the commencement of treatment. However, these factors vary from region to region. Significant others play a role in deciding the pathways to mental health care. Mostly, caregivers are the most important people in giving direction to the pathway of care to seek help (Trivedi and Jilani, 2011).

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter focuses on the methodology that was used in the study. It comprises tools and techniques which the entire study was based upon. Topics included are data collection methods, population, sampling and sample size, procedures used to collect data and data analysis methods. The researcher concludes this chapter with a brief overview of ethical considerations that were considered in conducting the study.

3.2 Research design

Research design is the overall decision that the researcher makes to plan for connecting the conceptual research problems to the appropriate and achievable empirical research (Creswell, 2012). In other words, the research design articulates what data was required, the methods used to collect and analyze this data, and how all of this was going to answer the research question (Creswell, 2012).

3.3 Research approach

In this study, the qualitative research approach was adopted. According to Ritchie, Lewis, Nicholls and Ormston (2014), qualitative researchers aim to have an in-depth understanding of human behaviour and the reasons for such behaviour. Specifically, the researcher used the phenomenological research design as elucidated by De Vos Strydom, Fouche and Delport (2011). The intention was to understand and describe lived experiences of caregivers in respect of help-seeking pathways that they follow to receive care and treatment for their loved ones.

3.4 Population and sampling

The population of the study included caregivers of mentally ill individuals in the Sinthumule-Kutama District area. The researcher used snowball sampling to select the

participants in the study. Snowball sampling is normally used when there is no knowledge of the sampling frame, and where there is limited access to appropriate participants for the intended study (De Vos et al., 2011). In snowball sampling, existing study participants recruit similar cases from among their acquaintances preferably more than one (Grinnell and Unrau, 2008). Although a total of ten participants were envisaged for the study, the researcher continued with data collection until the point of saturation (De Vos, et al., 2011). The typical process of a snowball sample begins by interviewing an initial set of research participants who serve as informants, not only about the research topic, but also about the potential participants (Morgan, 2008). The researcher identified one potential participant caregiver of mentally ill person(s) in the population. These participants recruited other caregivers of mentally ill persons to be included in the sample. The researcher encouraged participants to recruit more people to take part in the study until the point of saturation was reached.

The researcher only focused on caregivers of individuals with mental illness who reside in the Sinthumule-Kutama Municipal District area. Though an estimated number of 10 caregivers were intended, sampling was continued until data saturation occurred. The first participants were identified and approached to participate in the study. During the interview, the participants referred the researcher to other families who are taking care of individuals with mental illness. All the 12 participants who are caregivers of their loved ones with mental illness agreed to participate in the study.

Sinthumule-Kutama Municipal District is constituted by a combination of two communities, each with its own chief. It is a predominantly rural area situated on the western side of Makhado (Louis Trichardt) town, under Makhado Municipality in Limpopo Province, South Africa. It is a predominantly Venda speaking community with a mixture of Xitsonga and Sepedi speaking people.

3.5 Data collection

In this study, data was collected using in-depth semi-structured interviews**.** According to Gill, Stewart, Treasure and Chadwick (2008), a semi-structured interview consists of several key questions that help define the areas to be explored. This type of interview allows both the researcher and interviewee freedom to express their views in order to pursue an idea or response in more detail in order to address the research question broadly (Gill et al., 2008; Hugh-Jones, 2010). The semi-structured, face-to-face interview allows participants an opportunity to respond in their own words and in their own way**.** Participants were interviewed at their own home and the interview took approximately an hour. Interviews were conducted in participants' home language (namely, Tshivenda) to give them an opportunity to express their experiences more elaborately. Data was translated from Tshivenda into English by a Tshivenda language expert. The researcher used tape recording to record the interviews.

The researcher used an interview guide to ensure that the researcher covers the intended material and remains focused on the set topic (Rubin and Babbie, 2001) in order to address the aim and objectives of the study (Gill et al., 2008). The interview guide focused on exploring pathways followed by caregivers (see Appendix 1 (a): Interview guide and 1 (b): Interview guide in Tshivenda).

3.6. Data analysis

The researcher used interpretative phenomenological analysis (IPA) to analyze the data. According to Smith (2007), an interpretative phenomenology attempts to explore, understand and make sense of the subjective meanings of events and experiences of individuals. The aim of interpretative phenomenological analysis is to explore, in detail, how participants make sense of their personal and social world. The following steps as recommended by Pietkiewicz and Smith (2014) were followed in analyzing data for the present study.

Step 1: Multiple reading and making notes

In the initial stage, the transcripts were closely read several times for the researcher to familiarize herself with the data. Notes were made, listened to from audio tapes, brainstormed and immersed in the material over and over again. This helps researchers to immerse themselves in the data, recall the atmosphere of the interview and the setting in which interviews were conducted.

Step 2: Transforming notes into emergent themes

The aim of this step was to transform notes into emerging themes. Here, the researcher tries to formulate a concise phrase at a slightly higher level of abstraction, which may refer to a more psychological conceptualisation. In this stage, the researcher worked more with the notes made rather that with the transcript.

Step 3: Seeking relationship and clustering themes

This stage involves identifying connections between emerging themes, grouping them together according to conceptual similarities and giving each cluster a descriptive level. The researcher compiled themes for the whole transcript before she could start looking for links between themes. This was followed by a search for connections between key themes and their categorization by identifying clusters.

Step 4: Writing up the report

This step involves taking the identified themes and writing them up one by one procedurally. The researcher wrote an account of the phenomenon understudy and presented the data in a textual form.

3.7 Quality criteria

3.7.1 Credibility

According to Guba and Lincoln (1989), credibility is similar to internal validity. It relays to the method that the researcher uses to hypothesize generated knowledge. The participants expressed their views in the process of the inquiry. Credibility involves correspondence between the way in which the participants perceive certain issues, and the way in which the researcher portrays their viewpoints. In the present study, the researcher effectively placed boundaries around the study by stating the limitations such as variables, population and theoretical framework. The researcher was also objective in order to eliminate issues of biasness.

3.7.2 Transferability

Transferability refers to the possibility that what was found in one context by a piece of qualitative research is applicable to another context (Lincoln and Guba, 1985). In the data collection process, the researcher used multiple techniques such as face-to-face interviews with audio-recordings in order to ensure transferability.

3.7.3 Conformability

Conformability implies that the findings of the study can be confirmed by another person, and that evaluation can be done based solely on the data collected by the researcher. In order to comply with this, the researcher kept all the records, transcripts and data collected during the study to be confirmed by the supervisor and co- supervisor (De Vos et al., 2011).

