THE PERSPECTIVES OF SOME AMAXHOSA HEALTHCARE WORKERS REGARDING MENTAL DISTRESS: AN INTERPRETIVE PHENOMENOLOGICAL ANALYSIS

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By

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ABSTRACT

Mental distress is a universal phenomenon experienced by many individuals despite age, race, gender, occupation, or socio-cultural context and is slowly becoming a major contributor to the burden of disease in South Africa. However, mental distress fails to take precedence in SA because of inherent intricacies in understandings about it, as a result of ways of being conceptualised and interpreted differently across cultures.

This research study explored amaXhosa healthcare workers' understandings, knowledge, practices, and attitudes regarding mental distress amongst some amaXhosa people. The study aimed to investigate what mental distress means for some people who belong to the amaXhosa ethnic group, to uncover how they conceptualise mental distress, seek help or what behaviours prevent help-seeking. It aimed to highlight any prevalent attitudes of stigma and discrimination, to build insight into overlooked aspects in psychotherapy practice especially when dealing with non-western populations.

The study utilised interpretative phenomenological analysis (IPA) as its analytical lens; to explore and to enter as far as possible into the worlds of participants to generate rich data and in-depth analysis. Four participants were recruited through both purposive and snowball sampling and data were gathered using individual semi-structured interviews.

From the data collected, the findings illustrate a limited understanding of mental distress amongst some amaXhosa people due to lack of education and awareness on the subject, leading to the apparent silence in discussing such matters and inadvertently predisposing it to being viewed as taboo. The predominant themes as evidenced by the data were the use of language that sensationalises mental distress; misinformation; Afrocentric beliefs that rationalise mental distress; alienation and segregation of those affected; and the primary healthcare system as a source of reinforcing prevalent stigma and discrimination. The findings show a link between constructs around mental distress and the prevalent socio-

cultural environment, denoting that some perspectives can be linked to observations or modelling in childhood, from people in the respective communities in which people live.

Keywords: *mental distress, amaXhosa culture, stigma, western world views, Afrocentric principles*

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Maz'anethole!

DECLARATION

I, Siphosethu Ngqamfana, declare that this research is a result of my own work, except where otherwise stated. I have given the full acknowledgement of the sources referred to in the text. This study has not been submitted before for any degree or examination at any university.

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Siphosethu Ngqamfana

(February 2023)

DEDICATION

To my late grandmother, I never once imagined completing this journey without you, it set me off balance, but your presence never escaped my heart or mind. Your interest in understanding what it is that I do and how it can be beneficial to Africans especially amaXhosa has been the fuel I have needed to see this study to fruition. Thank you for grooming me to be conscientious, kind, loving and understanding, for I know your sound nurturance will transcend in my work with all the individuals I encounter. This is the manifestation of all your prayers I hope you are proud, Mama.

CHAPTER ONE: INTRODUCTION

1.1. Chapter Overview

This chapter will provide a rationale for the present study, including the research aim and questions. It will briefly outline the context in which the study is situated, followed by a preview of the subsequent chapters of the study.

1.2. Rationale for the research

The research aims to contribute to the literature on the perspectives of some amaXhosa healthcare workers related to their conceptualisation of mental distress and the sources of these understandings. It is concerned with uncovering existent attitudes of stigma and forms of discrimination experienced by individuals living with mental distress, through exploring the lived experiences of key informants. Furthermore, it aims to investigate help-seeking behaviours or methods most sought by some amaXhosa people in dealing with mental distress to better facilitate in-depth understanding of their experiences of this phenomenon.

Mental distress in Africa has not received the focus of attention as in many developed parts of the world. Daar et al., (as cited in Monteiro, 2015) postulated that most African countries on average spend less than 1% of their limited health budgets on mental health care. South Africa (SA) has paid some attention to mental distress, with the development of policies such as the Mental Healthcare Act (Act no 17 of 2002), but disparities exist between the development of policies and their implementation as part of primary healthcare (World Health Organisation, WHO, as cited in Boxer, 2005). It was made apparent in research conducted by the WHO that paradoxically to the neglect of mental distress, most populations in African countries face increased susceptibility to mental illness (Boxer, 2005). The causes of this were attributed to the numerous socio-economic risk factors of poverty, social inequality, war, conflict, disasters, migration, and urbanization (Lund, et al., 2013). It has also been indicated

that these social variables contribute to a cycle where the mentally distressed have limited access to treatment and therefore become increasingly marginalized (Griggs & Saxena, 2004).

Studies have shown that SA is particularly faced with increased vulnerability to neuropsychiatric disorders and substance use disorders given the high rates of unemployment and poverty, high rates of crime, and the potentially stressful living conditions (Nglazi et al, 2016). Petersen et al., (2012) noted that depression is estimated to become the second leading burden of illness globally by 2030. With the above in mind, it appears imperative for mental healthcare practitioners to begin applying their efforts and knowledge to firstly, understanding the context in which their patients exist; and furthermore, understanding the state of mental healthcare in those respective contexts, to start intervening effectively to treat people's mental distress.

Bubenzer et al., (2019, as cited in Shange & Ross, 2022) stated that Eurocentric definitions of mental health and interventions still dominate, overshadowing the under researched local traditions, cultures and rituals. Madu (2015) further noted that Black psychotherapists may inevitably experience tensions between Western forms of psychotherapy (embedded in Eurocentric values), as in many cases this may fail to adequately address or appeal to the needs of African clients; and does not incorporate African traditional forms of Psychotherapy, which have so far belonged to the exclusive domain of African traditional and religious faith healing practises. The use and overreliance on Eurocentric principles in psychotherapy as a blueprint to alleviating distress inhibits the emergence of a more African centric understanding of mental health and interventions, as even current training received by psychologists in SA today is highly embedded in principles proved to be effective and efficient with Western populations. Therefore, this creates a situation where mental distress as a phenomenon is preconceived as peculiar by Africans, widening the gap of underreported and diagnosed cases, which may further perpetuate apparent attitudes of stigma and discrimination

towards people experiencing it (Nglazi et al, 2016). Hence this study is concerned with understanding the conceptualisations of African people about these phenomena, hoping to uncover the help seeking behaviours most sought by some amaXhosa people affected by mental distress, to then make suggestions for integrated intervention strategies that might be more beneficial.

While the WHO (2017) defined mental illness as alterations in thinking patterns and behaviour whereby a person's contact with reality is disrupted, South African author Mkhize (2003), maintains that the African view of mental ill health currently encompasses a wide range of causes from ancestors, folk belief in witchcraft, to modern medical science. He further stated that then healing is based on restoring good relationships between the person, other individuals, and the ancestors in the spirit world, in both the past and the present. He explained that within traditional South African groups, mental distress is incorporated within the social way of life. Consequently, in African medicine, care of persons with mental distress has for decades been relegated to traditional and religious healers, who treat mental distress as part of general medical care. In this thesis therefore, the term mental distress is used to both incorporate the breadth of what is thought of in African view and moves away from the underpinnings prescribed by the biomedical view of illness. Where western medicine is concerned with finding out how the person became mentally ill so as to control the symptoms, African medicine questions not how but why things happen (Mkhize, 2003). Hence, the traditional healer seeks to help patients and their families to understand what the symptoms mean. This is imperative to the researcher as it depicts one of the differences in how Western and African people might adopt unique approaches to understanding illness, indicating the nuances in the ways that mental distress phenomena can be conceptualised and treated.

As a trainee clinical psychologist, I have found in my experience that black African clients enter the room with scepticism about the efficacy of the principles of the discipline of

psychology to address their seemingly diverse and complex difficulties. Although they may find comfort in engaging with someone who appears to be of a similar racial group to them, their scepticism does not immediately diminish as they demonstrate incredible astonishment that speaking about their difficulties might alleviate their distress. I often tried to position myself in the shoes of my clients and wondered how free, safe, held, understood I would feel and to what extent my self-disclosure would reach in a space where I was unfamiliar with the sort of help offered. I often pondered how they explain the sort of help or intervention to others in their communities, and the responses they might receive. I questioned what would maintain their commitment to therapy, without the social support of loved ones because of their lack of understanding of what their true difficulties may be. Madu (2015) asserts that using appropriate psychotherapeutic values for modern African clients is a challenge to many psychotherapists treating Black Africans. Therefore, the present study seeks to understand how informants report on how some amaXhosa people conceptualise mental distress; and using the analytical lens to enter as far as possible into the psychological worlds of participants, to obtain an in-depth idiographic picture of how some amaXhosa people understand and view mental distress.

1.3. Context

The study is situated within the SA context, which has a long-standing history of political turmoil, segregation and state of repression, where the majority of the population were severely discriminated against, violated and stripped of their primary essence as human beings during the Apartheid regime (Williams et al., 2007). Vega et al., (1991) reported that for many Black South Africans living in an unjust and divided society that was invested in white supremacy was harsh, as the discrimination on the basis of their race meant restricted movement, poor employment opportunities, isolation and segregated geospatial land. Black people had poor housing in this era, lacking running water and electricity, living in

overcrowded and unsanitary conditions, experiencing inadequate medical services, widespread poverty and extensive malnutrition, disease, high infant mortality and social disruptions (Vega et al., 1991). Education for African children was not compulsory, and the limited number of schools contributed to a small percentage of the African population being educated (Wilson & Rampele, 1989) up to completion of school. As a result, Black people were educated for being employed as semiskilled or unskilled labourers, who become migrant labourers in the mines where they generated wealth for white mine owners, while they were generating poverty for themselves as workers.

During this period African black women were forced to provide agricultural labour, while their men sought work in urban areas (Branson et.al., 2012). The Apartheid's migrant labour polices disrupted the most basic institution of any people, the family life of the African. Families rarely lived together as husband, wife and children. A six month to three-year separation was not uncommon due to the long distances and working conditions. Having to live apart from spouses and having to rear children alone resulted in loneliness, pain and despair for both men and women. The strain of the separation led to enormous financial, physical and emotional damage, with many men consequently breaking ties with families and widespread poverty, destitution, childhood malnutrition and illegitimacy becoming a common occurrence (Kon et.al., 2008). According to Kon et.al (2008) wages received by migrant labourers were insufficient and, in some instances, too little that no money could be sent to support families back home. The system exploited black people causing irreparable social and psychological damage. According to Bernstein (2007), the South African tragedy was that of thousands young women who were widows long before reaching the age of thirty, young women whose lives have been one long song of sorrow - burying one baby after another and lastly burying their estranged husbands.

The unavoidable humiliating effects on black people and arrogance-inducing effects on whites; the disruption of family-life by the enforced migrant labour system; the stunted brain development and behavioural effects from the widespread childhood malnutrition, the distortions and alienations in personality development on racial lines; the mental breakdowns and suicides that resulted from the physical and mental torture that detainees were subjected to while under police interrogation, have all left their harsh mark on Black South Africans (Stein et al., 2008). In addition, when mental health services were required they were grossly inferior for blacks, especially in the rural areas and particularly in out-patient care. According to Kon et al., (2008) many mental health professionals in SA during this time were vocal about the deleterious psychological and social impact of the oppressive and discriminatory Nationalist state policies. They described an urgent need for socio-economic and political reform, as these experiences referred to above inadvertently became the breeding ground for the numerous mental health difficulties in Black African South Africans, owing to the grave post-traumatic stress they survived from, in a system that largely made them believe they were subhuman and undeserving of basic rights.

Over 30 years later, the geospatial landscape of SA still reflects the Apartheid heritage, restricting access to employment opportunities and mental health services, resulting in increased economic and psychological distress (Jack et al., 2014). Bold attempts have been made regarding new policy development with an effort to provide equitable public healthcare to South Africans, the National Health Act was established. However even with the development of the Act, there is still a 75% treatment gap for common mental disorders nationally (Lund et al., 2012). This large treatment gap is alarming, and the present study is concerned with uncovering aspects related to this occurrence. Jacobs (2007) noted that in the absence of the translation of practical mental health policies, gaps and conflicts in treatment provision will exist. Research regarding mental health in SA is primarily centred on

collecting information to improve the mental health systems, policy reform, and integrating mental health as part of primary health care (Monteiro, 2015), with less emphasis placed on ensuring that current measures work on the general population.

Alase (2017) also highlighted that the focus at policy development level and infrequent discussions related to mental distress in SA were as result of the diverse cultural context of the nation. Mental distress has been said to be socially constructed and culturally dependent (Shezi & Uys, 1997), implying that discussions of such issues would require a basis of extensive knowledge and understanding of various cultures and sensitivity to cultural differences within this diverse nation. Researchers state that some more traditional African worldviews, ascribe the onset of a disease to possession by spirits, the evil eye, black magic or the breaking of taboos, which locates the rectification of the problems within a purview of traditional healers (Skeen & Lund, 2003).

While other demographic groups in South Africa experience cultural barriers regarding mental health, the prevalence of depression among Black South Africans is under-investigated and under-reported when compared to other groups (Dworzanowski-Venter, 2020). The studies that take ethnicity into account show a distinct difference in reports of psychological distress between Blacks and Whites (Jackson et al., 2010). This is due in part to environmental stress and the lower socio-economic situation that many Black South Africans find themselves in as a remnant of the apartheid system. Essentially, the mental health of ethnic groups in SA reflects the historical and current social stratification, and thus must be considered when attempting to understand the cause of mental health problems.

Research has also indicated that SA is characterised by an insurmountable and diverse burden of diseases and comorbidity of Major Depressive Disorder (MDD), including infectious diseases such as HIV/AIDS, high rates of violence and child illnesses. Flisher, et

al. (2012) reported that in SA HIV infection, substance use and exposure to violence increases vulnerability to mental disorders. As noted earlier, people in SA are likely to be vulnerable to the development of widespread neuropsychiatric disorders, given the adverse socio-economic circumstances they have experienced (Nglazi et al., 2016). Lund et al., (2013) add that low income also increases the risk for mental disorders, through increased risk of adverse life events and reduced access to resources that can buffer the effects of those life events, which contribute to the social causation of mental illnesses. Nglazi, et al. (2016) state that SA is under-resourced regarding mental health services and moreover there are barriers to help-seeking and treatment for mental illnesses, include stigma, low health literacy levels and financial difficulties. The mental health workforce of SA is understaffed and ill-equipped (Booysen et al, 2021).

With all of the above in mind, widespread psychological intervention is needed. Seedat, et al., (2004) stated that psychologists are called on to cast aside the myth of political neutrality and the disempowering aspects of psychology, so as to emphasise the potential of psychology. De la Rey et al., (2004) noted that many SA psychologists have debated how psychology could become more relevant to the local socio-political context. Among other things, this is due to the major factors responsible for the difficulties in applying Western healthcare, where these lenses mostly ignore culturally influenced realities of people in other contexts. Moreover, Western psychological practice has appeared to rely heavily on natural science, minimising the role of social conditions, power relations and societal institutional arrangements that shape people's conceptualisations of illness and help-seeking behaviours (Bojuwoye & Sodi, 2010).

Ratele (2017) noted the need for recognition by psychologists in SA that we are not immune to calls for the decolonization of society and encouraged psychologists to seriously engage in these evolving conversations. Decolonisation, dialogue and engagement between

scientific thinking and cultural beliefs are necessary, in order to challenge the perceived notion of African thinking as saturated in superstition, fantasy and backwardness (Ally & August, 2018). Decolonisation tackles the ways in which people have previously been discriminated against whilst oppressed, considering alternative worldviews that are more congruent with people's experiences; and also tackling the structural and institutional impacts that are the remnants of a divisive colonial heritage. This study is therefore part of considering ways in which psychology might be decolonised and constructed to better suit the majority of people in SA.

1.4. The research aims and chosen methodological approach

This research study aims to investigate how key informants conceptualise and report on how other amaXhosa people understand mental distress, including their methods of seeking help. It hoped to investigate the intersectional dynamic between mental distress and stigma through obtaining healthcare workers' perspectives on existent attitudes, which sustain and exacerbate self-stigma in mentally distressed individuals and observed public stigma or discrimination. The researcher also hoped to gain deeper insights into the phenomena under investigation from the idiographic experiences of the healthcare workers working in such contexts. This would aid in informing and creating awareness amongst trainee psychologists of often neglected or overlooked aspects in psychotherapy practice when dealing with non-western populations.

This research study seeks to achieve the aims above through answering the following questions:

(a) How is mental distress (including psychotic phenomena) conceptualised and understood by a recruited sample of amaXhosa healthcare workers?

(b) What are the perspectives of these healthcare workers regarding existing attitudes that sustain forms of stigma and discrimination towards individuals living with mental distress?
(c) What are the methods of treatment that are generally sought by some people within the amaXhosa ethnic group to address mental health issues?

This study was designed to make use of an interpretive phenomenological analysis (IPA), to explore thoroughly how people make sense of their worlds by taking a look at their experiences and what meanings they draw from them (Smith & Osborn, 2003).

1.5. Outline of the chapters of this research study

This study is organised into six chapters.

Chapter 1: An introduction that provides the rationale and context of the study followed by a brief outline of the research aim and questions of the study.

Chapter 2: A literature review that is focused on the existing literature regarding mental distress and existing attitudes of stigma and discrimination in South Africa that have been explored empirically.

Chapter 3: The research methodology section that outlines the most appropriate methodology including the research design used, in exploring the research questions.

Chapter 4: The findings section that provides the outcome of the analysis which includes an in-depth understanding of who the participants were, their conceptualisations of mental distress and their perspectives on the attitudes of stigma and the discrimination experienced by those with mental distress.

Chapter 5: The discussion chapter covers the main findings of the study and how they relate to the current literature on mental distress and its conceptualisation among some amaXhosa people, as well as understanding it within the South African context. The conclusion briefly summarises the exploration of the conceptualisations of mental distress among some

amaXhosa healthcare workers, as evidenced by the findings of the study. It provides suggested recommendations and reports on the limitations of the research.

1.6. Conclusion

This chapter has explored the SA context and state of affairs in relation to mental distress. It provided an in-depth historical background, with reference to the Apartheid regime which impacted and shaped the lives of many South Africans leaving adverse psychological implications. It highlighted the importance of mental healthcare discussions in SA. The chapter concludes with a brief outline of the subsequent chapters of the study.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

This chapter will provide an overview of the literature regarding the conceptualisation of mental distress. It will furthermore provide the context and background necessary to support the study through exploring how mental distress is conceptualised and understood by the majority of South Africans and more specifically among non-western populations, identifying what attitudes sustain forms of stigma and discrimination towards those living with mental distress and what treatment methods are sought to address mental distress among African populations. This will be achieved through outlining the various ways that mental health in SA is understood and framed within the available literature. Through this process, this chapter will provide the building blocks to contribute towards answering the research questions.

The definition of mental distress or illness that is understood universally was first put forward by Griesinger (as cited in Moncrieff, 2008), who stated that all mental illnesses are cerebral illnesses. This therefore suggests that mental ill health or distress is predominantly viewed according to the biomedical model. This model primarily asserts that mental disorders like schizophrenia, major depressive disorder, attention deficit/hyperactivity disorder (ADHD), and substance use disorders are biologically-based brain diseases. Within such a framework, illness and mental disorders are linked to biological abnormalities located in the brain, denoting that there is no meaningful distinction between mental diseases and physical diseases, and biological treatment is emphasized (Andreasen, 1985; as cited in Arrigo, 2002). This worldview leaves no room for the social, psychological, and behavioural dimensions of illness.

While the biomedical model minimizes the relevance of psychosocial contributions and assumes the eliminative reductionist position, according to Habibis (2005) mental

distress is rather viewed from a communal perspective when it comes to culturally diverse nations as in SA.

This chapter will review the constructions of mental distress among African cultures, providing literature to delineate the similarities or differences between Western and African views that contribute to the complexity of understanding mental distress. Social psychology is utilised as a theoretical lens to understanding stigma and discrimination and its effects. The chapter concludes with a summary of the Afrocentric perspective and its importance in practicing psychotherapy with non-western populations.

2.2. Understanding mental distress

As stated above for many Black South Africans, mental health is understood according to the biomedical field which unfortunately is not part of the cultural milieu (Thabede, 2008). South Africa has at least eleven main ethnic groups that speak different languages, forming different social and cultural identities. These ethnic groups have unique cultures, values, and belief systems that have developed based on their geographical regions. The different cultural identities may present challenges in constructing a definition of mental illness. According to Lund, et al. (2018) increasing global evidence exists that mental disorders in populations are strongly socially determined. Social and economic conditions have a direct influence on the prevalence and severity of mental disorders in people; adverse social and economic circumstances including poverty, income inequality, interpersonal and collective violence and forced immigration are the key determinants of mental disorders.

Nwoye (2015) asserts that Western (Eurocentric) psychology has been insensitive to the realities and challenges confronting African people. Eurocentric psychology has conceptualised a person in an individualistic way and does not give due importance to the influences of the society. It was indicated by Mkhize (2003) that modern psychology was

brought to developing countries as part of general transfer of knowledge and technology from the West. Some American and European research studies that have been conducted in Africa have proved to be disrespectful, misrepresentative and highly judgemental of the ways of living of African people.

Research illustrates that in some instances, African clients were labelled as pathological due to them being treated in European understanding of health and healing. This may lead to inaccurate judgements about inferiority in some instances or potential misinterpretation of the behaviour of Africans (Washington, 2010). It is due to the abovementioned facts that Amaeshi and Idemudia (2015) suggest that the current practice of Western psychotherapy in Africa be revised and that the concept of African or African-Centred Psychotherapy be pursued more vigorously. That means that a science that is oblivious to its culturally influenced environment condemns itself to irrelevance. Therefore, this implies that any form of psychotherapeutic practice without culturally influenced justification may be without substance and thus superficial.

It is important to realise that African influenced traditions put emphasis on kinship care, invisible loyalty to the guardianship of ancestral spirits, spirituality and the interconnections between the natural and the spirit world (Striker, 1994). An African psychology therefore needs to incorporate such important elements. In this light, Mkhize (2003) suggests that the use of only Western principles in therapy may create some tensions and possibly confusion. A more holistic approach leads to African psychology that is about the whole being (Washington, 2010), meaning a holistic view of the actual person.

Chipfakacha (1994) believes that all cultures have disease theories that explain the causes of illness. Therefore, in order to comprehend the notion of mental illness one needs to

understand the assumptions that influence the cultural value perceptions of people, particularly with regard to concepts of cause and effect.

2.3. AmaXhosa culture and mental distress

This section will briefly describe the concept of culture-bound disorders and the approach taken by the DSM- 5, how they present within the amaXhosa culture, for example *Amafufunyana* (the experience of what may be coined according to the West as auditory or visual hallucinations); and *ukuthwasa*, which is believed to be ancestral calling (Niehaus et al., 2004). The description of these conditions will provide insight into how amaXhosa view illness and will explore the meaning ascribed to the experience of emotional distress (Qangule, 2019).

Whereas previous versions of the Diagnostic and Statistical Manuals (DSM) proposed syndromes labelled "culture-bound disorders", the DSM5 incorporated a greater sensitivity to influences of cultural variables (APA, 2013). They recognised that symptoms may present in various ways across cultures, and that clinicians needed to be very aware of the strong influence of cultural factors such as ethnicity, religion and geographical contexts on presentations and explanations for mental distress.

What were previously termed as "culture-bound syndromes" combined various somatic and psychological phenomena, recognizable only in a specific societal setting. For example, *Amafufunyana*, which are culturally influenced conditions found among some amaZulu and amaXhosa (Niehaus, et al., 2004), suggest that an individual may be possessed by evil spirits, impacting on behaviour, speech and thoughts (Ally & August, 2018). From a Western diagnostic viewpoint, the symptomatology might seem similar to schizophrenic disorders; however traditional healers use spiritual and cultural explanatory models (Niehaus et al., 2004), often indicating a more positive sense of a "calling"; with the community

support for particular care for such individuals. This may be incorrectly diagnosed by the psychotherapist who is not familiar with the African worldview.

2.4. Western versus Indigenous views of mental distress

More generally, many researchers have written about the contrasts between Western and African worldviews, with Torrey (1972) specifically commenting that people do not see things in the same way, and the way they see things is dependent on their cultural beliefs. Gyekye (1995) expanded this notion, stating that the world is differently constructed in different places based on the ideas, values, conceptions of cause and effect that are uniquely shaped by one's culture.

While the colonisation of Africa by the West had aimed to modify Africa, the integrity of traditional African philosophy survived (Mazrui, 1986), in other words the worldviews of traditional Africans to a larger degree remained unchanged. It undoubtably, therefore, becomes inappropriate to apply Eurocentric theories of human behaviour to explain the behaviour of Africans (Schiele, 2000). The Afrocentric theoretical perspective and principles of social psychology posit that unilateral ways of thinking simply cannot be used to explain all human behaviour, in light of the evidently strong and divergent cultures, which influence people's ways of thinking.

Much research has demonstrated how European theories of human behaviour tend to claim to provide universal explanations of human behaviour, views which have passively gained momentum without contest from the majority world. Mkhize (2003) notes that using only Western principles in psychotherapy when working with African clients may create some tensions and possibly confusions. Nefale et.al., (2003) indicate that dominant Western principles applied to African people might involve unnecessarily labelling certain non-Western clients' experiences as pathological, based on conflicting models of explaining

illness, health and healing. European principles ignore cultural differences which marginalise the indigenous worldviews of people of colour (Schiele, 2000).

African worldviews differ from Western views in that Western ideas generally minimise the spiritual dimension of phenomena and focus on the visible, measurable, and the physical reality (Van der Walt, 1997). In Western ideologies supernatural causes are not considered to be significant in explanations of phenomena, while for Africans supernatural causes play an important role in explaining phenomena. The African worldview is much more concerned with the spiritual world and the forces that play a role in it. For many Africans, supernatural causes are regarded as explanations for everything.

According to Van der Walt (1997) western worldviews are often individualistic, with the dominance of intellectual explanations and reducing the emotional content of explanations, which are contrary to collectivist African attitudes, which are more involved, more personal, emotionally affective and expressive. This implies that Africans do not give primacy to objective analytical explanations, viewing things from a distance, but live in it as for them no objects exist outside reality. They are attuned to things and the earth and experience everything intensely and are part of everything (Kamalu, 1990). Western knowledge has acknowledged two main sources of knowledge mainly reason and sense experience, also known as rationalism and empiricism respectively. Daniel (2001) notes that African worldviews acknowledge affective reality as well as rationality, meaning that in Africans' viewpoints, one is not faced with the options of being rational or irrational; it is possible, rather, for one to relate to phenomena through all the modes or patterns of thought and being. Gyekye (1995) alludes to the idea of paranormal cognition as an important mode of knowing in African thought, further stating that spirit mediumship, divinations and witchcraft are common modes of cognition relevant in African worldviews and are recognised as large modes of knowing.

The above information is all pertinent to the study, which aims to understand how Black people, specifically amaXhosa in SA as Africans, construct their understandings of mental distress. It seeks to gather information on the sources of these conceptualisations, to facilitate in-depth insight into people's attitudes towards the phenomena under investigation. With the mental distress phenomena projected to be the largest contributor the burden of disease by 2030 worldwide (Monteiro, 2007), it becomes incumbent for psychologists to be aware of African thought patterns, so that they are able to choose appropriate intervention strategies that take into account the scientific, the irrational, the intuitive, the affective and the spiritual modes of knowing. The overall aim is to be better able to assist non-Western populations; and specifically in this study Black, isiXhosa speaking groups. According to Daniel (2001), some of these interventions needing to be employed may be outside the purview of the helping professions, in which cases helping professionals are expected to refer clients appropriately or work jointly with other service providers, such as faith healers, traditional healers and diviners.

2.5. Theoretical Framework

This study is concerned with uncovering the conceptualisations of mental distress. Here, some of the theoretical constructs from social psychology might assist in the attempt to understand the constructions of some amaXhosa healthcare workers, as related to these phenomena. Furthermore, the research is concerned with exploring the patterns of behaviours and reactions towards individuals with mental distress to trace how others think about, influence and relate to distressed persons. Social psychology is concerned with social relations, asserting that misunderstood individuals in society face the agony of being stigmatized and discriminated against, which has harmful effects on their social identity (Corrigan 2000).

Corrigan (2000) distinguishes between two types of stigma: namely public stigma and self-stigma. Public stigma refers to the perceptions of society that mental distress may be a disability (Corrigan, 2000). Philo (1996, cited in Cromby, et al., 2013) posits that disproportionate media coverage is a factor that contributes to the maintenance of widespread discrimination against people with mental distress, causing feelings of isolation and encouraging self-stigma. Self-stigma is explicitly evident when people with mental distress turn against themselves in agreement with a belief or negative emotional reactions of those around them (Corrigan & Rao, 2012). Social psychologists note that the negative implications of stigma and discrimination lead to reduced autonomy and self-efficacy. Self-esteem suffers and so does confidence in the future, leaving the person unmotivated to pursue opportunities and in extreme circumstances may even lead to suicidal attempts (Corrigan & Watson, 2002).

2.5.1. Attitudes of Stigma and Discrimination

Stigma is a phenomenon that has existed across time for diverse reasons and many populations of people are not immune to its experience. People have experienced stigma on the basis of living with diseases, such as HIV/AIDS, cancer, epilepsy, schizophrenia, or for having characteristics or behaviours that are considered undesirable and socially deviant (e.g. because they smoke, inject drugs, are obese, are sexually or gender non-conforming). Most researchers regard stigma as a social construction, a label ascribed by society that occurs when members of a group experience status loss or discrimination on the basis of some shared characteristic that is deemed undesirable by a dominant group (Crocker et al. 1998).

According to Thornicroft (2006) stigma is a multileveled term, which in this study will represent three constituent elements related to problems of knowledge including ignorance or misinformation, problems of negative attitudes prejudice, and problems of behaviour discrimination so as to understand the premise of it. Being labelled with a mental illness is the first step in the stigma process (Watson et.al., 2006). According to Corrigan

et.al., (2006) labels are given directly when a person's mental illness status becomes publicly discussed or indirectly through association, for example when a person is seen in a queue for psychiatric patients.

Unfortunately, mental distress is a complex phenomenon as on one hand the symptoms and medication side effects can negatively impact emotions, cognitive abilities, memory, problem-solving skills, decision-making abilities, social skills, and other domains of functioning, while simultaneously predisposing the person to the harsh experience of public and self-stigma that interfere with opportunities to attain and maintain life goals. According to Brockington et.al., (1993) mentally distressed individuals may be associated with three stereotypes, which are commonly perceived about mental illness: namely *dangerousness*, which implies that people with mental illness are unpredictable leading to concerns about violence; *blame* - people with mental illness lack personal integrity and hence are responsible for their mental illness; and *incompetence* - people with mental illness are unlikely to be successful in work or independent housing goals. Many people who have been labelled "mentally ill" face the prejudice and discrimination associated with a "spoiled identity" (Goffman, 1963). The current study will predominantly speak to two kinds of stigma: public and self-stigma.

Public Stigma

The general population demonstrates public stigma through negative reactions to people with severe mental distress. This may include overt marks and stereotypes that lead to prejudice and discrimination. This kind of public stigma may yield anger, fear, blame, and other emotional responses toward individuals with mental illness (Corrigan, 2000). Public stigma can extensively discredit an individual, reducing them to a tainted, discounted person, while discrimination diminishes the quality of life of individuals with mental illness.

Individuals living with mental distress generally receive fewer insurance benefits and medical services than the general public, and insurance plans provide fewer mental health benefits than physical health services (Druss, et.al., 1998). Therefore, stigma robs individuals of important life opportunities, including gainful employment, safe and comfortable housing, relationships, community functions, and educational opportunities (Corrigan et.al., 2005).