3.7.4 Dependability

Dependability is the alternative to reliability, where the researcher makes an effort to account for changing conditions in the phenomenon chosen for the study as well as

changes in the design created by an increasingly refined understanding of the setting. The researcher ensured that the research process was logical, well documented and audited. The researcher established dependability by consistently examining the research process as it progresses (De Vos et al. (2011).

3. 8 Ethical considerations

3.8.1 Permission to conduct the study

Before the researcher commences with the study, ethical clearance was sought and obtained from the University of Limpopo Research Ethics Committee (see Appendix 5 for Ethical clearance certificate).Permission to access the participants in the community was obtained from the local tribal authority in keeping with local communication protocols (see Appendix 2a: Letter to the Sinthumule-Kutama Tribal Authority- English version, and Appendix 2b: Letter to the Sinthumule-Kutama Tribal Authority- Tshivenda version).

3.8.2 Confidentiality

Taking cautions on confidentiality does not only apply to intentionally taking it upon oneself not to reveal to others what the participants revealed with the researcher in confidence, but it also places a burden upon a researcher to ensure that confidentiality is not breeched accidentally or as a result of carelessness (Gregory, 2003). Subsequently, the researcher ensured that confidentiality is maintained. In this regard, confidentiality was ensured by safely filing the interview schedules and participants' transcripts; and further ensuring that only people who took part had access to the research information. The researcher took full responsibility to ensure that privacy and identity of the research participants were safeguarded.

3.8.3 Informed consent

The researcher is obliged to ensure that the participants know and understand the purpose of the study and that their consent is requested without any coercion. Furthermore, consent is achieved when the participants in the study comprehend its objectives, and understand the level of engagement required in order to facilitate their agreement to co-operate (Baker, 1994). For the purpose of this study, participants were provided with all the necessary information about the study before they give consent. A consent form was therefore provided to the participants, and signed before the commencement of the study (see Appendix 3a: Consent letter and form English version and 3b: Consent letter and form Tshivenda version).

3.8.4 Voluntary participation and autonomy

The norm of voluntary participation is easier to accept in theory than to apply in practice. However, no one should be forced to participate (Barbie, 2016). For the purpose of this study, participants were allowed freedom to decide whether or not they can form part of the study. Furthermore, the research participants were advised that they were free to withdraw from the study at any time should they choose to, and that the decision would not affect them negatively in any way.

3.8.5 Aftercare for participants

Given the nature of the subject matter, it is possible that some participants may show some adverse emotional reactions during the investigation. Participants who would show such adverse emotional reactions would be referred to psychologists or social workers at the nearest hospital for counselling. During data collection, all participants coped well with the process, it was not necessary to refer them for counselling.

CHAPTER 4: THE FINDINGS OF THE STUDY

4.1. Introduction

The chapter discusses the findings of the study. Firstly, the demographic profile of the participants and phenomenological explication are discussed. The following themes attained from the participants will be deliberated: a) participants' understanding of events that could have led to their family member's mental illness; b) participants' own understanding of mental illness; c) pathways followed by the participants before their family member (s) received mental health services in the hospital; d) reasons that led to mental health care services; e) experiences after their family member (s) had received services from the mental health care system; and f)other agencies currently used except or in addition to mental health facilities. The summary of the results of the study will conclude this chapter.

4.2. The demographic profile of the participants

Table 1: Demographic details

Participants No	Age	Gender	Residential Area	Religion
1	52	Female	Ha-Manavhela	ZCC
2	52	Female	Muduluni	Born again
3	24	Male	Muduluni	ZCC
4	53	Female	Ha- Manavhela	Traditional
5	64	Female	Ha-Ramantsha	Apostolic
6	28	Female	Madombidzha	Born again
7	88	Female	Madombidzha	Lutheren
8	57	Female	Ha-Magau	Traditional
9	39	Female	Ha-Magau	IPC
10	59	Female	Madombidzha	Traditional
11	64	Female	Madombidzha	Traditional
12	48	Female	Ha- Pitela	Born again

The above table illustrates the demographical information of participant caregivers that were interviewed. There was one male (1%) and eleven females (99%). All of them were drawn from villages around Sinthumule-Kutama Municipal District area, Limpopo Province. Participants were included in the sample because they had some experiences to share concerning the pathways they followed in seeking help for their family member (s) with mental illness. The distribution by ethnicity showed that all participants (100%) were Tshivenda speaking. They were all caregivers of individuals with mental illness and most of them were taking care of their family members from the onset of the illness. Two caregivers took over after the individual with mental illness mothers died.

4.3. Phenomenological explication

4.3.1 Participants understanding of events or factors that could have led to their family member's mental illness.

The findings from the study suggest that caregivers of individuals with mental illness make different observations about the events that could have led to their family members' mental illness. Identified among others are: social stressors, witchcraft and being born with the illness. They believe that the cause of mental illness is religion or culture. The following quotations from the interview substantiate their understanding:

"I think that he was mentally disturbed during birth. Isn't that sometimes children got disturbed mentally during birth if something goes wrong? I don't know exactly what happened but I think he was born like that." [Participant 1, female, 52 years]

"She was born like that, she took long to walk, started walking when she was 6 years old. After birth doctors told me that she won't be a normal child, will not even make it to school. So I knew by then that she is not normal". [Participant 5, female, 64 years].

From the above quotations, it is indicated that caregivers acknowledge that complications during pregnancy or delivery may be predisposing factors that could have led to mental illness. Another factor indicated to be the cause of mental illness in some participants was

witchcraft. Jealous was believed to lead to the performance of witchcraft. The main reason for witchcraft as reflected in the extracts below is to prevent the person's potential to achieve good things in their lives:

"I believe that it was caused by people's jealousy. You know as Africans witchcraft is real" [Participant 4, female, 53 years]

"Our mother was a normal person and selling in order provide for us. Suddenly she changed and became mentally disturbed, closing herself in the house and at times refusing us to go out of the house. What led to her mental illness in unknown because we were still very young to prove it, but we believe she was bewitched by people who were jealous of her selling and her business was going well" [Participant 6, female, 28 years].