Self- stigma

Some people internalize public stigma, harming themselves in ways that result in negative cognitive and behavioural outcomes (Corrigan et al., 2002). A study conducted by Link et.al., (1987) showed that the negative effects of self-stigma on psychological well-being can endure even when psychiatric symptoms have remitted and just like public stigma it may also interfere with the pursuit of rehabilitation goals such as living independently and obtaining competitive work (Wahl, 1999). Link et.al., (1987) argued that people with mental illnesses who internalize stereotypes about mental illness experience a loss of self-esteem and self-efficacy (Markowitz, 1998). Self-stigma is notable when individual's internalized attitudes reflect devaluation for example: "I have a mental illness, which must be my fault, and I won't be successful''. This stereotype may lead to self-discrimination, in which individuals engage in behaviours related to the stereotype application. The harmful effects of internalised stigma lead to the avoidance of seeking better opportunities, for example: "I have a mental illness and I won't be able to succeed, so I'm not going to look for a job" capturing an individual in a cycle of self-devaluation which perpetuates low self-efficacy (Corrigan et al., 2002).

According to Corrigan (2004) there also exists a third group of people, those who do not yet have a mental illness history, but who fiercely avoid mental health care in order to escape the experience of stigma. Sirey et.al, (2001) found a direct relationship between

stigmatizing attitudes, as perceived by people with a mental illness, and lack of treatment adherence. This reflects the aims of the study to understand stigma and its role in the experience of mental distress. With the aim of understanding people's conceptualisations of mental distress, the researcher also hoped to investigate the intersectional dynamic with stigma, through obtaining the perspectives of some amaXhosa healthcare workers on those patterns of behaviours and reactions of mentally distressed persons.

2.5.2. The Afrocentric perspective

The study will also make use of the Afrocentric theoretical perspective as its analytical lens, so as to situate the premise of the study that is concerned with making psychology applicable for non-western populations. Gray (2001) expressed the need for placing African culture at the centre of any analysis that involves studying African people. He reckoned that the term Afrocentric, refers to the idea or perspective that African people can and should see, study, interpret and interact with people, life, and reality from the standpoint of their people as opposed to adopting the viewpoint of European people or other non-African people. This implies that Africans should view phenomena from an African worldview, which is in turn informed by African culture.

The Afrocentric theoretical perspective is invested in the display of how developing knowledge of another culture from the perspective of that culture can transform professional practice (Swigonski, 1996). The research study is concerned with understanding the constructs held by some amaXhosa people regarding mental distress from their idiographic experiences so as to assist psychologists not to fall down the slippery slope of holding a unilateral understanding of mental distress. The study hopes to demonstrate that the Afrocentric theoretical perspective is beneficial for the helping professions in SA, to create space for the subjugated, marginalised African culture-based epistemologies, such as broadening ideas related to clinical intervention. The premise of this perspective

acknowledges the significance of African culture in providing social services to African people and reinforces the notion that it is acceptable for phenomena to be viewed from the point of view of Africans themselves. Furthermore, researchers have stipulated that Afrocentric perspectives should be a significant part of the knowledge base and practice, existing alongside current Eurocentric intervention theories and practices. This is in order that the helping professions will reflect the worldview and cultural values of the majority who are recipients of mental health services in SA, to acknowledge that such cultural knowledge is important in addressing the psychological, intellectual, spiritual and emotional needs of African people.

According to Barker (1999) knowledge developed in this way enables the profession to work more profoundly for the empowerment of clients. This means that an Afrocentric perspective starts with the questions: does this place Africans in the centre? Is this in the best interest of African people? An Afrocentric perspective further describes the principles and the values of Africans. Afrocentric work reorganises the African frame of reference so that African history, culture, and worldviews become central for understanding African people (Gyekye, 1995). Adopting the Afrocentric framework focuses on establishing culture-based indigenous knowledge, to mitigate the problem of relevance regarding mental health concerns that the helping professions are facing in this culturally diverse nation.

2.6. Conclusion

This chapter has described the universal understanding of mental distress and provided the context from which psychology emerged in SA. It further compared African and Western worldviews related to understanding illness, highlighting pertinent differences in views that might influence responses to the research questions. The constructs of social psychology provided a base from which prevalent stigma and its implications might be viewed. Lastly the need for African viewpoints to be adopted instead of relying only on

Western principles in discussing illness cannot be overemphasized. The next chapter will detail the methodology used in the study.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter will outline the research design and methodology employed by the researcher in the study. A discussion for the utilisation of an exploratory qualitative research design as well as the motivation for choosing interpretive phenomenological analysis (IPA) as the analytical lens for the study will be detailed. This involves a discussion of the theoretical underpinnings of IPA and its principles as a methodology used in this study. This chapter will contain details of how the researcher worked with participants to generate data in order to respond to the research questions. Details of the ethical considerations, sampling technique, data collection, data analysis, reflexivity and study limitations will also be discussed.

3.2 Research design

According to Burns & Grove (2001) a research design refers to the clearly defined structures within which the study is implemented. This research study was conducted by means of an exploratory qualitative research design, utilising an Interpretative Phenomenological Analysis (IPA) as its framework. In exploring qualitative research, Polit and Beck (2004) highlighted that it needs to be seen as emphasising the dynamic, holistic, and individual aspects of the human experience, and as an attempt to capture those experiences in their entirety, within the context of those experiencing them. These aspects are reflected in the framework of IPA since IPA aims to explore in detail how people make sense of their personal and social worlds (Smith, 2006).

The focus of this study was to accurately reflect the participants' understanding of mental distress and explore their perspectives on any existent attitudes of stigma and discrimination experienced by those living with mental distress. The study was influenced by the researcher's ethnic background, her own desire to investigate and understand the meaning of mental distress amongst some amaXhosa people, as a trainee clinical psychologist, to

understand apparently prevalent attitudes of stigma that exacerbates the negative experiences of mental distress among some amaXhosa people. According to Smith (2003) IPA is particularly effective in examining topics which are complex, ambiguous, emotionally laden and that are of personal interest to the researcher.

The choice of a qualitative approach was largely informed by the rich descriptions that are gathered in a qualitative inquiry; especially as the study is concerned with exploring and understanding themes that contribute to attitudes of both public and self-stigma and discrimination faced by those who experience mental distress, to gather data and to build concepts rather than more positivistic research concerned with testing hypotheses. IPA focuses on the importance and meaning of the experience to the participant, therefore adopting a person in context stance (Larkin & Thompson, 2012). This reflects the researcher's stance in this study.

3.3 Interpretative Phenomenological Analysis and idiography

According to Larkin and Thompson (2012) IPA's focus is on "being-in-the-world" and "lived experiences" with the underlying assumption that human beings are not passive perceivers of objective reality but rather active interpreters of it, whose understanding of their world is shaped by their social and personal worlds (Brocki & Wearden, 2006). IPA views the participants as experts in their experiences and the role of the researcher is to gain an understanding of the experience as told and experienced by the expert (Reid et al., 2005). This study is committed to explicating the individual stories shared by participants. Each case is analysed on its own (Smith & Osborn, 2003) to facilitate the depth of analysis required in an IPA study.

IPA is founded on three theoretical underpinnings namely phenomenology, hermeneutics and idiography (Pietkiewicz & Smith, 2014). Idiography explains that exploration should be done case by case before any generalisations are made and for this reason IPA uses small,

purposive samples. Idiography is exemplary as the foundation of IPA because of its core commitment to in-depth analysis of individual experience, with a focus upon participants in their unique contexts. IPA utilises idiography to holistically keep a focus on all aspects of the lived experience, which may include wishes, desires, feelings, motivations, belief systems and how they are evident or not in behaviour and actions. This approach is aligned with the researcher's aims and reasoning for the sample chosen for the study.

Concerned with understanding how individuals make sense of their experiences within a specific context, IPA therefore also affords the researcher the opportunity to enter into the psychological and social worlds of participants, in order to adequately respond to her research questions and gain new insights (Smith, 2009). IPA probes for the person's thoughts and beliefs regarding what needs to be uncovered and their relatedness to the world and the things in the world that matter to them (Larkin & Thompson, 2012).

3.4 Interpretative Phenomenological Analysis and Phenomenology

Phenomenology was first studied by Husserl (1931) who conceptualised it as a way of understanding the context of the lived experiences of people and the meaning they ascribe to those experiences. He further stated that the experience should be investigated in the way that it occurs (Smith et al., 2009). Phenomenology was extended in description by Brocki and Wearden (2006) as focusing on the richness and texture of the experience, which is understood through rich engagement with another person's "lifeworld" (Lawthom & Tindall, 2011). Husserl famously argued that we should go back to the thing itself, the thing being the experiences of people transformed into consciousness (Merriam & Tisdell, 2016). This refers to the immediate experiences, activities, and contacts that make up the world of an individual or the world of concrete experience as lived by people. Phenomenological studies have been distinguished as focusing on how people perceive and speak about objects and events to

provide detailed descriptions, rather than describing phenomena according to a predetermined categorical system or scientific criteria (Smith et al., 2009).

Through phenomenology, Husserl's goal was to seek ways that would facilitate a process whereby someone might know their experience of a particular phenomenon in detail and the research rigour needs to allow them to identify the essential qualities of that experience to allow other insights into the experience (Smith et al., 2009). By doing this the details of the experience would be more than the circumstances at face value. Thus, phenomenology is interested in elucidating both that which appears and the manner in which it appears (Creswell, 2007). According to Polkinghorne (1989) a phenomenological inquiry is one that can be understood to ask "What is this experience like?" as it attempts to uncover meanings as they are lived in everyday lives of participants.

3.5 IPA and Hermeneutics

Hermeneutics was theorised as the act of interpretation by German philosopher Heidegger (1962), and as a prerequisite to the meaning-making nature of phenomenology (Pietkiewicz & Smith, 2018). Heidegger (1962) proposed that phenomenology is the start of an interpretative process where participants describe and provide meaning of their situated experiences of a given phenomenon; in turn, these utterances are interpreted by the researcher (Gallagher, 1992). This making of meaning by both the participant and researcher is thus known as hermeneutics (Smith, 2011; Wagstaff & Williams, 2014).

Hermeneutics serves as a method of generating as accurate as possible a sense of participants' lived experiences, inadvertently leading to the development of new insights due to the interpretative nature of engagement with the experience (Smith & Osborn, 2003). Smith et al., (2009, p.35) note that "without phenomenology there would be nothing to interpret and without hermeneutics, the phenomenon would not be seen, making

phenomenology and hermeneutics integral to facilitating an in-depth understanding of phenomena".

According to Pietkiewicz & Smith (2014), the hermeneutic process of interpretation is not linear but rather a cycle, referred to as the hermeneutic circle. It is based on the notion that there exists a dynamic relationship between the part and the whole at different levels. This means that to understand any part of a phenomenon you look to the whole, to understand the whole you look to the part (Smith et al., 2009). Therefore, a two-stage interpretation process, or a double hermeneutic, evolves. Participants are trying to make sense of their worlds, while the researcher is trying to make sense of the participants trying to make sense of their worlds (Smith, 2009).

Because IPA researchers attempt to understand what their participants have experienced, hermeneutics as a theory of interpretation is imperative to IPA. IPA also requires that the researcher reflects on their own experience and assumptions on the topic at hand and not only engages with peoples' experiences (Larkin & Thompson, 2012). When a researcher accesses their participants' experiences, whatever interpretations are derived from these experiences will depend on the researchers' context (Smith & Osborn, 2003). Thus, the hermeneutic circle is only left where the researcher analyses the data but recognises that they are now influenced by the newly found knowledge (Larkin & Thompson, 2012). The circle is entered again by engaging with the participants through a process of re-reading and listening to transcripts again, with this new knowledge and acknowledging both the whole and the parts, as interpretation continues (Smith et al., 2009).

3.6 Ethical Considerations

Ethical approval for this study was granted by the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University and the Rhodes University Ethical Standards Committee (RUESC); the letter is attached (Appendix A). Berg

(2007) reported that research within social sciences has the tendency to intrusively explore the social lives of other human beings and raises a need to follow greater ethical obligations, various policies, practices, and laws. Runswick-Cole (2011) indicated that this is especially relevant related to interviews, which is the method used to obtain data for the study that involves investigating people's private lives with the aim of describing these experiences publicly, hence the need for increased ethical care.

The ethical considerations relevant to the study include informed consent, consent for audio recordings as well as issues of anonymity and confidentiality of participants and lastly non-maleficence. Informed consent concerns itself with informing participants about the intentions and nature of the study, as well as the possible risks and benefits that may result from their participation (Brinkman & Kvale, 2008). Informed consent was carefully gained through providing participants with accurate information about the proposed study and about the voluntary nature of participation by means of the Consent form (Appendix C) and in alignment with IPA guidelines that participants should be adults with consenting ability. Participants were made aware that they could withdraw from the study at any point without any disadvantage to them and that participating in the study is solely by choice.

The information sheet (Appendix D) detailed how data was to be collected, what was expected of participants, how long the semi-structured interviews would run for and what the collected data will be utilised for. Each participant granted their permission by agreeing to semi structured telephonic interviews and by being read a consent form for audio- recordings. Confidentiality in research is an essential ethical principal which according to Brinkman and Kvale (2008) can be understood as the maintenance of identifying data of the participants private from the public, while anonymity means that participants remain nameless. During the study participants were made aware that private data identifying them would not be

reported to maintain confidentiality and that no data would be linked with their names as they will remain nameless to ensure anonymity.

Non-maleficence as defined by the HPCSA (2008) is the minimisation of any possible risk or harm to the research participants when conducting research. The study was judged to have mild risk to participants: firstly, due to the nature of sharing of their lived personal experiences which might elicit certain emotional reactions; and secondly, by virtue of this being an IPA study that tends to delve deep into participants' personal world than perhaps anticipated. However, this was managed by informing participants of their rights to withdraw from the study at any point; and participants were provided with support contact details of the Rhodes University Psychology Clinic. The researcher, as a trainee clinical psychologist could provide containment for participants before concluding interviews to minimise the risk of leaving participants feeling vulnerable and uncontained. In terms of benefits, the study may offer representation of participants' experiences in the academic world and allow the voices of the participants to be heard through the sharing of their experiences (Smith et al., 2009).

3.7 Sampling

Participants for the study were initially selected through a purposive sampling method to ensure that a relevant sample of people for the study was met. A purposive sample is one that is selected based on the characteristics of a population that best meet the objective of the study (Etikan, et al., 2016). The target population was amaXhosa health care workers and retired psychiatric nurses working in a non-profit psychosocial rehabilitation centre in Makhanda. As key informants their perspectives on mental distress, its conceptualisation and the effects of self- and public stigma amongst some amaXhosa were valuable to the study. As part of the study's inclusion criteria, participants needed to be isiXhosa speaking, involved in or had in the past provided some sort of healthcare to individuals experiencing mental distress and had to be 18 years and older.

Participants were to be sought from one rehabilitation centre in Makhanda, with experience as retired psychiatric nurses. However, due to factors owing to the Covid-19 pandemic and lockdown regulations, the targeted group as outlined above could not be accessed. This then meant that the researcher needed to look more broadly for participants via snowball sampling. According to Struwig et.al. (2001) it is not uncommon for the researcher after obtaining information from one participant, to enquire from them about other individuals who would add valuable contributions to the study to achieve an adequate sample. It was highlighted that purposive sampling may be adjusted to accommodate snowball sampling.

The researcher conducted a series of individual semi-structured interviews with a total of four selected participants. According to Smith (2006) the minimum sample size was thought to be adequate for an IPA analysis, to provide rich data with thick descriptions; this also being an exploratory study, in-depth work with fewer participants was inevitable. Furthermore, Smith (2003) stated that small samples are more practical for the idiographic mode of inquiry of an IPA study, as detailed case by case analysis of transcripts individually is time consuming. Therefore, to have a relevant sample population, participants were recruited from three non-profit psychosocial centres in Makhanda (namely the Khulanathi psychosocial rehabilitation centre, the Raphael Centre, and Sibanye Disability Centre). Informed consent was obtained from all participants involved in the study.

3.8 Data collection

For the study, data were gathered through the use of semi-structured individual telephonic interviews with the selected participants. According to Willig (2008) interviews are widely used in qualitative research and are common in IPA, as they provide the researcher first-hand experience of the participants' reactions, which can prove to be useful in exploring the lived experiences of the participants. The premise of semi-structured interviews is to establish

rapport and communicate empathy to participants which was pertinent to the study and in heeding the researchers aim to creating a comfortable atmosphere for participants to share openly. It is an open-ended inquiry which allows a greater flexibility of coverage and leads the interview into novel areas producing richer data (Plummer, 2000; as cited in Smith, 2006). Semi-structured interviews fall between the open-endedness of unstructured interviews and the predetermined nature of structured interviews.

In IPA research, the researcher has an idea of their area of interest with the aim to enter as far as possible the psychological and social world of the participants (Eatough & Smith, 2008). Smith (2003) notes that in IPA research the questions are asked to allow the participant to influence the direction the interview takes and can introduce ideas the researcher has not thought of. Using semi-structured interviews, the researcher had a set of questions on an interview schedule, to guide the interview rather than being dictated by it (Appendix E). This resultantly encouraged participants to share their perspectives, ideas, feelings and experiences freely, as the researcher strived to explore and comment on any interesting views they expressed. The interview schedule in this study was also utilised as a means to indicate the general area of interest and provide cues for when the participant encounters difficulty (Smith & Osborn, 2003) while simultaneously anticipating areas that may be covered (Dunne & Quayle, 2001, as cited in Smith & Osborn, 2003). At the end of an interview, the researcher checked that she had covered all the questions as thoroughly as possible. The schedule was helpful in that it enabled the researcher to address difficulties that might be encountered in terms of wording or sensitive areas, to give some thought as to how these difficulties might be ameliorated (Eatough & Smith, 2008), while permitting the researcher to concentrate more carefully on what the participant was saying.

The researcher invited the participants to the interviews via Whatsapp, SMS messages and through telephonic interaction. Once they had agreed to participate in the study an interview

appointment was set up with them telephonically (Appendix C). Participants were informed of the duration of the interview and voluntary nature of the study, and they gave verbal consent for their responses to be used in the research without identifying data (Appendix C). Furthermore, an explanation of the use of verbatim excerpts was given. The interviews were conducted by the researcher through adopting her interpersonal skills, conducting interviews in a conversational style in the person's home language, which was isiXhosa. According to Reid et al. (2005) one-on-one interviews allow rapport to be developed and allow participants to think, speak and be heard. As a trainee clinical psychologist, the researcher also employed her skills of empathy, personal disclosure, and authenticity to engender a comfortable atmosphere for the interviews. This made both the researcher and participant more relaxed.

Interviews with participants were audio-recorded to ensure rapport building and smooth running of interview. Riesmann (2008) further stated that audio recording of dialogues represents what was said in the interview with great precision; capturing not only the gist of what is being said but also important nuances (Smith & Osborn, 2007), which is important for the form of interview required for an IPA. Hence the researcher asked participants to sign an audio-recording permission form along with the informed consent form prior to the interview (Appendix C). Some of the participants however provided verbal consent to have their interviews recorded as they faced challenges with signing the documents due to technical difficulties.

3.9 Data analysis

Analysing data in an IPA study requires the researcher to fully immerse themselves in the data and attempt to step into the participants shoes as far as possible (Pietkiewicz & Smith, 2014). It was important that the data analysis do justice to the meanings participants had revealed about their worlds (Smith, & Osborn, 2003) as the essence of IPA research is

meaning-making and is achieved through understanding the context and complexity of those meanings rather than measuring their frequency (Hefferon & Gil-Rodriguez, 2011).

The researcher approached the analysis process using the Pietkiewicz and Smith (2014) perspective that guidelines to IPA analysis can be adapted to the researcher's objectives. Langdridge (2007) presents a four-stage analysis method that was also used as a guideline for this analysis. In the initial stage of the analysis process the researcher began with a close reading of the transcript coupled with revisiting the audio recording a number of times with the aim of familiarising herself with the data. The researcher made comments that revealed anything of interest related to mental distress and any attitudes of stigma and discrimination on the margin of the transcript. After familiarizing herself with the data the researcher looked for excerpts in the data that best answered the phenomenological questions of: how do key informants, some amaXhosa healthcare workers, conceptualise and understand mental distress (including psychotic phenomena); what insights can be gathered regarding their perspectives of existent attitudes that sustain forms of stigma and discrimination, and what in the data is telling about the most prevalent methods of help-seeking amongst some amaXhosa? These excerpts were written in a three-column table; on the right-hand side the researcher made notes about what was significant in what the participant was saying, highlighting direct quotes, taking note of expressed emotions and on the left interpreting what the participant was saying that was perhaps not explicit in the third column. From the interpretations made, themes began to emerge in each case and were labelled according to what they revealed about the data. Data from each case were subsequently clustered under the different themes, which were clustered into groups, depending on whether they spoke to similar aspects of the research questions. Final commentary from these themes was written up using verbatim extracts.

3.10 Data organisation

Data were collected through individual semi-structured interviews and organised by translating and transcribing verbatim interview responses (Pietkiewicz & Smith, 2014). The researcher then listened to the interviews a couple of times while reading the transcription to ensure that she had captured the data as accurately as possible given the data collection method. Verbatim translations were made by the researcher, whose first language is also isiXhosa. According to Pietkiewicz & Smith (2014), the use of participants' own words allows the reader to access the pertinence of the interpretations, while retaining the voices of the participants in the study. Names of participants were kept anonymous to ensure confidentiality, thus each interview transcript was assigned a number for reporting purposes

3.11 Evaluating the research

Yardley (2000) describes four broad principles that are applicable in assessing the quality of an IPA research study. These are: (a) sensitivity to context, (b) commitment and rigour, (c) transparency and coherence, (d) impact and importance.

Yardley (2000) notes that it is important to have a good understanding of the philosophical background of the methodology as this allows for the research to be judged according to its own standards. As the researcher, being immersed in IPA was helpful in the recruitment process, the sampling and engagements with gatekeepers as this had the potential to impact the participants' lived experiences (Smith et al., 2009). An example of this was liaising with gatekeepers and participants that interviews needed to be carried out in a private environment free from any distractions, to ensure confidentiality and uninhibited sharing of their experiences. Interviews were conducted in an inviting conversational dialogue to diffuse any power imbalances between the researcher and participants and to enable participants to feel like the experts of their lived experiences. It was important that the researcher familiarize themselves with the current literature on the topic to ensure that they approach the study with

the sensitivity it deserves. The use of language, social interactions and culturally respectful ways are at the centre of meaning making, which IPA is concerned with. When doing IPA, one must pay attention to the language and the context of the words used as this is important in interpreting meaning (Yardley, 2000). Sensitivity to context was displayed by the researcher allowing the participants to respond in their home language when the need arose, being aware of the cultural nuances that participants draw from, which may be useful when interpreting data.

When engaged with IPA the researcher needs to be committed to being attentive to participants while collecting data, paying attention to each case during analysis (Smith et al., 2009). This means the researcher works carefully case by case, having to be immersed in the data for some time by reading the transcripts over and listening to the recordings thoroughly (Yardley, 2000).

Rigour refers to the thoroughness of the study as it relates to the suitability of the sample bearing in mind the research question, the quality of interview and the completeness of the analysis. The sample in this study was appropriate to the question that seeks to explore the lived experiences of some amaXhosa healthcare workers, as such studies need to be kept small and homogenous (Smith et al., 2009), to gain in-depth understandings.

Smith et al. (2009) state that transparency refers to how the researcher has explicitly described the stages of the research process. Transparency has been achieved according to Yardley (2000) in this study by clearly describing the data collection process and analysis, making use of quotes so that the reader can identify patterns revealed by the analysis. Yardley (2000) states that coherence is achieved through the appropriateness of the research question, the philosophical perspective, the method of investigation and analysis used in the study. Simply put, coherence according to Smith et al. (2009) refers to whether the argument makes sense. To achieve coherence the researcher has chosen IPA as the methodology that best

addresses the research question and provides a rich body of data, to enable the narrative accounts of participants to have been elicited and presented.

The test of impact is whether this study tells the reader something worthwhile. It is important that a study reaches the objectives of the analysis, and the findings are applied in the relevant context and population (Yardley, 2000). The findings of the research were designed to address the aims of the research by exploring and documenting how some amaXhosa healthcare workers conceptualise mental distress. The findings were not intended to be generalised to a large population, but rather should be used to build insight among psychologists in the region, about existent attitudes of stigma and discrimination; in order to potentially begin a process of thinking of how to address such issues in practice.

3.12 Limitations of the study

IPA was used as a research methodology to capitalize on the approach’s unique focus on the idiographic experiences of research participants to provide thick and rich descriptions. According to Smith (2008) the idiographic nature of IPA is to pay attention to specific experiences or phenomena and not focus on generalising findings. Congruent with IPA were the researcher’s interest in idiographic experiences of a recruited sample of amaXhosa healthcare workers from primarily three institutions in Makhanda. Therefore, research participants were not representative of all amaXhosa people but rather expressed their views from their own experiences as amaXhosa situated in their local area.

The selection of these participants reflects some homogeneity due to living in a particular area. Smith et al., (2009) stated that “samples are selected purposively (rather than through probability methods) because they can offer a research study insight into a particular experience” (p.146). This research methodology seeks to develop contextual depth through the specific selection of healthcare workers who have been exposed to phenomena of mental

distress. Thus, this somewhat restricted sample results in findings of this study not being easily generalizable to other populations, but may give insight to similar contexts.

3.13 Reflexivity

Another important aspect of conducting research is the researcher's ability to critically look at their own role in the research process (Smith & Osborn, 2003). Reflexive practice exists to improve the quality of research by ensuring that it is valid and accounting for the limitations of the knowledge produced, which leads to a more transparent research process (Guillemin & Gillam, 2004). As the researcher in the study, I had the task of managing my own perspectives related to my understanding of how some amaXhosa people may conceptualise mental distress, so as to not impose nor influence my participants' responses to the phenomenon under discussion. Because IPA acknowledges the researcher's role in meaning-making, it also recognises that the way the researcher interprets their findings will also be affected by their own lived experience and conceptions (Shinebourne, 2011; Smith et al., 2009). Hence, Moustakas (1994) advocated for a phenomenon known as "bracketing" of the researcher's personal experience from that of the research participants' lived experiences.

The premise of being reflexive in research also enhances the ethics of research and ensures that any form of researcher bias would be accounted for. Throughout the study, reflecting on the motivation for a study that focuses on the perspectives of healthcare workers was important, as it provided an opportunity to acknowledge the role of subjectivity and its impact on the study, which I had to constantly be aware of. Supervision became a useful space to continue the process of reflection in order to delineate the expectations I had as the researcher related to participants responses and the array of new insights gained, thus leading to me having to keep a diary to document personal reflections.

Further reflexive comments may be found in the final chapter of the study.

3.14. Conclusion

This chapter has outlined the methodology in depth, giving important details should replication of this study be planned in the future. The next chapter will provide a summary of the findings derived from the in-depth interview data. These findings will be arranged thematically, to synthesise the common themes that became evident as the researcher immersed herself in the data analysis.

CHAPTER FOUR: FINDINGS

This chapter is divided into two parts. The first section consists of a description of research participants, while the second section describes and discusses the findings according to the themes identified as related to the research questions.

4.1. Description of participants

A total of four participants were interviewed for the study. Participants all had experience related to mental healthcare as some assist in mitigating the transition process for psychiatric patients after discharge from hospital to the community while others encounter mental distress in the contexts they work in as healthcare practitioners. Participants were both male and female, black and isiXhosa-speaking.

Table 1: *Description of participants*

	Age	Location	Ethnicity	Education Category	Experience
P 1	> 65	Makhanda	Xhosa	Tertiary education	Psychiatric nurse
P 2	> 40	Makhanda	Xhosa	Tertiary education	Social worker
P 3	48	Makhanda	Xhosa	Tertiary education	Acting Manager
P 4	41	Makhanda	Xhosa	Incomplete diploma	Healthcare worker

Participant 1**:** P1 is an isiXhosa male, retired psychiatric nurse, with 44 years of working experience as a psychiatric nurse. He has worked in a variety of hospitals and has extensive experience in dealing with an array of mental health disorders. After having worked with patients in psychiatric settings for a long time, he was passionate about patient care and often wondered what happens to patients after discharge from hospital (gated setting) and how they negotiate their way back to the community. Hence, he decided to open a centre that

continues the rehabilitation process for psychiatric patients and equipping them with psychosocial skills to face their new reality. He described hoping to halt the magnitude of discrimination face by those living mental ill health.

Participant 2: P2 is a Xhosa female and a qualified social worker. She reported to have left her previous place of employment because of the lack of satisfaction with the position she felt she held. She describes that she did not enjoy just sitting and listening to people's problems but felt that she could be taking a more active role in impacting the community she comes from more positively. She is involved with numerous projects but is currently working at a non-profit organisation in Makhanda that provides a diverse number of services, along with psychoeducational programs and HIV testing and counselling. She holds the position of acting Manager of the Centre and reported encountering mental distress on a day-to day basis due to the work she does. One of the projects in which she gets to deal with mental distress is the Gender-based violence program that entails storytelling and open disclosure by group members where she's expected to offer a containing presence.

Participant 3: P3 is a female with formal experience as an educator working with pre-schoolers. She notes struggling with finding employment and later found a 3-year campaign called *Kha ri gude* run by the department of Education which she became a part of. Part of her job during the programme was to equip Adults with literacy skills. The experience she gained through the programme ignited her passion for working with vulnerable groups in her community. She later opened a day care centre for children living with disabilities ranging from mental disability, cerebral palsy and autism. She described herself as wanting to extend love and kindness, and patience to children living with disability. She comes across mental distress when dealing with the parents and caregivers of these children, but also explained her personal challenges with mental health.

Participant 4: P4 is a female who works at the day care centre with the abovementioned participant. She has a grade 12 education and unfortunately could not complete her diploma due to financial reasons. During the time she was seeking employment she enrolled for courses in First Aid, Care-Givers short course, basic counselling skills and HIV and AIDS information course. She stated that her passion has always been in the helping profession and describes the experience of working with children living with disability as invaluable. Her encounters with mental distress are through her sister who has a child living with disability.

To summarise, each of the participants interviewed reside in Makhanda. They all have a grade 12 level education, with three of the participants having completed tertiary education and obtaining professional qualification in their respective fields, while one of the participants has an incomplete diploma qualification. They all have some experience as healthcare workers. While one of the participants has worked in psychiatric care, three of the participants have started and are involved in community programmes that hope to impact communities positively, alleviate certain ills and distress experienced by people, working with a minority/vulnerable population and providing psychoeducational work to equip people to face their challenges. Passion for helping others in need has been a common theme amongst all participants interviewed, as they expressed wanting to take action against issues of gender-based violence, discrimination against individuals who are differently abled and helping individuals living with distress to cope with stigma, while renegotiating their transition to communities. They have different lengths of time working as healthcare workers ranging from 5 to over 40 years of work experience.

4.2. Responses to Research Questions

This section aims to answer the research questions of: How is mental distress (including psychotic phenomena) conceptualised and understood by amaXhosa healthcare workers, including their perspectives regarding existing attitudes that sustain forms of stigma

and discrimination towards those living with mental distress? It also aims to answer the question of what methods of treatment are generally sought by some people within the Xhosa ethnic group to address mental health issues?

As a phenomenological study the interest of the research is to look at the lived experiences of participants in order to gain in-depth understanding of the phenomena under investigation and build insight. Themes that have emerged from the analysis and interpretation of the research findings have been identified and listed below. The pertinent themes were grouped into six clusters. Although the themes have been separated, many of them are interlinked and related to each other, which becomes apparent throughout the chapter. It is therefore important to consider each theme in relation to the holistic experience and the hermeneutic circle. In what follows, the verbatim excerpts in italics are attributed to specific participants by noting the participant number to support the findings of the study. I have aimed to sample the excerpts proportionally across participants, so as to ensure that individual voices can be heard and individual experiences can be illuminated. Throughout this chapter, I have aimed to explore both depth and breadth whilst also highlighting both shared and distinct experiences therefore capturing divergence and convergence in experiences.

According to Smith et al. (2009), the process of finding themes is based on the researcher engaging in a double hermeneutic (see discussion in chapter three). As such, it is important to note that the themes presented in this chapter are one possible understanding of the phenomenon of some amaXhosa healthcare workers' conceptualisations of mental distress.