"I think her missing uniform led to her being like this. People are against me and they are making me suffer through this child. They are jealous that this child will be a successful person". [Participant 10, female, 59 years]

"One of his family members told me that I should take him after hospitalisation because he will die if he can go back to the royal house. This people are responsible for my son's illness. They did this to him because he was a clever boy, they knew that he will take away my poverty". [Participant 11, female, 64 years]

Another factor that was mentioned by some participants was social stressors. These stressors appear to be attributed to the onset of mental illness, which includes financial difficulties, occupational and medical conditions. The following quotations corroborate the participants' understanding of factors that led to their family members' mental illness:

"What caused his mental illness is stress and frustration, he invested his money at the bank and after he lost his job, he went to the bank to withdraw the money and the money was gone. I think this frustrated him and caused him to be sick" [Participant 2, female, 52 years]

"What happened to my mother was caused by epilepsy, it led to my mother having mental illness. It started long time before I was even born. I believe the more she had seizures the more it affected her brain". *[Participant 3, male, 24 years]*

"She was hit by the car when she was young which might be the main contributor. She was also diagnosed with epilepsy" *[Participant 9, female, 39 years]*

The following comment appears to hold the cultural believe that a person who is being breatfed by the mother who has mental illness will automatically be mentally ill.

"What led to his mental illness is that he breast fed from his mother who had mental illness and transferred the illness. According to our culture, she was not supposed to have breast fed this child being mentally ill because this child drank this mental illness from the mother's breast. The doctors didn't look at the mother's breast after giving birth that it will be problematic if she breast feed". *[Participant 7, female, 88 years]*

From the above extracts it is indicated that the belief cause of mental illness influences how they perceive the illness. Most of the events that were identified to have led to mental illness were religious or cultural orientated.

4.3.2. Participants' own understanding of mental illness

Mental illness was defined as alterations in behaviour whereby a person loses contact with reality. Every participant used different descriptive words related to their experiences as caregivers. Some participants seems to lack knowledge about what mental illness is. The following quotations illustrate the participants' understanding of what mental illness is:

"I heard that is when a person's mind is no longer thinking like us, the right way. When we are talking about this topic, the person with mental illness will respond in an irrelevant way. I see this with my brother, sometimes he will talk normally sometimes he will be

totally irrelevant and illogical. I will see that we are not in the same line with regard to our mind set. To me that is mental illness" *[Participant 2, female, 52 years]*

"I think mental illness differs, in my case he was born like this and he is just slow at school. He was never going to pass at school. With other they are more crazy and aggressive to people" *[Participant 1, female, 52 years]*

"It is difficult for me to explain exactly what mental illness is but I see when it starts with my mother. I will see her talking alone, being aggressive and walking up and down the whole yard. Then I will understand that oh today things are not well, mental illness has started again" *[Participant 4, male, 24 years]*

"I don't know what this illness is". *[Participant 5]*

"We believe that mental illness can be caused by many things. In our mother's case it was witchcraft". *[Participant 6]*

In the quotations given above, participants seem to have little understanding of mental illness. Almost all participants did not give a clear definition of mental illness. They used the manifestation of their family members' symptoms to describe what they understood to mean mental illness.

4.3.3. Pathways followed by participants before their family member (s) received mental health services in the hospital

People use different pathways and strategies to manage diseases of different kinds. Mostly, the pathways that are chosen by caregivers are either informed by their culture or religious belief system. From the interview, faith healers seem to be trustworthy, and in some cases, consulted first or after most participants have sought help from health facilities. Caregivers appear to be the ones taking decisions in terms of treatment to be followed. Most participants believe that individuals with mental illnesses are unable to

decide for themselves as they are ill and incapable of making sound decisions concerning pathways to follow in seeking treatment.

Participant 1: female, 52 years old

*"Before going to the hospital, as a believer in God I went to the ZCC church. Before this was worse they prophesied me at church and told me this child will not be normal for the rest of his life. They gave me Ndayela (instructions) so that I can overcome this trial" **[1st treatment point]***

*"After sometime, I took him to the hospital so that they can examine maybe they will be able to help from their side. Also to assess him to go to the special school and I see that they helped, there is a difference now after the doctor and psychologist recommended that school". **[2nd treatment point]***

Participant 9: female, 39 years old

*"Her mother took her to churches to be prayed for. **[1st treatment point]***

*"She was also taken to apostolic prophets for her to be strong and overcome this trial". **[2nd treatment point]***

*"Then later she was taken to the hospital for medication. Even though the medication is not helping much" **[3rd treatment point]***

Participant 10: female, 59 years old

"*I went all over the place, I exhausted all the money that I have. Poor as I am but I heard to seek help for her. I started by consulting traditional healers, they told me that this was done by a person but they didn't heal her*". ***[1st treatment point]***

*"Then I moved to churches, I stayed with my daughter at Moria for 2 months, the challenge is after we came back she refused to drink the tea and follow dzi ndayela (instructions) from the church. That is why she is not getting better". **[2nd treatment point**]*

"I also visited prophets from different churches but haa I didn't get any help" ***[3rd treatment point***

"Recently I bought pills from someone who told me that those pills are going to heal her. I just lost money that I don't even have. The pills were over a thousand. I really don't know what to do, I tried everything I could do". ***[4th treatment point]***

My plan now is to take her to the hospital. Maybe they will help her. I lost hope now and when I think of the money that I spend, it breaks my heart. ***[Planning 5th treatment point]***

The above extracts reveal that when people are faced with illnesses, they try everything to help their family members to get well. They even spend money that they do not have because of the need to help. Cultural beliefs have an influence on the paths that caregivers choose to seek relief for their family members' discomfort. From the interviews, some participants started with mental health care services. When they did not get satisfaction, they moved to other agencies. The following quotes illustrate participants' responses:

Participant 11: female 64 years old

*"My son was staying at his father place, at the royal house after his father died and I went back to my family. His family there didn't like him and they kept on saying he should follow me but he refused. One day I received a call saying that he is admitted at the hospital. I visited him and found out that he was in a psychiatric ward. This braked my heart because I left him and now he is like this****" [1st treatment point]***

"After hospitalisation, I took him to traditional doctors. I was told that they cannot help him because this was done by his family. You know how royal houses operate, if they do something it is irreversible" ***{2nd treatment point]***

"He is now going to church (ZCC). I see a different as well that since he started going to church he is calm, easy to communicate with him and I can even send him to the shop to buy bread or post office to collect post". ***[3rd treatment point****]*

The results of the current study indicate that diverse health care providers have been visited by these participants as soon as they discovered that their family members had symptoms of mental illness. These include, among others, medical doctors (general practitioners), faith healers, traditional healers and mental health care facilities as their initial treatment point. However, some participants indicated that health care systems were their initial treatment. Most of those whose first choice of treatment was health care services, the decision was informed by the severity of symptoms. For example, symptom worsening, uncontrollable and aggressive behaviour, and advice from teachers and general practitioners.