Figure 1: Summary of findings derived from the raw data

4.2.1. Mental distress as a social construct

This theme encapsulates some of the definitions offered by participants while constructing their meaning of mental distress. They reflected on the difficulties and complexities that exist amongst some amaXhosa people, when it comes to defining mental distress, as there firstly appears to exist no formal jargon within the Xhosa culture that can precisely explain disorders such as depression or anxiety. Therefore, in such situations most people tend to rely on community interpretations of what may be going on for an individual, because certain behaviours are socially agreed upon to indicate or mean something in society. The reliance on community conceptualisations have created overt hesitancy and scepticism to offer their own insights, as evident in participants responses leading to the apparent silence related to mental distress issues amongst some amaXhosa people.

Use of community conceptualisations to explain mental distress

This was a pervasive theme among three out of the four participants. All participants displayed a heightened level of hesitancy, with slight expressions of doubt and shame when asked about their understanding of mental distress or mental illness. It appeared as though the phenomena were new to them. Participants even with specialised knowledge and experience as healthcare workers struggled to share how they individually comprehend or conceptualise mental distress, as there appears to exist some sort of intrapsychic conflict between what they know and what has been socially agreed upon to define mental distress; and rather comfortably relying on community myths agreed upon in their respective communities to describe mental distress.

P1: Erhm (nervous chuckle) mental distress is (pause) … there is a lot related to it. To us it is difficult to define or distinguish mental illness as black people unless you are aggressive or violent and are going around assaulting people. To us it is not mental illness until you are violent. In fact, in our communities, while we were growing up that's what we saw as mental illness

P1 firstly acknowledges how complex the mental distress phenomena is in comparison to the understanding some amaXhosa people have of it. He attributed his understanding of mental distress to teachings or lack thereof during his childhood, stating that aggression and violence were often the most awarded indicators of mental ill health. He speaks of mental distress as an overt behaviour linked to a high levels of dangerousness. Thus, from a very early age he was socialised to believe and construct mental illness as such, this became incorporated into his own understanding and way of making meaning, that even as an adult with formalised knowledge he first nervously offers what he has known as a primary worldview of mental distress derived from his people. When discussing the

definition of mental distress, the participant still maintains that he observes this as a way some amaXhosa people view mental distress even today.

P2: Ehhh… uhmmm… during the time I was growing up you would hear older people saying you are that "one"…that rebellious child, who does not listen and just that child that never does anything right. We fail to notice mental distress and other times when a person starts going around picking up papers or litter in the street, undressing in public spaces or eating from trash bins we begin to note them as unwell and crazy.

Similar to P1, P2 describes mental distress according to what she observed growing up. It was described to her as an act of rebellion and the act of being deviant from negotiated ways of doing things in society. In her understanding she highlights the singling out of people with mental distress and portrayal of them as markedly different from the rest of the population and as such socially undesirable. Furthermore, she reported on other behaviours that signalled mental distress which were unavoidable behaviours thereby corroborating P1's statement that mental distress for some amaXhosa people needs to be overt before it can be identified, and it is almost always disturbing behaviour that most people fear.

P 4: Growing up you would see someone smoking or using drugs, and then when they are intoxicated or when the substances wear off people will say that they are mentally unwell because of how they act after the drug use. People who smoke drugs are scary because they don't act like themselves.

P4 discussed how mental distress is associated with drug use. In this instance the drug use is both ascribed as the cause of the illness and the illness itself. The participant reveals that because someone smokes and may display odd behaviour, which may not be representative of their character when intoxicated or withdrawing from substances, people develop feelings of concern and fear, which leads to them to viewing those individuals as

mentally unstable because of the drug use. Thus, it appears that when a person displays unusual behaviour they are presumably classified as unpredictable therefore being mentally unwell.

Most of the descriptions shared by participants were dated back to observed behaviours in their childhood and from what some adults taught them about mental distress. They seem to display comfort with community conceptualisations as opposed to their own understandings. When speaking about mental distress they were carefully selecting their words to ensure utmost sensitivity, because for the most part socially, language that is sensitive is unlikely to be used when speaking about people experiencing mental distress. Participants interestingly all first acknowledged the socially agreed upon understandings of the phenomena under investigation, despite their current knowledge. Fear of holding peculiar opposing views than the majority of the population are evident, thus making community myths become a more centralised understanding of mental distress to date.

Limited understanding of mental health issues

This theme refers to the limited or lack of understanding of mental distress among some amaXhosa people. Most participants reflected how unfairly those living with mental distress are defined and treated on the basis of their condition being poorly understood. Participants contrasted the limited understanding that exists in relation to mental distress to there being no sources of knowledge to draw from or relate it to in Afrocentric populations.

P1: Ehhh… Firstly, someone who is mentally ill, is not treated like any other person suffering from any other chronic illness… mental distress is not taken seriously among amaXhosa people nor viewed as difficult.

P1 states that mental distress is poorly understood and not seen as having adverse implications on holistic health. He alludes to how mental distress fails to be viewed like any

other chronic illness because of the limited understanding of its trajectory. The participant also describes how some amaXhosa people fail to acknowledge the complexity of mental distress nor it being a condition needing urgent medical care, owing to it being viewed as something not so difficult to work through.

P1: There was an adult male who was mentally distressed near my house, that man was treated like a child, that you even start seeing children ridiculing the man because no one can explain what is going on.

P1's statement describes his experiences of observing a mentally distressed person being spoken to or treated infant-like, with heightened fragility that even children would start ridiculing them. This he inferred as the inability to explain what is happening for the said individual, later this misinformed narrative becomes the understanding and construction of the mental distress phenomena, especially for children because this is the modelling they see and come to accept as they grow up.

P2*: We would also say that the person is pretending to be sick and that they are not actually mentally distressed.*

P4: To us being mentally distressed only exists in one form which is violence. You can hear in the manner in which we speak that we don't understand mental health, it's painful.

According to P2, because of the lack of understanding of mental distress symptoms, individuals living with it often face being told that they are pretending to be unwell. It appears as though some amaXhosa people struggle to believe the authenticity of the symptoms and its presentation. This links back to what P1 above highlighted, that among some amaXhosa mental distress fails to be viewed as serious or difficult, suggesting that it is not a condition expected to cause deterioration in functioning. P4 similarly shares that there exists only one conceptualisation and understanding of these phenomena amongst amaXhosa,

which is understood within the context of erratic violence. One can make sense of the limited understanding of mental distress by listening to the manner in which the distress is spoken about according to P4.

P3: If maybe we had something that could explain it… for example, sometimes someone will say they feel tired or drained and we can see that physically they don't look fine, but we will take it literally that the person is feeling tired not probing further into other feelings that may exist when someone says "I feel overburdened and my mind feels congested" and take that seriously. Instead, we assume that the person is just tired or mentally exhausted.

P 2: Depression is not a condition that is necessarily viewed as a mental health problem, but we would say that the person is lazy. I would say there is that thing of being ignorant.

P3 provides an explanation of the minimisation of the gravity of others experiences unintentionally due of the lack of understanding the depth of others' experiences. She reveals that at times people do share their symptoms, particularly those that signify depression, which are often misinterpreted and reduced to more trivial feelings. She further stated that there exists no real concern or seriousness towards individuals experiencing this kind of distress because of the assumption that the symptoms will subside on their own. P2 also shares how depression is not conceptualised as a mental health issue but rather reduced to laziness and attributes this approach and view to ignorance. Mental distress thus feels like an illusion and mystery for some amaXhosa people.

All participants indicated that there exists no accurate language to use when speaking about mental distress. The lack of understanding of mental distress results in people treating individuals living with distress the way they perceive them, with little regard and

empathy. Similarly, to the subtheme discussed above people with mental distress are treated uniquely because the manner in which they would behave was not adequately understood often deemed as erratic and unpredictable.

Silence and silencing related to mental distress

This theme speaks to the lack of discussions around mental health problems especially within Black communities, which contributes to the inability to conceptualise the phenomena. Participants have noted that there is a level of silence among those experiencing mental distress about their symptomology simply due to the fact that they cannot attribute their experiences to anything tangible or substantial that others can understand or deem significant to cause debilitation in functioning. As such most people doubt the validity of their experiences of mental distress and even minimise its impact on their functioning.

P1: We feel ill equipped to speak about mental distress… uhm… working with mentally handicapped people I've observed that in the Xhosa communities it is still very much taboo. People are not interested to learn about mental health, they are nonchalant, they don't attend any workshops related to mental health. AmaXhosa feel very much invincible towards it because it's like a white people thing…

P1 explains the silence around mental distress from his experiences and has observed that the mental distress phenomena are still viewed as taboo amongst some amaXhosa people. He describes how some amaXhosa people feel out of their depth in terms of speaking about mental distress and highlights how mental distress is still viewed as a western concept that rarely affects Black people. The lack of interest in mental healthcare issues results in the evident silence as stated by the participant.

P3: It's like, I think to me, other people feel shy or embarrassed that they suffer from depression.

P3 suggests that people are possibly ashamed when they begin to notice significant changes with their functioning, because they do not understand what they are experiencing and may become hypersensitive to what others may say about their experiences. This embarrassment predisposes them to hiding their symptoms and not seeking help. There is a sense that people don't know how to speak about mental distress or their experiences of it which consequently results in the silence and limited understanding.

P4: People are afraid… other people think that someone who goes to Fort England Psychiatric Hospital is a crazy/mad person who is irredeemable, so they hardly speak about their symptoms because they are afraid that they will be labelled as crazy and needing to be sent to FEH… so they always say they will be fine and not say when things get too much. P3: People experiencing distress, or any form of stress sometimes may feel alone, they start feeling like their own family members will abandon them because of their problems …also they don't want to speak out loud because they don't want people to be speaking about them.

Both participants 4 and 3 interestingly highlight the fear associated with being singled out and discriminated against on the basis of mental status as outweighing the desire to seek help. It becomes evident again that mental distress is viewed as something that can resolve itself. The misconception about psychiatric institutions maintains the silence and fear in those experiencing distress, because being labelled as crazy and mad are terms used about those living with mental distress, with those individuals are perpetually viewed as unstable. P3 details how isolating mental distress can be and lists fear of abandonment as another cause for the silence.

P4: I've noticed that other people hide their children who are disabled, they don't explain to other children that their child is different in which ways. Like, you can tell that normal children mostly look at other kids living with disability in a funny way because this is

not spoken about. Others even have siblings who are disabled but those kids are treated differently from them, and they do not understand why … and I think this mental distress thing is the same with how disabled people are treated.

P4 shares her own experiences of working with children living with disabilities and draws attention to some similarities of what mentally distressed individuals may also go through. The participant details how there are few dialogues held about differently abled individuals, with the inclination to hide them from the world as if ashamed. She draws attention to how other people tend to look at those who are different from them with unpleasant stares, which she believes is due to the unwillingness to share and explain the condition of the individual linked to limited understanding and underlying feeling of secondary embarrassment. It becomes apparent that at times it is difficult to explain why or how someone is ill when speaking to others, which perpetuates misinformation.

P3: AmaXhosa have a saying to mock people that says, "First sweep the dirt of your own home before you go around to sweep the dirt of others". So, we are afraid to help, we don't want to be humiliated or too inquisitive and be labelled as speaking of others' problems… so nothing gets done. It's each to their own.

P3 similarly to P1 highlights the taboo attached to this phenomenon and the fear of speaking out of turn about mental distress, because then one risks being labelled as spreading rumours and having their character defamed. It appears as though most people are cautious in extending help, in sharing their views and seemingly let the families or relatives of the individual decide according to the saying quoted by the participant. The final statement is rather ironic, given the general amaXhosa commitment to communalism.

Three out of the four participants listed a combination of factors that of fear, embarrassment, limited understanding, unwillingness to learn, lack of interest in mental

health care as contributing to the silence that is prevalent about mental distress phenomena among some amaXhosa people.

4.2.2. Referring to indigenous beliefs to conceptualise mental distress

The recruited sample of amaXhosa healthcare workers reported that most amaXhosa people approach mental health issues using their indigenous knowledge and belief systems. The difficulty to distinguish mental distress from Folk beliefs become glaring in participants explanations. Participants reflected on how these belief systems have inhibited people to explain and understand mental illness, then to begin redressing its effects in accordance with that understanding.

Blurred lines between Western and folk belief explanations

There exist rather subtle intricacies between what may be considered abnormal in Western practice and what is culturally acceptable according to some Afrocentric values. This exacerbates the visible limitations in comprehension and ability to delineate symptomology related to mental distress among some amaXhosa people. Different cultures and communities explain symptoms in various ways. Participants reported that there exist cultural factors, which influence people's perspectives about the symptomology of mental distress, that they often rely on to make decisions.

P1: And is very difficult to distinguish between the ancestral calling (intwaso) and a person who is experiencing mental distress. A psychologist can say someone is having hallucinations and the person or family can argue and say it is the voices of their ancestors who are calling them. Which one are they going to take?

P1 highlights how mental distress can be easily viewed and understood to be linked to one's cultural practices and their folk understanding of mental distress. Because of the cultural roots of some amaXhosa people, they have explanations for the presence of odd

voices that are believed to be linked to ancestral calling. As a psychiatric nurse P1 stipulates that it becomes intrinsically difficult especially for a person who does not come from a specialized environment to distinguish symptoms.

P3: *It is not easy for us as amaXhosa ... uhmm that when we think someone has the calling to entertain the idea that they could be mentally unwell. It feels wrong or unjust to think like that.*

P3 further postulated that the ability to think outside of what they know and believe as amaXhosa feels foreign even labelling it as unjust. This solidifies participant 1's observation that it is most likely that some amaXhosa people will honour their beliefs first because they provide a sound historical basis for how the manifestation of certain things occur and possibly how to respond to them.

P2: Someone could be experiencing distress because of intrusive memories from an accident they had, but you will hear people say no, that individual needs a particular ceremony to be done in order to feel better and to remove the black cloud hovering over their life.

P2 makes an example of an event that could cause mental distress, but could be interpreted differently by some who is amaXhosa because of their indigenous knowledge and folk beliefs. The cause of the accident seemingly could be linked to a message from ancestors or their wrath that results in the individual needing a ceremony to be done to cleanse them from the "black cloud" in their lives, as stated by this participant. This illustrates how the phenomenon of mental distress becomes quite difficult for some amaXhosa people to grapple with and conceptualise as they possess a fund of knowledge based on their culture that includes and explains some of the behaviours coined as mental distress; which they have

come to know to be connected to their beliefs and understanding of their ancestors, religion and spirituality.

Indigenous beliefs

Participants noted that some amaXhosa people externalise certain experiences they do not know the causes of to some external power. They often would speak of being unfortunate and unlucky.

P2: People tend to say I'm so unfortunate, I'm so unlucky things are not going well, my life is a mess, I need prayers, let me go to a faith healer for prayers

P2 describes how mental distress can be viewed as punishment, misfortune and as a bad omen needing the intervention of a diviner. This participant shows how indigenous beliefs play a significant role in how a certain group of people can conceptualise distress. Interestingly when individuals seem to lose hope or control over things they once could control they tend to relinquish their control to a believed and trusted superpower. This way of understanding distress makes the distress and the individual two separate entities, placing the rectification of it almost outside of the control of the individual as caused by something "supposedly greater".

P3: In our minds as amaXhosa we believe that the white man will not be able to detect nor understand everything related to amaXhosa people especially things like bewitchment

P3 shares how the belief in bewitchment by some amaXhosa people predisposes them to dismissing the possibility that those who do not share a similar worldview to them could help to find solutions to their difficulties. Because of their indigenous beliefs, some amaXhosa people tend to feel that Eurocentric principles may fail to inadequately attend to

their problems, thus there appears to be more trust in traditional healers and faith healers when dealing with some sorts of distress.

P4: Our beliefs are hard… because other times you would observe a child being told they have the calling (yokutwasa) because of odd or rebellious behaviour they display and yet they are so young and then we make a decision that they can only receive help from traditional healers.

P4 depicts further the extent to which some amaXhosa people seldom question whether there could be other explanations for certain behaviours that occur among their people. Because they trust traditional healers, it becomes hard to question the validity of what they say because of the sound historical evidence of their ability to heal their people.

Some of the attributions amaXhosa people make relate to mental health issues. It becomes clear that amaXhosa strongly associate the occurrence of mental distress to something tangible that they believe about their lives. It is important to note that when participants spoke about mental distress they included their cultural beliefs and values. This makes sense of possible assumptions of the misunderstanding of mental distress and an indication that there is a strong association of mental health issues to folk beliefs.

4.2.3 Referring to life adversities to rationalise mental health problems

Participants highlighted that some amaXhosa people also make sense of mental distress in relation to difficulties that people may be facing in their lives. With the noted intricacies in identifying its occurrence or the inception of symptoms, there exists a presumption that certain life events are significant enough to bring about distress and dissonance in people's lives. The inability to cope with certain life events has been a way most amaXhosa people have attempted to make meaning when it comes to mental distress.

With this said, the inability to cope is also however a double-edged sword because it is "allowed" as a way to rationalise the possibility of the occurrence of mental distress, but simultaneously to a greater extent is dismissed as a reason to completely debilitate one's functioning, as you are supposedly expected to cope.

Inability to cope with the loss of a loved one, family and work pressures

According to some amaXhosa healthcare workers the inability to cope with the loss of a loved one, family and work pressure are among the identified life adversities expected to cause a change in people's behaviour. According to P1 these events are considered credible to cause distress in people's lives.

P1: *It becomes hard to pick yourself up, especially when you feel overburdened and for example you have lost your husband or a family member, then you cannot cope any longer.*

The link between life adversities (death in this situation) and mental distress becomes an example of the cause of distress among some amaXhosa people and a possible understanding of it, as they have incorporated it into their understandings of observable causes of mental distress.

P2: Raising a teenager who abuses drugs… uhmm raising such a child causes a lot of heartache and stress and inability to cope with the situation. These things can cause a parent to be depressed.

Similarly, P2 speaks of family issues as causing distress and makes an example of raising a child who abuses drugs as a significant factor that may cause mental distress for the parents. The emotional burden and the stress that comes with raising a child who is deviant from negotiated ways of existing in society is understood to cause disharmony in one's life. Because of the observable emotional constraints, which can be linked to an active stressor,

the presence of mental distress is not considered unusual and seemingly becomes an acceptable way to make sense about mental distress.

P 4: *I have a friend that was in an abusive marriage, and she would usually say she is going crazy "I'll go mad" or say weird things, because of her husband's behaviour and his refusal to financially support them*

P4 depicts how people can come to understand that a particular situation is causing them distress, but lack the ability to see the depth of circumstances that may lead to seeking help, instead they seem to rationalise their distress in accordance with current stressors and as something that could possibly disappear with the stressor. Being in an abusive relationship or marriage is seen as something that can cause distress: the occurrence of this implicitly appears expected or normal. The participant's response also highlights how mental distress is loosely reduced to going crazy or rather how people still view it as madness, owing to the salient difficulties in conceptualising it.

Interestingly, referring to life adversities to rationalise mental distress, P1 also revealed that some amaXhosa people, regardless of the situations faced, have an expectation that one must continue to manage the difficulties without much unravelling.

P1: *We expect people to continue with life regardless of what they may be experiencing, it has happened it has happened. But if we could pause and take a look at how people are coping mentally and look to their hearts we could see the damage of the unpleasant life misfortunes they face… but instead you'll be ridiculed and viewed as weak because as Black people we don't expect life to be hard. Life isn't hard … you just have to chin up.*

The recognition that certain life adversities may contribute to daily stress seemingly does not supersede the expectation to cope with them. P1 further spoke about how the impact

of these life events later become ridiculed and deemed not severe enough to cause complete debilitation in functioning and not easily considered as severe enough that one would need to receive mental health care. Even though at a conscious level these circumstances are reasonably judged as difficult to work through. At a subconscious level there exist a resource of learnt knowledge that people who have experienced such losses had managed to overcome them, making it impossible not to judge nor minimise the experiences of others. This breeds the foundation of the current predicament related to mental distress, as many amaXhosa people have learnt to invalidate their own feelings, keeping them in a cycle of being unable to truly process or speak about their experiences and coping mechanisms.

Use of denial as a coping mechanism

In addition to referring to life adversities to rationalise mental ill health, participants also revealed that maladaptive coping strategies, especially those of denial, are used at times to nullify the significance or existence of mental distress. This subtheme specifically emphasises the attempts made by service users to re-integrate themselves back into their respective communities. In their quest to assimilate where they were before the occurrence of the illness after discharge from hospital they often discount the existence of the illness, attributing its occurrence to particular events in their lives that may not be there any longer.

Participants reported that the adopted defense mechanism of denial leads to service users rationalising non-compliance with treatment because of how well they feel.

P 2: Even though people have been hospitalised, informed of their mental illness and prescribed treatment, they come back and discontinue treatment because they do not want to hear they are unwell or mentally ill

P2 explains how some service users struggle to acknowledge their diagnosis and often use denial to rationalise their mental illness. Because of the improved mental state and

discharge from hospital, service users seemingly find it difficult to accept that they live with a certain mental diagnosis as they attempt to regain their previous social status. This is further elucidated in P3's statement:

P3: This mental health issue is difficult for people to accept, especially for Black people, most of them are in denial and they claim to be fine when they return… they start smoking drugs and using alcohol again because they are well. You'll hear them relate their mental distress to things like fights with family members, partners or drinking too much etc…

As evidenced by both participants above, mental illness becomes a difficult diagnosis to accept for a variety of reasons for some amaXhosa people. Because of the uncertainty of what mental ill health means in most communities, service users find it hard to accept and consequently live in a state of denial because it is difficult to live with a diagnosis you cannot easily defend. In most cases service users are aware of the stigma that mentally distressed individuals experience, hence their desperate need to appear well and then use maladaptive coping strategies like non-compliance with medication and substance use.

P1: others flushed treatment without guardians knowing, stating that they won't live on treatment

The improved mental state visibly fuels the denial and propels services users to rationalise that they are not mentally unwell.

P2: the medication makes me drowsy; it drains my energy, it doesn't work for me any longer, I'm gaining weight because of it … uhm I can't eat certain food because of it. There are just too many excuses they use to convince themselves that they are well and stop treatment.

P2 highlights the use of medication side effects as an excuse to convince others that the treatment is no longer necessary. Three out of the four participants stressed the inherent

difficulties in accepting a diagnosis of mental distress and the use of denial as a coping mechanism. This also highlights the difficulties that come from feeling different or being othered. The self-esteem seems fragile to withstand the stigma that comes with the illness, because perhaps some of the service users have been a part of it, thus using denial to defend against experiencing the discrimination that comes with the diagnosis; and protecting their status within a community becomes an important factor after discharge from hospital.

4.2.4 Stigmatisation and Discrimination

Participants evidenced that in their respective communities the manner in which people speak about those living with mental distress is dehumanizing and degrading. They speak of them as a lost cause, undeserving of dignity, love, respect nor possessing the ability to contribute positively to society. This then leads to labelling of persons and using language that sensationalizes mental illness reinforcing stigma through the use of degrading names and derogatory terms.

Use of language that sensationalises mental illness and reinforces stigma

All participants reported that the language used to describe people experiencing mental distress is usually unpleasant and incites fear in most people towards them. P1 described the painful degradation experienced by those living with mental distress in their communities as they become treated in an infantile manner with untoward fragility. Participants highlighted the derogatory names used towards people experiencing mental distress, in attempts to distinguish them from the rest of the population and as a way of magnifying their faults.

P1: In Black communities someone who is mentally ill, is not treated like any other person they are referred to as mad/crazy, hafityi (half a brain), ndlongo-ndlongo (meaning

aggressive) no sense left and or loose head. Once someone says uligeza meaning crazy, we don't expect anything good to come from you, we expect violence.

P4: Have you seen so and so, he has gone crazy yhoo, I'm soo scared of him I don't even want to get close.

Both participants echo similar sentiments in relation to how others react to those living with mental distress. P1 shares explicitly some of the derogatory terms ascribed to those living with mental distress, importantly stating that when you are known to be living with mental distress people generally have low expectations of you, further referencing that no good is expected from such an individual. Violence and aggression are highlighted again as the only expectation from mentally distressed individuals, which changes the manner in which they would interact with the individual, coming from a place of fear. P4 corroborates P1's statement depicting the fear people display and illustrating how people think and speak about people experiencing distress. P4 also shows how fear incites the divide between those living with mental distress and everyone else.

P4: There is nothing he can do for himself; he is vulnerable and fragile

P4 described how the sense of self of those living mental distress gets taken away from them, while they are also being incapacitated by others on the basis of their illness, leading to them being viewed as fragile. There is a sense that others sympathise with those living with mental distress as they may perhaps feel that they could never be the same again or possess any sense of agency for their lives.

P1: We tend to speak of mentally distressed individuals with a heightened level of discrimination that our kids even run when they see someone we have labelled as igeza (crazy)

P4: Yhoo iyakubetha isaylon translated as "a crazy person will assault you"

P2: Other times any little thing they do, we tend to say oh it has started again, he/she has become like that again it's their season to act like that again

Participants 1 and 4 allude to how people commonly tend to project their fears on others by influencing them to hold similar fears about mentally distressed individuals. These projections become pervasive because of the generalised lack of understanding of mental illness. This fear guides the language people mostly use as they attempt to caution others to fear mentally distressed individuals. P2 describes the manner in which we refer to mentally distressed individuals when they react to situations rather than responding. Language that sensationalises mental distress becomes used. It appears as though normal emotions like anger, irritation, or frustration that everyone experiences, become ineligible to experience without it being viewed in the context of their illness.

The narrative of unpredictability and dangerousness ascribed to mentally distressed individuals are consistent and pervasive. There is an indication that people believe that all persons who live with a mental illness diagnosis are not capable of reasoning coherently and intelligently. There exists an underlying assumption that individuals living with mental distress should not be trusted because they can assault you. A common understanding or belief of some amaXhosa people is that the behaviour of mentally distressed individuals cannot be accounted for and are more often than not violent.

Labelling a person by their mental illness

Participants have felt that stigma and discrimination is exacerbated by the labelling of people with their diagnosis. This has been especially noted to be prevalent in primary healthcare settings, which are perceived to instigate the labelling through publicly segregating and calling the mentally distressed individuals into separate lines or spaces. Participants have noted this to cause embarrassment to those living with mental distress and how it further serves to divide and exclude them from others. This behaviour for people who do not

understand mental distress reinforces their myths and maintains their fear of those living with mental distress.

P2: I don't know if that manner in which things are conducted at our local clinics maintains the stigma because they separate people living with mental distress diagnosis into a separate space from the rest of the community

P2 highlights the prevalent discrimination of mentally distressed individuals and subsequent identification of them by their illness. Participants reflected on the limited or lack of understanding of mental distress among some amaXhosa people, that the evident divide that occurs in primary healthcare settings appears to reinforce the attitudes of stigma in the general population. The singling out of people as different sustains the attitudes that exist in communities that identifies them as different, thereby creating a situation where these individuals also simply struggle to see themselves like any other person or as normal.

P1: During traditional ceremony its expected of every man in the community who is in attendance to stand up and say a word or two at the kraal, but as soon as a known individual living with mental distress stands to speak they are immediately and harshly told to sit down because what can they say, they are belittled and called names like crazy.

P1 speaks to the pervasive discrimination and stigma faced by those living with mental distress and how they are seen as incapable of contributing constructively to public life. This statement implies that they are not viewed as valuable but rather as a liability and the labelling of them by their illness becomes widespread because no one stands up for them.

P4: Can you believe that we even label children according to their disabilities or their scholastic difficulties as iiKuyasa which refers to the kind of school they go to which caters to their specific needs

P4 corroborated what was said, that labelling of people by their difficulties is widespread, denoting that children even face this kind of discrimination and carry the stigma of their difficulties. P4 also noted the significant role played by the naming in this way.

P3: These names have a tendency to stick, and mentally distressed individuals start to easily response to them.

P3 describes the process through which stigma becomes pervasive and how it is reinforced through the use of derogatory names that describe mentally distressed people and how they become complacent.

Participants have observed that in their respective communities the manner in which people speak about those experiencing mental distress is dehumanising and degrading and consequently incites attitudes of stigma and discrimination incrementally. This lays fertile ground to disregard, disrespect others on the basis of their differences.

Alienation and Segregation

It becomes clear that the fear experienced by some is insurmountable when it comes to mental distress, causing them to consciously or unconsciously feel the need to protect themselves by alienating and segregating those living with distress from them. There also appears to exist a tendency to shamefully hide those experiencing mental distress, incapacitate them, pushing them further away from society and participants have noted this to be strongly governed by projected feelings of fear and shame.

P1: Truly speaking mentally distressed people do not receive the acceptance and warmth they experience in hospitals after discharge which creates no chance for them to be completely free

P1 highlights the lack of warmth experienced by mentally distressed individuals after discharge from hospital. This distance that inevitably forms unfortunately due to their mental

illness alienates these individuals, as they struggle to find people who can empathise with their experiences. Their differences become magnified when they come back to society because they are still viewed according to the behaviour that they displayed prior to receiving mental healthcare. This lack of trust displayed by the community members impedes recovery of patients, as they are not offered the same freedom which they had previously, thus inhibiting their recovery. It can lead them to feelings of inadequacy and hopelessness.

P2: Because most people are persistent with the labelling of those with mental distress, even when they become better and are seeking opportunities for themselves, most people tend to give them negative attitudes and continue pulling them down and breaking their souls with the labels thus removing them from relating with others because there is no trust.

P1: The person left having broken his family's heart, or put the lives of children in danger and unfortunately that impression holds

P2 describes that despite the recovery of those living with mental distress, it becomes difficult for others to acknowledge their improvements as they continue segregating them. Their attempts to seek opportunities to better their lives are met with heightened negative attitudes because of their perceived difficulties. Communities are not receptive to the changes recovered patients display, as the derogatory labelling towards them does not stop when they become better. P1 further explains that the lack of trust and inability to view the individual living with mental distress from a positive perspective is due to the lack of understanding of mental distress and its trajectory, the harm or damage caused and difficulties with forgiveness or forgetting past behaviour of the individual, feeding the gap that contributes to the lack of receptiveness and warmth towards the individual.

P4: We as people … do not allow our differently abled children to be free and for them to feel included because we perceive their differences. We unfortunately want to hide them similarly to our mentally distressed relatives because we feel ashamed, what will others say, and we don't know when they will be unwell in the presence of others.

Here, P4 refers to her experiences of working with differently abled children who subsequently also experience alienation on the basis of their differences to the greater population. Similarly, to the reflection of the above participant, fear becomes noticeable as a driving factor in discriminating against those who are different. People internalise their own experiences above that of the individual with the said illness or distress, limiting and depriving mentally distressed people of their freedoms. The secondary shame and fear of judgement of family members inhibits the progression against stigma and discrimination.

P1: We often dictate certain chores we feel they can do despite their eagerness to try. We tell them they cannot do it; they'll make a mess trying and we inform them there are others who are better suited for those tasks. Workwise you would even hear when some has been said to be ill, especially mentally. Even if you were in a supervisory position, you would get demoted and not even be given a clear reason as to why

The divide between "them" and "others" becomes wider as their behaviour becomes more controlled by their guardians at home. The segregating of tasks that they can perform contributes to incapacitating them. Such control can be detrimental to their agency, leading to further feelings of worthlessness and the alienation that they experience. The participant further demonstrates how the stigma and discrimination may translate to the workplace, which usually results in sudden and poorly explained demotion from supervisory positions, after a diagnosis of mental distress, which can further segregate the person. Lack of attempts to understand those from whom we have different experiences, in order to learn, clearly

depicts the rigidity that exists amongst some amaXhosa people, as they would rather detach themselves from those experiencing mental distress based on the misconception of mental distress that exists.

Manifestation of self-stigma

Overidentification with diagnosis, internalisation of what is being said to them by others and self-pity have been noted to result in self-stigma by some participants. Individuals who are living with mental distress are postulated to have weakened self-efficacy thereby easily infiltrated by others' beliefs of them.

P2: *Why was I chosen to be like this, how is it that I can't be like others, I'm never going to be better*.