Participant 7: female 88 years old

*"I didn't take him anywhere else, I am a born again Christian so I believe that God can use doctors to heal someone. That's why I took him straight to the doctor and he was referred to the hospital. Now he is placed at Hayani hospital because he was uncontrollable**". [1st treatment point]***

Participant 12: female, 48 years old

*"When he started becoming mentally ill, he was aggressive, we couldn't control him, and he had this strong power that I have never seen. So we had to phone the police to help calm him down. The police took him straight to Elim hospital. My heart was broken, after hospitalisation I took him to church for deliverance". **[1st treatment point].***

*"I knew that God never gave me an ill child, so I had to stand up and seek spiritual intervention because this was caused by the enemy. After continuous prayers of deliverance and healing from my pastors and the church, now he is well. No more having the illness". **[2nd treatment point].***

Participant 2: female, 52 years old

*"This person was never taken elsewhere except the hospital. When my mother was still alive she saw his condition worsening then took him to Elim hospital. There at the hospital they discovered that he has mental illness". **[1st treatment point]***

4.3.4. Reasons that led to mental health care services

The study revealed that participants sought treatment from different services to ease the pain of their family members with mental illness. Their reasons for moving from one service to another was influenced by factors such as lack of improvement and worsening symptoms The other reason given was the fact that participants and other family members were unable to manage the behaviour of the individual with mental illness and the severity of the symptoms. The following extracts illustrate some of the participants' reasons for using the mental health care system:

"I have realised that nothing was changing. Even though he is being prayed for his condition didn't change" [participant 1, female 52 years old]

"After realising that this person has lost his mind and his condition became worse. He was no longer sleeping" [participant 2, female, 52 years old]

"That time it was difficult to manage her, she was troublesome and uncontrollable. So we were advised to take her to Elim hospital to get treatment. So we decided to take her to the hospital because she was worse and it was difficult for us" [Participant 6, female, 28 years old]

"He was very aggressive and it was difficult to control and manage him, that's why I pushed that they place him at the institution. Her mother died and then I was unable to look after him" [Participant 7, female, 88 years old].

The finding from the study also revealed that some participants were motivated by the fact that if the child is not copying in the mainstream school, he or she will qualify for disability grant. Another reason was that some participants were forced by the schools to take their children to special schools. With some participants, lack of knowledge was the barrier for not seeking help for their family members from mental health services.

"I took him to the hospital because I was advised to do that by the school. They wanted him to go to the special school" [Participant 8, female, 57 years old]

“So I was forced to take him to the hospital because teachers were complaining about his academic progress. I felt like he was becoming a burden to other children at school so I decided to take him to the hospital to assess him” [participant 1, female, 52 years old]

“We didn’t know that she can go to a special school until we were advised by one nurse to take her to the hospital so they can assess and help her with social grant to be able to pay to a special school. We decided to take her and they referred her to a psychologist and psychiatrist who assessed her and filled in forms for her to go to the special school”. [Participant 5, female, 64 years old]

“I realised that all this things that I tried didn’t help, so I decided to take him to the hospital so he can get social grand to be able to enrol him to a special school” [participant 4, male, 24 years old]

The following extracts highlight evidence that some people will first consult general practitioners before going to mental health services for opinions and advice. On the other hand, mental health services are perceived to be easily accessible and reliable to treat mental illness. Some participants highlighted that when they are incapable of managing the behaviour of their family members, they involve the police, who will take the individual to the hospital. Therefore, they are left with no option but to take the individual to seek help from the mental health system.

“Then we were advised to take him to the doctor. We took him to a GP then we were advised to take him to Elim hospital”. [Participant 2, female, 52 years old]

“Because the situation was worsening, I had to call the police and they took him to the hospital. He was very aggressive I was unable to calm him down. He was admitted to Elim for few months”. [Participant 11, female, 64 years old]

“For me the hospital is easy to access and they are trained to treat mental illness. The police also take her there and I find it helpful” [participant 3, male, 24 years old].

4.3.5. Experiences after family member (s) received services from the mental health care system

Another area that was explored in this study was the participants' experiences after taking their family members to the mental health system. The findings in this study discovered that most participants noted the improvement, but few symptoms still did not give them satisfaction. The following extracts illustrate the participants' experiences:

"I see him better ever since he was treated at Elim" [Participant 2, female, 52 years old]

"Since I started taking care of her and make sure she takes her medication every day, for the past 2 years she is stable. No more seizures and mental illness. She is well and taking good care of herself. I haven't experienced any challenges ever since then".

[Participant 3, male, 24 years old]

"Ever since he started taking medication, he is no longer falling more often. It can only happen once a month which is much better. Medication is helping a lot because he is no longer aggressive and taking alone. He is now stable". [Participant 4, female, 53 years old]

"We think she is much better ever since she started taking medication. If a person doesn't know cannot tell that she has mental illness" [Participant 6, female, 28 years old]

One participant showed their frustration and loss of home with the mental health services as their family member's symptoms of mental illness worsened with medication. Another participant did not try the mental health system because of the strong belief that her daughter was bewitched. The participant did not even believe that her family member could be helped by the mental health system. Other family members pressured her to decide to take her family member to the mental health services.

"I cannot say that she is well, I feel that at the hospital they are not helping much because she is still having seizures, aggressive and standing in a sun the whole day. I went there

several times requesting that they change her medication but the medication comes back the same from the hospital. I also believe that this medication is making her worse, maybe it is too strong or too much for her" [Participant 9, female, 39 years old]

"My plan now is to take her to the hospital. Maybe they will help her. Because her condition is worse, she takes out clothes. I can't carry on like this. My family members are not happy about me not taking her to the hospital. I now see that it is only the hospital that can help. I have lost a lot of money, I'm tired and frustrated".

[Participant 10, female, 59 years old]

4.3.6. Other agencies currently used in addition to the mental health facilities

The findings of the study revealed that participants have other agencies that they are using concurrently with the mental health services. These agencies are reported to be used to boost treatment in the mental health system. Some participants used other agencies for protection. These practices were influenced by the participants' cultural or religious beliefs. For example, someone who is a Christian will take their family members to church for prayers, deliverance and healing from the discomfort they are going through. On the other hand, someone who believes the cause of the illness is witchcraft is more likely to seek help for their family member to be protected from evil forces. Other participants use other agencies because symptoms on their family members are worsening due to medication from mental health services. The majority of the participants testified to be using other agencies to boost treatment in the mental health system. The following remarks illustrate the participants' responses:

"The help that I get now is to believe in God. I take him to church and make sure he is prayed for. I see that he is better since taking medication but I wish to see him completely healed. I believe that when they pray for him at church he will be delivered from this illness and will be healed completely and no longer take medication". [Participant 2, female, 52 years old]

"Yes, she gets another help at church. They pray for her and give her ndayela (instructions) to stay strong and health". [Participant 3, male, 24 years old]

"It is better when she goes to church, it is better that this medication. At church they pray for her and she will spend a month without fits". [Participant 9, female, 39 years old]

"He is now going to church (ZCC). I see a different as well that since he started going to church he is calm, easy to communicate with him and I can even send him to the shop to buy bread or post office to collect post". [Participant 11, female, 64 years old]

"I didn't stop taking him to church, so his continuous treatment is prayers and medication" [Participant 12, female, 48 years old]

From the above extracts, it is indicated that most of the participants use other agencies together with mental health services to seek relief for their loved ones. In most cases, other agencies are used for protection based on their beliefs as causes of mental illness. Some participants believe that other agencies like faith healers will heal their family members' illnesses completely.

4.4. Summary of findings

The sample comprised 12 participants aged between 24 and 88 years, who are caregivers of individuals with mental illness. All participants were Tshivenda speaking from Sinthumule-Kutama area in Limpopo Province. The majority of the participants were Christians; and few belonged to African traditional religion. The findings of this study revealed that participants hold different perceptions and beliefs about the causes of mental illness. These perceptions and beliefs appear to be religious or culture-based. Participants used their own experiences to define what mental illness is, according to the symptoms they see on their family members living with mental illness.

The study further revealed that participants visited a number of agencies to seek treatment for their family members. The pathways that were followed were influenced by several factors such as the perceived cause of the illness, their religious or cultural beliefs, severity of symptoms and advice from general practitioners and school teachers. Most participants made use of more than one service providers to seek help for their family members. The path either started with the formal setting, then moved to the informal setting and vice versa. In most cases, factors that influenced caregivers to take their family members to mental health services were the severity of the symptoms and their inability to manage their family members' aggressive behaviour. On the other hand, as soon as individuals with mental illness are discharged from hospitals, caregivers consulted other service providers mainly to enhance the treatment they are receiving, and for protection from evil forces.

CHAPTER 5: DISCUSSION OF FINDINGS

5.1. Introduction

In this chapter, the findings of the study and how they relate to existing literature is presented. These findings will be discussed in relation to the themes derived from the data and review the contribution of the study in terms of the aims set. The findings will also be discussed in relation to their implication on the theoretical approaches on help-seeking pathways.

5.2. Participants' understanding of events or factors that could have led to their family members' mental illness

The present study showed that caregivers of people with mental illness have different interpretations of the factors that cause mental illness. Some of them included social stressors, and witchcraft, which were reported as the major factors. The latter seems to be consistent with the findings of a study by Quntanilla (2010) who reported that the attribution of mental illness to supernatural powers dates back to the ancient Greek times. Quintanilla (2010) further states that the naturalistic point of view changed in the middle Ages after the Black Plague epidemic that wiped out about 30 million, which was half the population of Europe. After that devastation, mental illnesses were no longer seen as a result of natural causes, but of supernatural forces or malignant spirits that physicians were not able to deal with. At the end of the Middle Ages, more precisely during the Renaissance, the blame fell on witches and diabolical possession. Not only did this account support the present findings about witchcraft as cause of mental illness, it further lent support to the view in some African communities, tragedies and calamities of humanity are often attributed to the fault of witches (Jaco, 2017).

Szasz (1974) states that people have personal needs, opinions, social aspirations and values, which are attributed to physicochemical processes which in due time will be

discovered by medical research as mental illnesses The only difference, between mental illness and physical illness is that the former affects the brain whereas the other one is affecting other organ systems (Levine, 2017).

The present study did not cover the clinical causes of mental illness as stated by Pang et al. (2018), wherein undesirable or uncontrollable events were pointed out as having a detrimental effect. Although the first approach was originally designed to categorise the different ways that stressful situations affect people psychologically, what it helped to do was establish that different types of stress manifest in different ways.

5.3. Participants' own understanding of mental illness

In the present study, participants tended to mainly perceive mental illness as a condition whereby a person loses contact with reality. This perception of mental illness appears to be consistent with the finding by Jaco (2017), who defined mental illness as a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. In support of the present study, mental health problems are more common and include the mental ill health that can be experienced temporarily as a reaction to stresses of life.

5.4. Pathways followed by the participants before their family member (s) received mental health services in the hospital

Although people tend to follow different pathways and strategies to manage different types of illness, the study found that faith healers and traditional healers are major healers because they seem to be the trusted, and in some cases, consulted first or after the participants have sought help from health facilities. The decision to make use of Western health care services tended to be informed by the severity of symptoms. For example, worsening symptoms, uncontrollable and aggressive behaviour, and advice from teachers at school and general practitioners. The World Health Organization (WHO,

2002) estimates that about 80% of people who need mental health care in developing countries go to indigenous or faith healers for care. Jack-Ide, Makoroand Azibiri (2017) shared similar sentiments, stating that people's beliefs in the power of God, the availability of churches and the low cost of getting healed by men of God influenced their visit to a religious healer first or just after the health facility.

The World Health Organization (WHO, 2013) further supported the idea of religion and culture, stating that the pathways to care for mental illness are diverse and dependent on sociocultural and economic factors. In their collaborative study which included a centre in Kenya, WHO has reported that in those settings in which faith and traditional healers are active, there are delays in securing psychiatric help**.**

Some studies have been done to explain the popular use of informal sources of care alternatives. Various reasons have been suggested and beliefs in tradition and religion were noted as central (Burns and Tomita, 2015; Pang, Subramaniam, Lee, Lau, Abdin, Chua and Chong, 2018). These include an alignment of the illness beliefs of patients and healers, easier or more flexible accessibility, and cost. Furthermore, the reason why many people seek help from informal sources of care is based on what they believe is causing their symptoms.

In many traditional African belief systems, mental illness is perceived to be caused by ancestors or being bewitched. Traditional healers and religious advisors are seen as expertise in treating these illnesses (Sorsdahl et al., 2009). These informal sources of care are viewed as more accessible than western forms of mental health care. In one study in India, it was argued that different types of healers may hold different worldviews. These in turn influence how they conceptualize or think about different illnesses (Trani et al., 2015). However, in a contrasting study of Zimbabwe psychiatric unit in Harare Hospital, most patients had by-passed the primary care facilities altogether and presented themselves directly to tertiary facilities (Booysen et al., 2016). The study further reported

that although a significant proportion of patients had consulted traditional healers, this did not seem to be associated with delays before receiving specialist mental health care.