P2 draws attention to the self-blame and weakened self-efficacy that individuals living with mental distress experience. They at times get stuck in a negative feedback loop system where they question the occurrence of the illness as a means to attempt sense making. They feel less of themselves, they feel doomed because of their diagnosis and the limited understanding they have of mental illness, thereby acting in ways where they feel less deserving of certain things.

P3: I won't be able to leave the house and go out because what happens if I get out there and fall because I am a mentally ill person

P3 reflects on how some mentally distressed individuals internalise some of the community myths, becoming fears which begins the process of stigmatising against the self. When they begin to question their abilities, they subconsciously breed a space for doubt and that can irrationally and negatively affect their outlook. This affects their self-esteem.

P4: I'm dependent on this treatment, the doctors told me I have depression so in order for me to become well I have to use this treatment, I can't do things like other people because

of this depression e.g. I cannot even attend meetings or be a part of certain groups- I'm just a crazy person, I'm unwell I'm even on disability grant

They begin feeling helpless and overidentify with their diagnosis, which can be detrimental to their self-esteem. They also begin to deprive themselves of certain opportunities and experiences to assimilate with others because they feel incapable. They begin operating on the fear that others may not understand them, based on their limited understandings of their own illness as well. They also start speaking about themselves using derogatory terms and exclude themselves on the basis on the words they use to define them.

P4: My sister did not tell us when she was going through depression, she was doubting her own experiences of mental distress and whether they were real or not, she reported that she always felt like she was going crazy when she would try explain her symptomology that when she once spoke to us she said I think I am crazy

P4 highlights how peculiar experiences, especially those that people have no tangible reference to, or do not comprehend, leads to internalising and self-judging because it is perceived that others would think along the same lines. Many individuals with silent symptomology feel there is something inherently wrong with them, they experience shame and some sort of guilt about the occurrences, thus leading to the self-stigma and silence about reporting symptomology.

This theme highlights that lesser-known symptomology of mental distress may be a cause of self-stigma which is apparent in the self-blame, shame and lack of self-efficacy.

4.2.5 Remove stigmatisation and empower

A recurring theme was that of participants' hope for redress when it comes to mental distress and the pivotal role that important stakeholders within communities can play to halt

stigma around mental distress. Participants expressed their wish to empower communities with knowledge so that conceptualizing mental distress like any other chronic illness might begin, which they believe would be helpful in reducing stigma.

Needs for psycho-social support and education

Participants noted the value and importance stakeholders (psychiatrists, psychologists, and nurses) have in effecting change. They reported that they should begin taking active measures to educate people in the communities they are coming from about mental distress, to empower them with knowledge which would soften the fear they have towards mentally distressed people.

P1: After discharge you return to an environment that has a particular assumption about you, the groundwork should begin before you leave hospital the social worker should be preparing the family and psychologists getting them counselling if necessary to reduce the fear attached to the patient's image

P1 notes the importance of restoration at both an individual level (patient) and at group level, which here would be the family. The participant states that because of the encountered traumatic event of observing their mentally distressed family member behave in a peculiar manner would need support and if necessary counselling, in order to adequately assist their recovering loved one. This is indicated by the participant to preferably take place before patients are discharged. The relevant stakeholders involved in managing the patients should begin this process to ensure smooth transition to home environments through this psychoeducation and support offered to family.

P1: The one thing I emphasise to families is that the patient should feel accepted at home even if they've fallen ill mentally, to become adjusted you need to treat them with

respect like adults not like children don't be too restrictive but careful at the same time. They need to be close to people, feel connected for them to use medication properly.

P1 emphasised how important it is for the individual living with mental distress to feel accepted, loved and normalized. This also further highlights that this kind of support and acceptance might positively contribute to treatment compliance. This kind of support can build the trust between services users and relatives and soon the recovered relatives can feel empowered and that they have a second chance at life.

P3: I'm not alone in this journey, having someone to talk to, knowing there are people who are like me out there, feel loved which encourages them to have the drive to want to live life, encourage independence and initiative

P3 corroborates what P1 stated, further emphasising the importance of feeling connected to others and knowing that there are people who are living with the same difficulty as you, seemingly encourages the will to want to live, which encourages feelings of self-worth. By speaking to families about the ways in which they can assist their recovering loved one fosters the understanding necessary for recovery.

While three of the participants reflected on the importance of support and psychoeducation for families, P4 shared the painful and denigrating effects that comes with not having that support. P4 draws attention to how isolating mental distress can be. The lack of social support and its implications for the individual living with distress play a significant role in their recovery. Although acknowledging that this is primarily caused by lack of understanding of the phenomenon of mental distress, it leads to reduced sensitivity in the ways we speak of it.

P4: because our relatives speak ill of those experiencing mental distress, we often don't know what to do, confused and isolated we die inside, everyone is busy with their own lives

All participants emphasised the benefits of emotional and social support especially from loved ones because feeling accepted and a sense that you belong contributes to empowering those living with mental distress.

Advocacy

This theme refers to the practical ways in mental distress can become better understood by certain communities. Participants reflected on how the prevalence of stigma and discrimination can be halted by equipping communities with knowledge regarding mental health issues as discussed above. It became evident through participants' responses that one such method that can be used is that of advocacy for mentally distressed individuals, in order to begin seeing change related to how people view those with mental distress.

P2: People are teachable, in some projects I do take some participants and use them as sort of associates to teach the next group which becomes helpful as they learn from one another.

P2 speaks of the recruitment of past individuals who have been part of the learning group to begin passing of knowledge and skills, as a powerful and encouraging way of educating and equipping the greater communities. It seemingly appears to be quite profound to have people the community can relate to, who share similar lived experiences teaching, guiding, and correcting one another towards transformation. P2 believes that people are teachable and just need the knowledge to take initiative to attempt to reach out with understanding and patience.

P 3: I think if we could have workshops, then we start with educating community leaders. Then we encourage them that when they have community meetings they should include mental health information, advertise it and direct members to clinics if they have concerns and further questions. In clinics there is always a large number of people gathered to share this knowledge to so also having mental health days could be helpful. At churches we could ask for sessions maybe at church we could ask for an hour any day of the week for something like this. In prisons too…

P2 lists the ways in which advocacy for mental distress can be promoted. Clinics, churches, and prisons are places where there are a large number of people gathered and this can be utilised to better achieve the notion of imparting knowledge about mental distress. The participant feels strongly about educating and empowering community leaders so they can impart the knowledge to community members similarly to what was stated above by P2.

P3: But if we could have radio interviews, whereby we will interact with people. Whereby we can explain to people about mental distress and actually also have time for questions where they can call and have certain questions are answered. I've witnessed people reference pills they heard on radio of certain health conditions in conversations. People listen to the radio wherever they are, even those without TV will have a radio.

P3 recognises the radio as one practical way of having wider reach to people in the community in attempting to open discussions about mental distress. The participant also notes the power and influence of radio on the public and that often times people share with others the knowledge they hear about certain health conditions. This is an inexpensive method, with a large number of people who have access to radio, therefore being a sustainable method in the future for advocacy around mental health discussions.

P1: start at home when they are on board and understand mental health, this information easily spreads to the next-door neighbour and gradually transcends to the community at large. Also positively advocating for independence and rights of mentally distressed persons to be honoured. He must be given chances as well, like the mentally well individual

P1 firmly believes that advocating for lasting change begins with the education of the immediate family who then become the bearer of more accurate information into the greater community. Empowering one family may have ripple effects in that slowly more families become empowered and extending more widely. This participant furthermore advocates for equality for those living with mental distress and believes that they should not be treated differently on the basis of their illness.

Participants have demonstrated that there is hope for mental distress to begin becoming a topic of discussion among some amaXhosa populations and communities. Participants have reflected that they have faith in people having a teachable spirit and simultaneously emphasised the role important stakeholders can play in effecting change to the current silence and misinformed views that people have of mental distress, through listing the primary steps that can be taken in this endeavour.

4.2.6 Healthcare seeking behaviour amongst the mentally distressed

In sharing the most prevalent help-seeking behaviours considered by some amaXhosa people, participants postulated that some amaXhosa people are strongly governed by their traditional and cultural beliefs especially in matters related to illness and healing. They reported that because amaXhosa people have explanatory models for illness and healing they will instinctively consult traditional healers or faith healers in the quest to make sense of what may be happening for their mentally distressed loved ones.

Primary consultation with traditional healers

Participants reported that most amaXhosa people when things are not going well, or when met with a series of misfortunate events, start believing that there is a message their ancestors are trying to communicate with them. They often attribute mental illness to unappeased ancestral spirits and *ukutwasa* (the calling).

P1: you will hear at times, when people hear about someone who has recently become mentally distressed they want to advise the family and tell them to take the person to a traditional healer, because the behaviour is not characteristic of the person so it could be that its bewitchment, maybe others are jealous of the person. That the family must act fast

P1 reports that when someone begins to act in ways that are uncharacteristic of their behaviour, people tend to speculate about the cause of their illness and often externalise the problem, with the first port of call being that of consulting a traditional healer. Bewitchment and jealously become frequent explanatory models used to construct an understanding to explain the behaviour of the person. Shared beliefs and understandings become persistent and widespread as people within the community start advising the family of the distressed individual, according to socially understood methods of seeking meaning. This implies that before family members can make sense of the illness, people have already began paving a direction for them to consider.

P3: *Yho let me go consult because I don't understand what is happening, I've become stuck let me go get a reading / news of my life from a healer, there is something wrong maybe I am sick. Why do I feel this way, I shouldn't be?*

P3 corroborates what P1 stated and further depicts the thinking process that an individual goes through, when faced with emotions or situations that they do not understand. They become suspicious and may question their own sanity at times. There appears to be a level of trust and comfort that exists regarding consulting with traditional healers to get to the

causes of things. Participants 1 and 3 allude to the powerful role of traditional healers within their communities because of they explain difficult life situations and provide solutions.

P2: And then sometimes people would say that you need a particular ritual done, then they would do those rituals. They would slaughter, you will be cleansed and all other proceedings that Xhosa people usually do would be done for you to receive relief

P2 describes some of the rituals that are performed in order for people to receive relief. These stated options to health and healing are examples of rectification of problems under the guidance of traditional healers. It becomes clear that traditional healers observe a problem and suggest a solution.

Through participants' responses it becomes evident that traditional healers are believed to be able to connect with the spiritual world and have the gift of foresight, enabling them to shed light on matters not easily seen by others. Within the amaXhosa culture, they are especially trusted for their ability to explain illness and also methods of addressing illness based on the perceived causation of such illness. Their need to first make sense of what people may be going through has been a prominent narrative throughout the study.

Faith healing because mental distress is viewed as a demonic possession

Participants revealed that some amaXhosa people believe mental distress to be the wrath of God and needing repentance by an individual for the assumed wrong deeds. Alternatively, others revealed that sometimes mental distress is explained as a demonic possession and the person needs to be taken to a religious diviner to receive deliverance.

P2: And then there usually follows prayers, and you take the person to church because when you do not receive healing from traditional healer's people start believing that it's a demon and then the discussion is that the person should be taken to church.

P2 reports that such more Christian spiritual consultation is secondary to traditional healers. When there appears to be no relief from traditional healers, the belief that there is a demonic possession brews and is entertained as a possibility. People are said to then act on the basis of this assumption and take the individual to church.

P3: Other people, usually say "pray" or "go to a diviner". Yes, I do pray at times and speak to God and sometimes I kneel and ask God for strength but sometimes that's not the same as speaking to someone

In contrast, P3 highlights how invalidating people may be: they advise prayer or to consult faith healers with these difficulties. Because there is limited understanding of mental distress, when people attempt to speak about their problems and are met with subtle rejection, they may feel there is a cause for serious concern, or alone, or burden to others when no one seems willing to listen. There appears to exist a salient panic to find a solution to a person's problem and rather than being able to engage with them on their problems, people rush to advise them. Furthermore, people may begin to pathologize their experiences in a manner that leaves them believing their problems may be greater than they realise.

Delays in seeking treatment

This subtheme refers to the noted delays in seeking treatment due to beliefs that the cause of the illness is as a result of something the person has done. Other participants stated that this belief results from cultural influences on conceptualizations of mental distress.

P3: *Our ways of seeking help become affected because it becomes difficult to acknowledge and accept we have certain issues, instead we persevere and hide our symptomology and or emotions. The fear is also related to fear of being judged.*

P1: It's like that, it's like that even when it's clear and obvious that someone is severely mentally distressed, and the person is unwell, because of our traditional beliefs we

say let's take the individual to go to a traditional healer and let them live in their shrine (African healing place) for a period of 6 months when it's not even related to that. Even though we don't see much improvement or progress we have faith.

P1 narrates again how traditional beliefs are so strong and how trust in them can easily make people lose sight of what appears evident. This thus indicates that because some amaXhosa people believe in traditional healers they often delay seeking interventions because of being rigid in ways of doing things.

P3: My sister would flush her son's treatment, because there are myths out there that disability is not real and that there are traditional healers who could heal him, and she was sending her child to different healers, but the child still cannot do anything for himself

P3 similarly to P1 depicts how traditional beliefs can outweigh what people hear and are told by medical doctors. Because of strong traditional beliefs and the denial of diagnoses, shared beliefs are used to rationalise the phenomena. It is important to note again that denial and rejection of diagnoses play a role in the delay of treatment regimes.

Integration of Western & Afrocentric modes of treatment

Participants reported that although the majority of amaXhosa people they have encountered use Afrocentric modes of treatment, when those seemingly do not assist the individual, they do consider other methods of treatment. They begin to look to Western modes of treatment; and some because of their belief systems will use traditional medication in conjunction with psychiatric treatment.

P1: I don't care if someone holds certain beliefs, but traditional medication and western medication must work together and for one another. I tell patients you don't stop the one treatment regime because you say your cultural beliefs don't allow you, you use them both until you are better

P1 shares how he advises patients who are strongly influenced by their cultural beliefs to continue using western medication and incorporate it into their cultural treatment regime, in unison. There is an underlying dilemma highlighted by this participant that patients who believe in Afrocentric modes of treatment may be sceptical of both modes of treatment working in conjunction with one another, influenced by their understandings of illness.

P4: Like people can go to the doctor, and they will be told they are mentally distressed and receive treatment, but they still want to consult with traditional healers about the root of their illness. They will then continue using the medicine from the doctor but also traditional medicine. We will hear them say I don't know which ones will work but I know they will surely both heal me

P4 echoes similar remarks to P1, highlighting people's desperation to get relief from symptoms. This participant speaks about how some amaXhosa people may consult with western trained professionals and receive treatment, but will also consult with traditional healers in their quest for health. Consultation with traditional healers is pervasively framed as a search for the causes of the illness, its trajectory and importantly the efficacy of medication for healing. The participant also gives an impression of the trust vested in traditional healers and their medications, even with a Eurocentric diagnosis. The participants also suggest that there is a tendency for people to integrate different medications.

P1: Because we are Black people, if there were things like certain rituals that were not done which are necessary I usually would advise that the patient ask his/her family members to have them done especially also if the patient believes that that is a contributing factor, and that the ritual would aid in them feeling and or becoming better.

Participants all shared that after primary consultation with traditional healers and faith healers secondarily, individuals who have not received the necessary relief from their

symptoms do consider consultations with Western doctors. However, there is also an observation that after consultation with medical doctors most patients attempt to use both medications together.

4.3. Conclusion

This chapter has explored the perspectives of key informants regarding their conceptualisation and understanding of the mental distress phenomena. The results are presented according to the identified themes. The findings suggest that some amaXhosa people rely on socially agreed upon conceptualisations of mental distress, which are based on a limited understanding of the phenomena. They seek to understand causation of the symptomatology and primarily rely upon traditional healers to provide these. Most importantly the findings have demonstrated that conceptualisations of mental distress seem outdated, owing to a lack of insight about the phenomena, resulting in the apparent poor understanding of it as the manifestation of violence or aggression coupled with unpredictability, becoming the only notable symptoms to indicate mental distress. It was evidenced that the lack of words to adequately and respectfully describe mental health conditions has resulted in reduced dialogues about mental distress and it being viewed as taboo. Over-reliance on Afrocentric principles among other beliefs have been highlighted as a hindrance to prompt help-seeking. Suggestions were made by participants for advocacy and ways of striving to change discourses, in order to better meet the needs of people.