5.5. Reasons that led to the use of Western mental health care services

The study revealed that participants seek treatment from different services to ease the pain of their family members with mental illness. Their reasons for moving from one service to another were influenced by factors such as lack of improvement and the worsening of symptoms. The other reasons given was the fact that participants and family members were unable to manage the behaviour of the individual with mental illness. The severity of symptoms and their decision to use mental health service was influenced by friends, close family relations and the deteriorating condition of illness. This finding is similar to a study of social network as a determinant of pathways to mental health service utilization in Nigeria by Lasebikan (2016), which showed that the majority were influenced by friends and relatives to access and use mental health services. Therefore, the significant role of friends and other support groups can play a role in advising and assisting with mental health service. Referral pathways need to be recognized by policy to develop activities and programmers to involve this group in the support of people living with mental health problems.

5.6. Experiences after family member (s) received services from the mental health care system

The present findings of this study appreciated that some people with mental illness have, to a certain extent, improved after using mental health services and few symptoms still did not get their satisfaction. Abdulmalik, Kola and Gureje (2016) shared a similar view on the success of mental health care wherein decentralization of health services has been promoted, and primary care services have been identified as playing the vanguard role in providing mental health care. However, in a contrasting view, a study in Nigeria noted that spiritual healers, traditional healers and general practitioners were the first to be contacted by majority of patients (Abiodun, 1995).

A conflicting belief that traditional medicine is the best has been found as a major setback for families to promote medicine adherence. The pathway model emphasised that people follow in responding to the illness may be influenced by a number of factors. Their perception regarding the illness determines which system to follow when faced with mental illness. The study established that family members still believe modern medication worsens the person's condition and then they will go back to indigenous ways of treatment. In a study conducted by Wang et al. (2007), supporting evidence to this sentiment was found, where it was argued that the disbelief about the modern care system was core to non-adherence. The same study then recommended that the two systems, that is the traditional and the modern, should work hand in hand to fight this problem.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter presents the conclusions and recommendations based on the study's findings. This section is into conclusions and recommendations.The aim of the present study was to explore pathways followed by caregivers of mentally ill persons seeking mental health care services around Sinthumule-Kutama area. The conclusions were drawn from the findings which were presented in themes following the specific objectives of the study, which includes (a) to determine experiences of caregivers in caring for persons with mental illness; (b) pathways that caregivers engage in seeking treatment for mentally ill patients before and after they were diagnosed with their condition; and (c) to establish whether or not caregivers make use of other forms of interventions in addition to the formal treatment that they receive from health care facilities.

6.2. Conclusions

The study concluded that caregivers vary in their understanding of causes of mental illness. Witchcraft, which is attributed to societal jealousy, was found to be the main cause of mental illness. Social stressors were perceived to be predisposing factors, with genetics also perceived as contributory factors in mental illness. The stressors were also perceived to be linked to someone's social economic status (that is, low income, unemployment) of patients.

When it comes to understanding mental illness, the study found that caregivers lack knowledge. In other words, they have low knowledge with regard to understanding mental illness. It was acknowledged that they were only able to explain "mental illness" by describing its signs and symptoms. Furthermore, the study concluded that the majority of mentally ill patient's health-seeking behaviour is informed by their culture and religious background and affiliation. Hence they consult faith healers and traditional healers before

going to the modern health care facility. However, between the two, it was concluded that traditional health is most trusted.

The study further concluded that patients seek mental health care services after their illnesses have become serious and not showing any sign of recovery. Furthermore, the advice of caregivers can also be concluded to be instrumental in seeking mental health care services. Improved and satisfaction was noted as the majority of patients visit the mental health care. Thus mental health care services were concluded as effective for mental illness.

Lack of knowledge, negative attitudes and fear of social stigma regarding mental illness play a role on help-seeking pathways that people with mental illness and their caregivers choose. Therefore, mental health education is important to South Africans about the consequences of alternative practices to ensure that they make an informed decision when choosing which pathway to take when faced with mental illnesses.

6.3. Recommendations

Based on the findings of the study, the following recommendations are made:

6.3.1. Community health education and awareness

The study recommended increase in public awareness by the Department of Health (caregivers and patients) of the mental health that might be needed to increase the understanding about mental illness. There are demands and calls for education for earlier recognition of mental illness signs and symptoms as well as appropriate help-seeking issues. Moreover, social network and social support may assist in increasing the knowledge level about mental health problems such as those of children and cognitive decline, as well as the promotion of well-being. Community-based interventions, by Department of Social development including education and enhancing social capitals

might contribute to mental health promotion. As was noted in the study, many patients attended health care service only if the illness of their loved ones got worse. It is therefore assumed that it might be lack of knowledge to change their attitude and to practice good health-seeking behaviours.

6.3.2. Changing health-seeking behaviour through behaviour change models

Through health education, the study recommends the adoption of the Knowledge, Attitudes and Practices (KAP) model (Basch, 1987), which will assist in the utilization of mental health care. Although this study did not directly ask mental health providers, the lack of actual knowledge or the understanding of mental illness and health-seeking patterns and reasons were evidence of misinformation or lack of knowledge. Accordingly, this calls for an adequate dissemination system to change patients' attitudes so that it may boost good help-seeking behaviour. Furthermore, community health workers are encouraged to offer open discussions about mental illness in a non-judgmental environment which is essential to help patients of mental illness to make educated decisions about health seeking care services.

In order to enhance a positive attitude towards mental health care, health talk sessions offered by clinics/hospitals can cast away the fear of stigma among patients who will be seeking mental health care. Additionally, there should also be a mutual and collaborated relationship between the service provider and the patient in need of mental health care service. Specific policies should have been deliberated to guide psychiatric and clinical nurses about issues such as non-judgemental attitudes towards the patients.

The study's findings and discussions recommended the Health Belief Model (Rosenstock, 1974), which is a psychological health behaviour change model developed to explain and predict health-related behaviours, particularly regarding the utilization of mental health care services. This model can be adopted to change the different beliefs, particularly as noted in this study that people delay seeking medical attention due to cultural and

religious beliefs. The health belief model suggests that people's beliefs about health problems, perceived benefits of action, barriers to action and self-efficacy explain engagement or lack of engagement in health-promoting behaviour.

With respect to the promotion of mental health care services, HBM should aim to increase perceived susceptibility to, and perceived seriousness of the consequences and health adverse effects of delaying seeking medical treatment. Therefore, the scope of health education should focus on prevalence and incidence of mental illness, individualized estimates of risk, and information about the consequences of delayed medical treatment (e.g., medical, financial and social consequences).

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APPENDICES

Appendix 1(a): Interview guide

Objective	Interview questions
1. To determine experiences of caregivers in caring for persons with mental disorders	a). I would like you to share with me your perception of mental illness?
	b) As a person who is taking care of an individual diagnosed with mental illness, I would like you to share with me your understanding of events and factors that could have led to your family member's mental illness?
	c) I also would like you to explain, in your understanding and experience, what mental illness is?
2. To investigate help-seeking pathways that are followed by caregivers of patients with mental disorders before and after they were diagnosed with their condition	d) After realising that your family member is ill, and before going to hospital, where did you go in order to seek help for your family member?
	e). Will you explain to me what led you to take your family member to the mental health care system?
3. To determine whether or not caregivers and patients make use of other forms of intervention in addition to the formal treatment they receive from health care facilities.	f) Please share with me your experiences ever since your family member has been receiving services from mental health care system?
	g) Kindly share with me about other agencies and providers of health care

	that you are currently using for your family member?

Appendix 1 (b) Nḓila ya kutshimbidzele kwa mbudzisavhathu

Zwipikwa	**Mbudziso dza mbudzisavhathu**
1. U bvukulula tshenzhemo dza vhaḓisi vha ṱhogomelo kha vhathu vhane vha na vhulwadze ha muhumbulo.	**a).** Ndi humbela uri vha nkovhele kuvhonele kwavho kwa vhulwadze ha muhumbulo.
	b). Sa muthu ane a khou thogomela muthu ane a vha na vhulwadze ha muhumbulo, ndi humbela uri vha nkovhele kupfesesele kwavho kha uri ndi mini zwo bvelelaho kana u itea zwe zwa swikisa kha uri muraḓo wa muṱa wavho a vhe na vhulwadze ha muhumbulo?
	c). Ndi humbela uri vha ṱalutshedze, u ya nga kupfesesele kwavho na tshenzhemo yavho vha vhona u nga vhulwadze ha muhumbulo ndi mini?
2. U ṱoḓulusa nḓila dzine vhaḓisi vha ṱhogomelo kha vhalwadze vha muhumbulo vha tevhedza dzone phanḓa na murahu ha musi vho no ṱhaṱhuvha vhulwadze uvho.	**d).** Nga murahu ha u wanulusa zwauri muraḓo wa muṱa wavho u khou lwala, na nga murahu ha u ya sibadela, vho ya ngafhi u ṱoḓa thuso ya u thusa muraḓo wa muṱa wavho?
	e). Ndi humbela uri vha ṱalutshedze uri ndi mini tsho vha swikisaho kha uri vha ise muraḓo wa muṱa wavho kha tshiimiswa

	tsha u thusa vhathu vha re na vhulwadze ha muhumbulo?
3. U bvukulula uri vhaḓisi vha ṱhogomelo khathihi na vhalwadze vha muhumbulo vha a shumisa naa dziṅwe nḓila sa nyengedzedzo kha dzilafho ḽa tshiofisi ḽo randelwaho nga vha zwiimiswa zwa mutakalo kana hai.	**f).** Ndi humbela uri vha nkovhele tshenzhemo u bva tshe muraḓo wa muṱa wavho a thoma u wana thuso kana dzilafho kha tshiimiswa tsha u thusa vhathu vha re na vhulwadze ha muhumbulo?
	g). Ndi humbela uri vha nkovhele zwiṅwe zwiimiswa kana vhaḓisi vha thuso ya zwa mutakalo vhane vha khou shumisana navho kha muraḓo wa muṱa wavho?

Appendix 2 (a): Letter to Sinthumule- Kutama Tribal Authority

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date _____

Sinthumule-Kutama Tribal Authority
Makhado
0920

His Excellency: Chief Sinthumule and Chief Kutama

Re: Permission to conduct research within Sinthumule-Kutama community

I am a registered student at the above mentioned institution. I am conducting research as part of the requirement for Master's Degree in Psychology. The title of the research project is: **Help-seeking pathways followed by caregivers of mentally ill persons receiving care and treatment from health care facilities within the Sinthumule-Kutama area.** The purpose of the study is to explore pathways followed by caregivers and their perceptions and experiences of taking care of mentally ill individuals.

I hereby request to be granted permission to conduct this research within Sinthumule-Kutama community. It is important to state that the researcher will maintain confidentiality concerning the identity of the participants in this research project. The participants will be assured about the voluntary nature of this study. They will be informed that they are free to withdraw from the study any time should they wish to do so.

The method of data collection will be semi-structured face to face interviews with caregivers of mental ill persons within Sinthumule-Kutama area.

Yours Sincerely

_____ _____

Faith Ratombo Date

Masters student

_____ _____

Dr. S.E. Nkoana Date

Supervisor

Appendix 2 (b): Letter to Sinthumule- Kutama Tribal Authority (Tshivenda version)

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date _____

Sinthumule-Kutama Tribal Authority
Makhado
0920

Kha Mavu/Musanda vha ha Sinthumule-Kutama

Khumbelo ya u ita ṱhoḓisiso kha muvhundu wa ha Sinthumule-Kutama

Ndi mutshudeni o ḓi ṅwalisaho na tshiimiswa tsha pfunzo dza nṱha tsho bulwaho afho nṱha. Ndi khou ita ṱhoḓisiso sa tshipiḓa tsha ṱhoḓea dza digirii ya masiṱasi wa vhaḓivhi vha muhumbulo (Psychology). Ṱhoho ya ṱhoḓisiso yone i ri: **Help-seeking pathways followed by caregivers of mentally ill persons receiving care and treatment from health care facilities within the Sinthumule-Kutama area. (*Nḓila dzine nga khadzo vhaongi vha ṱhogomela vhalwadze vha mihumbulo na dzilafho ḽine vha ḽi wana kha zwiimiswa zwa mutakalo kusini kwa ha Sinthumule-Kutama)***

Muhumbulo wa ṱhoḓisiso ino ndi u ṱoḓulusa nḓila dzine dza tevhelwa nga vhaḓisi vha thuso na kuvhonele kwavho na tshenzhemo ya u ṱhogomela muthu ane a vha na vhulwadze ha muhumbulo.

Ndi hafha nga u humbela thendelo ya uri ndi do kona u ita ṱhoḓisiso kha muvhundu wa Sinthumule-Kutama. Ndi zwa ndeme u amba kana u bvisela khagala uri ṱhoḓisiso ino i ḓo

dzhiela nzhele vhuḓifari vhune ha kwama u dzumba madzina a vhathu vhane vha ḓo vha tshipiḓa tsha ṱhoḓisiso ino. Vhadzheneleli vhane vha tama u vha tshipiḓa tsha ṱhoḓisiso ino vha fhulufhedziswa nga ha u ḓi nanga arali u tshi ṱoḓa u vha tshipiḓa tsha ṱhoḓisiso ino. Vha ḓo vhudzwa uri vho tendelwa uri vha litshe kana u sa bvela phanḓa na u vha tshipiḓa tsha ṱhoḓisiso ino tshifhinga tshiṅwe na tshiṅwe tshine vha ṱoḓa.

Nḓila ya u kuvhanganya mafhungo i ḓo vha mbudzisavhathu ine ya ḓo itwa na vhathu vho lavhelesana zwifhaṱuwo na vhathu vhane vha ṱhogomela vhathu vhane vha na vhulwadze ha muhumbulo kha muvhundu wa ha Sinthumule-kutama.

Wavho a fulufhedzeaho

……..	……..
Faith Ratombo	Datumu
Mutshudeni wa Masiṱasi	
…….	…….
Dr. S.E. Nkoana	Datumu
Mudzudzanyi	

Appendix 3 (a): Participant consent letter and form

Department of Psychology
University of Limpopo
Private Bag X1106
Sovenga
0727
Date _____

Dear participant

INFORMED CONSENT

Thank you for demonstrating interest in this study. It focuses on help-seeking pathways followed by caregivers of mentally ill persons receiving care and treatment from health care facilities within Sinthumule-Kutama area. The purpose of the study is to understand pathways followed by caregivers and their perceptions and experiences of taking care of mentally ill individuals.

Your responses to this specific 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 your participation in this study is voluntary and that you have the right to terminate your participation at any time.

Kindly answer all the questions as truthfully and honestly as possible. Your participation in this research is very important.

Thank you for your time

Yours Sincerely

_____ _____

Faith Ratombo Date

Masters student

_____ _____

Dr. S.E. Nkoana Date

Supervisor

Appendix 3 (b): Vhurifhi ha thendelo na fomo kha vhadzheneleli

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

Date……

Kha vhadzheneleli

Ndi khou livhuwa u takalela havho u bvisela vhuḓipfi havho kha ṱhoḓisiso ino yo ḓisendekaho kha u ṱoḓulusa: Nḓila dzine nga khadzo vhaongi vha ṱhogomela vhalwadze vha mihumbulo na dzilafho ḽine vha ḽi wana kha zwiimiswa zwa mutakalo kusini kwa ha Sinthumule-Kutama.

Muhumbulo wa ṱhoḓisiso ino ndi u ṱoḓulusa nḓila dzine dza tevhelwa nga vhaḓisi vha thuso na kuvhonele kwavho na tshenzhemo tsha u thogomela muthu ane a vha na vhulwadze ha muhumbulo.
Phindulo dzavho kha mbudzisavhathu iyi dzi ḓo dzumbiwa. Muṱoḓisisi ha nga ḓo lingedza u amba dzina ḽavho na phindulo dzavho kha mbudziso dza mbudzisavhathu kana u amba dzina ḽavho sa mudzheneleli wa ṱhoḓisiso ino. Vha eleletshedzwa zwauri u dzhenelelwa havho kha ṱhoḓisiso ino vhone muṋe vha tou nanga na uri vha na pfanelo dza u litsha kana u ḓibvisa tshifhinga tshiṅwe na tshiṅwe.
Vha humbelwa uri vha fhindule mbudziso nga vhungoho na u fulufhedzea nga hune vha nga kona. U vha tshipiḓa tsha ṱhoḓisiso ino ndi zwa ndeme.

Wavho a Fulufhedzeaho

_____

Faith Ratombo Datumu

Mutshudeni wa Masiṱasi

_____ _____

Dr. S.E. Nkoana Datumu

Mudzudzanyi

Appendix 4 (a): Consent form to be signed by the participant

Consent Form

I_____ hereby agree to participate in a Masters Research project that focuses on help-seeking pathways followed by caregivers of mentally ill persons receiving care and treatment from health care facilities within Sinthumule-Kutama area.

The purpose of the study has been fully explained to me. I understand that I am participating willingly and without being forced in any way. I further understand that I can terminate my participation in this study at any time should I wish to; and that this decision will not affect me negatively in any way.

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

Signature _____

Date _____

Appendix 4 (b): Fomo ya thendelo ino ḓo sainwa nga mudzheneleli

Fomo ya Thendelo

Nṋe…… ndi khou tenda u vha tshipiḓa tsha ṱhoḓisiso ya masiṱasi ine ya lavhelesa Nḓila dzine nga khadzo vhaongi vha ṱhogomela vhalwadze vha mihumbulo na dzilafho ḽine vha ḽi wana kha zwiimiswa zwa mutakalo kusini kwa ha Sinthumule-Kutama.

Muhumbulo wa ṱhoḓisiso ino wo ṱalutshedzwa nga vhuḓalo. Ndi khou pfesesa zwauri ndi khou vha tshipiḓa nga u ṱoḓa ndi sa khou kombetshedzwa. Ndi dovha hafhu nda pfesesa uri ndi nga kona u litsha u vha tshipiḓa tsha ṱhoḓisiso ino tshifhinga tshiṅwe na tshiṅwe arali ndi tshi ṱoḓa na uri tsheo yanga i nga si vhuye ya lala yo nkwama nga nḓila isi yavhuḓi.
Ndi khou pfesesa uri muhumbulo wa ṱhoḓisiso ino asi u vhuedza nṋe sa muvhudziswa. Ndi dovha nda pfesesa zwauri zwidodombedzwa zwanga sa zwine zwa khou vhonalisa zwone kha ino fomo a zwi nga ḓo vha na vhuṱumani na mbudzisavhathu yo dzudzanywaho na uri phindulo dzanga dzi ḓo dzumbwa.

Tsaino…….

Datumu……

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 4029, Fax: (015) 268 2306, Email:Abdul.Maluleke@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE CLEARANCE CERTIFICATE

MEETING: 07 February 2018

PROJECT NUMBER: TREC/06/2018: PG

PROJECT:

Title:	Help-seeking pathways followed by caregivers of mentally ill persons in Sinthumule-Kutama, Limpopo Province.
Researcher:	F Ratombo
Supervisor:	Dr SE Nkoana
Co-Supervisors:	Prof T Sodi
School:	Social Sciences
Degree:	Masters in Clinical 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.