CHAPTER FIVE: DISCUSSION AND CONCLUDING COMMENTS

5.1. Introduction

The aim of this research was to uncover how some amaXhosa people conceptualise mental distress, prevalent attitudes related to stigma and discrimination and help-seeking methods when dealing with mental distress, through exploring the lived experiences of amaXhosa healthcare workers.

The study relies on participants' experiences in understanding how some amaXhosa people make sense of phenomena related to mental distress. The following brief discussion is based on the findings that reveal how mental distress is understood by key informants. IPA was the chosen tool of investigation, which assisted the researcher to enter as far as possible into the psychological world of participants to obtain thick descriptions and rich data.

5.2 Discussion of findings in the light of the literature

This section will cover existent literature related to mental distress and will include a discussion that incorporates my findings. I interpret and describe the significance of my findings, while responding to my research questions in an attempt to discuss the perspectives of key informants regarding mental distress.

5.2.1. Mental distress as a social construct

The findings revealed that key informants acknowledged the prevalent difficulties related to having discussions about mental distress among some amaXhosa people owing to their cultural underpinnings and particularly to the lack of formal jargon within their culture to coin the magnitude of mental distress disorders that exist. Research has evidenced that mental distress is perceived to be socially constructed and culturally dependent (Shezi et.al., 1997). In their responses participants strongly reflected that mental distress definitions are highly influenced by an individual's observations during their formative years and is

maintained by what becomes socially agreed upon by community members. Participants' reflections are consistent with views offered by Shezi et.al (1997) that discussions around mental ill health would require a basis of extensive knowledge and understanding of various cultures and sensitivity to cultural differences within the diverse South African nation.

Participants displayed concerns related to the lack of formal jargon of mental distress which they perceive could lead to a slippery slope of viewing mental health difficulties as insignificant because some amaXhosa people maintain that mental distress is largely a Western phenomenon with no bearing on their holistic health. This is congruent with what was noted by Mkhize (2003) that psychology is in its true nature a discipline that is developed in the West with biomedical definitions of illness and underpinnings rooted in Western culture which marginalizes the significance of other cultures influences.

Unfortunately, with non-Western cultures of the sentiment that mental distress does not affect them as Africans, Nglazi et.al., (2016) postulated that this creates a situation where mental distress as a phenomenon is preconceived as peculiar by Africans, widening the gap of underreported and underdiagnosed cases. In the findings participants described this a silencing or silence around mental distress issues with some amaXhosa people even viewing the phenomenon as taboo.

Madu (2015) explained that black psychotherapists may inevitably experience tension between Western forms of psychotherapy when working with African clients. Participants reflected on the tensions they experience as a healthcare worker, when having to address mental health issues. They reported the experience of an intra-psychic conflict between their formally acquired knowledge about mental distress and what they have been socialized to understand about the phenomena. They recognised how they retreat to rather non-sharing of information among people of their culture out the fear of being alienated. This unfortunately exacerbates the limited understanding of mental distress among some amaXhosa people.

It becomes interesting that even healthcare workers display hesitance in imparting knowledge at a primary level to people of a similar culture to themselves about the phenomena, because there exist limited sources of knowledge to draw from or relate mental distress to. This demonstrates the strong need for the development of Afrocentric principles and makes clear the existent gaps related to mental distress issues for trainee psychologists. As supported by Ally et.al., (2018) there is a growing surgence for decolonisation, dialogue and engagement between scientific thinking and cultural beliefs, in order to challenge the perceived notion of African thinking as saturated in superstition, fantasy and backwardness.

5.2.2. Referring to indigenous beliefs to conceptualise mental distress

Literature sourced for the study showed that widely accepted definitions of mental distress reflect Western understanding and view of illness while little research exist denoting the experiences of black African people specifically in South Africa. It was evident in the findings of the study that participants prioritize and rely on sources of knowledge and traditions they are familiar with, and which they trust the efficacy of. Participants highlighted their belief in ancestors, supernatural powers, witchcraft, and their understanding of spirituality as important sources of knowing and thinking about mental distress. Throughout their responses it becomes clear that these cultural factors generally tend to govern people's perspectives about the symptomology of mental distress and that some people often rely onto them to make decisions. This was endorsed by Mkhize (2003), who shared that the African view of mental ill health currently encompasses a wide range of causes from ancestors, folk belief in witchcraft, to modern medical science. This directly implies that western understanding of illness cannot be sufficient to address the problems of African people. Additionally, Van Der Walt (1997) agrees with this noting that African world views differ from Western views in that the Western ideas generally minimize the spiritual dimension.

Participants shared examples to further illuminate their claims to the differences in beliefs and ways of understanding between African and Western populations stating that in the Xhosa culture there is a process known as *ukuthwasa* which is understood to be the ancestral calling in which the called individual may hear voices or experience an array of somatic sensations. The characteristics demonstrated when they have the calling, can be interpreted to resemble the onset of mental illness (like schizophrenia) according to Western principles. This can lead to misattribution of symptoms and misdiagnosis of people. This was also supported by Nefale et.al., (2003) who postulated that dominant Western principles applied to African people might involve unnecessary labelling of the non-Western client's experiences as pathological, based on conflicting models of explaining illness, health, and healing. Therefore, it appears that for amaXhosa, because of their corpus of culturally-based knowledge, explaining some of the behaviours termed mental distress, which they believe to be connected to their religion, and spiritual understandings about their ancestors, it becomes a complex task to delineate symptomology to conceptualise the mental distress phenomena.

Participants recounted the discomfort they experience linked to thinking outside of what they know and belief as amaXhosa people stating that it feels foreign and unjust. Thus, one can argue that the overreliance and deeply rooted faith in indigenous beliefs serves to preserve sacred parts of their culture. Participants have also admitted to making various attempts to disregard Western principles in addressing the mental distress phenomenon because fundamentally they view their lives as significantly different from that of Western populations. The disregard can then be interpreted to indicate a rejection of Western influences and that it is impossible for principles specifically that of psychology, to accommodate and resolve African problems. Thus, the overt dissonance some amaXhosa people experience when it comes to conceptualising mental distress becomes understandable to a larger extent. This theme in some part addresses my research question concerned with how some amaXhosa

people make sense of mental distress and the responses facilitate an understanding of where the sources of understanding mental distress are derived.

5.2.3. Referring to life adversities to rationalise mental health problems

Participants acknowledged that some amaXhosa people recognize the emotional turmoil and cognitive distortions that may come as a result of undergoing stressful life events, however highlighted that these circumstances tend to pose as a double-edged sword for people because the expectation that they continue and cope with life despite current difficulties is greater. In the study reference is made to the Apartheid era where the majority of South Africans were discriminated against on the basis of their skin colour and underwent gross human violations, but displayed resilience and strength in the face of adversity. They faced immigration, poverty, inadequate medical services, and stressful living conditions (Kon et al., (2008) but continued with life. According to Bernstein (2007) the system exploited Black people causing irreparable social and psychological damage. Perhaps black people became socialized to hardship, considering how they had to cope during the Apartheid era for the greater well-being of their children, spouses, and families. This is reflected in the thinking patterns of some amaXhosa people, as participants reflected that life is not hard, a person just needs to keep going, creating the notion that being overwhelmed or experiencing certain life crises should not hinder progress in life.

Participants used further examples to illustrate the apparent disregard of the amaXhosa for their emotional well-being, for example in the loss of a spouse (an emotionally debilitating event) but also one in which the person is expected to overcome the emotions and strive for a better life for the greater good of everyone. Although this way of being is not uncommon in collectivists cultures, like African cultures, it does not heal the experiences of trauma for the individual. The experience of marital problems and prolonged exposure to these was also regarded as emotionally damaging. However, the view that life is not hard leads to some

amaXhosa people remaining in debilitating situations in an attempt to not appear as defeated or weakened. According to Bernstein (2007) it becomes clear that the psychological trauma experienced by black African people in the past has inadvertently predisposed them to harbouring pain and sorrow and normalized it as a way of life/living.

Denial was also a strategy used to rationalize the existence of the illness by some amaXhosa people. Participants have evidenced the difficulties that comes with defending living with a diagnosis you cannot relate to something you know/have observed, one which your social group has no explanations for and in fear of being different it becomes easy to deny the illness and rationalize your circumstance in relation to current stressors. When there exists an identifiable stressor- they remove the illness from themselves project it on the situation and blame medication side effects as a possible hinderance from their holistic health. The denial therefore serves to protect the ego of the individual. Although participants can weigh the significance of certain life events to cause disharmony and distress, one can argue that black South African people have been handicapped to attending to their difficulties.

Socio-economic and political reform is needed in SA because of the grave post-traumatic stress many South Africans live with, due to Apartheid. This was also supported by many mental health professionals in South Africa during that time (Kon et al., 2008). This theme helps in reflecting the need for psychological intervention that exists for among some amaXhosa people.

5.2.4. Stigmatisation and discrimination

The findings of the study reveal that because mental distress fails to be viewed like any other chronic illness especially amongst some amaXhosa people, mental health service users face the harsh wrath of being stigmatised against by others who exist in the same social contexts as them. Participants commented on the dehumanising names and the degrading behaviour displayed towards mentally distressed individuals. This is supported in literature

conducted by most researchers that stigma is a social construction and a label ascribed by society that occurs when members of a group experience discrimination on the basis of some characteristic that is deemed undesirable (Crocker et al. 1998). It is clear that some amaXhosa people still strongly believe that mental distress only affects people of Western origin, thereby treating some of their own living with a mental distress diagnoses in unjust ways.

Consciously or unconsciously mainstream society feels the need to be protected from those living with distress, by alienating and segregating them. As a result of the stigma and labels, there exists a narrative that all persons who live with a mental illness are not capable of reasoning coherently and intelligently. The ideas of unpredictability and dangerousness become attached to mentally distressed individuals and remain consistent and pervasive. Therefore, one can discern that the cost of the lack of understanding of mental distress has adverse consequences on how distressed individuals view themselves. Corrigan (2000) supported this by stating that negative attitudes towards mentally distressed people have harmful effects on their social identity.

The singling out of people as different is an issue that sustains the attitudes that exist in communities that identifies them as different, thereby creating a situation where these individuals also simply struggle to see themselves like any other person or as normal. Their differences become magnified when they come back to society because they are unfortunately still viewed according to the behaviour that they displayed prior to receiving mental healthcare. Participants also reflected on the lack of warmth mentally distressed individuals receive after discharge from hospital. These attitudes by community members arguably impedes the recovery of patients, as the freedom they had previously becomes restricted, inhibiting their recovery. Furthermore, participants stated that demotion from higher positions in the workplace are not uncommon. These were noted to occur suddenly and were unexplained, which can be postulated to affect the self-esteem and efficacy of these individuals. This

therefore further serves to segregate and alienate mentally distress from partaking actively in opportunities that encourage advancement and progression.

Frequently mentally distressed individuals overidentify with their diagnosis because of pervasive public stigma, internalising what is being said to them by others and taking that as truths about their capabilities without contest. It was stated by Watson et.al., (2006) that individuals who are living with mental distress experience weakened self-efficacy as their thoughts are influenced by others' beliefs about them. Researchers have commented on the fragmented sense of self that develops as a result of being labelled as different by others. In addition, employment opportunities, liberty to comment on public matters and the ability to make their own decisions is limited for mentally distressed individuals. This theme answers the research question related to what attitudes maintain stigma and discrimination, which is evident in the stripping away of primary rights, opinions, and freedoms of mentally distressed people through stigma. Corrigan (2000) in agreement with the above stated that discrimination diminishes the quality of life of those living with mental distress.

5.2.5. Remove stigmatisation and empower

Participants highlighted the need for psycho-social support and education. They reflected on the lack of social support for mentally distressed persons, which results in prolonged alienation and segregation. In light of this discussion and literature it has become clear that some amaXhosa people hold opposing understandings and views of the mental distress phenomena. Therefore, because of the unfamiliarity with western diagnoses there is a noticeable lack of support. People struggle and resist what they do not understand. Therefore, this indicates the need for education about mental distress amongst amaXhosa people as urgent, as they are not immune to experiences of mental distress that affect people of all races, cultures, and genders.

Participants highlighted the need for advocacy. The study has revealed the need for the development of Afrocentric theoretical modes of thinking first that could then potentially encourage advocacy. Research shows that mental health issues are still primarily at policy development level in SA focused on reform and integrating mental health as part of primary health care (Monteiro, 2015), with less emphasis on ensuring that current measures work for the general population. Participants highlight the effective role that could be played by important stakeholders (e.g., nurses, psychiatrists, psychologists, and social workers) as catalysts in the process of integrating mental healthcare as part of primary healthcare. Therefore, insights around where psychologists could intervene at a primary level become evident through this theme.

5.2.6. Healthcare seeking behaviour amongst the mentally distressed

The findings of the study propose that some amaXhosa people are strongly governed by their traditional and cultural beliefs especially in matters related to illness and healing. They reported that because amaXhosa people have explanatory models for illness and healing they will instinctively consult traditional healers or faith healers in the quest to make sense of what may be happening for their mentally distressed loved ones. As a primary mode of enquiry participants noted that many amaXhosa people in search of answers predominantly consult traditional healers (as in Skeen & Lund, 2003). The question of why a certain illness is present rather than how is important for amaXhosa because this provides them with opportunities to rectify the problem. It may also demonstrate that some amaXhosa tend to have a strong internal locus of control, meaning that they internalise blame and believe that illness is as a result of something they have done wrong and can control.

Because some amaXhosa people strongly associate mental distress to unappeased ancestors it places the rectification of the issue within the purview of traditional healers. This was supported by Chipfakacha (1994) who corroborated that all cultures have disease theories

that explain the causes of illness. Secondary to this method of help-seeking would be consultations with diviners. As the findings of the study have depicted, the spiritual dimension for amaXhosa people is important (Van der Walt, 1997) as they tend to also conceptualise mental distress as the wrath of God or demonic possession.

Interestingly the findings indicate that in the absence of relief from symptoms, some amaXhosa people consider Western methods of treatment. This gives the idea that although some amaXhosa people strongly adhere to their traditional beliefs, they are able to collaborate with other modes of thinking in the quest for solutions. This also does not mean they neglect their own beliefs, but rather possess the ability to explore alternative perspectives when it comes to healing. It thus can be argued that they initially explore methods familiar to them because they perceive these to be better understood, seen, heard which minimises the risk of cultural differences being marginalised.

5.3. Recommendations

More research and effort could be invested in devising strategies that can be implemented at primary healthcare level, where some still view mental distress as being for the weak, further leading to the prevalent stigma for those affected. Psychology needs to be perceived as supportive and a means of building strength rather than as a service rendered to debilitated people. People appear to express their distress in road rage, substance abuse and criminal activities because they do not know how to identify and adequately deal with their challenges in a healthy manner. Thus, research and education on how stigma can be addressed at healthcare level, would be helpful for the vast majority of the SA population that rely on state services.

There is an important need for relevant stakeholders (healthcare workers, psychologists, nurses, and doctors) of African origin to spearhead mental health

conversations, as evidenced by the research. Having professionals that are representative of SA context speaking about the impact and manifestation of mental distress of their people in their language could assist the majority of people in SA with becoming aware of the phenomena related to mental distress. It is also imperative that psychology becomes representative, appealing to the diversity of the people it aims to serve. This could alleviate the misperceptions that psychology is for western populations because it is a discipline developed in the West, the negation of mental distress and the significant impact on people's lives. Research (e.g. Lund et al., 2013) shows that it is fast becoming a major contributor to the burden of disease in SA, thus increasing the need for all people to be proactive in learning when to seek help.

Further, it would be valuable to study how African clients who have experienced psychotherapy, both living in rural and urban areas in the SA, report their experiences, similar to the Qangule (2019) study of psychologists. Such a study could yield valuable insights on some of the aspects of psychology that non-western populations find beneficial and also highlight those areas that may have impeded their processes.

5.4. Limitations

The findings of this study are not representative of the experiences of all amaXhosa people but only reflect the perspectives of a sample of some amaXhosa healthcare workers located in Makhanda in the Eastern Cape, who have some experience with mentally distressed individuals. The researcher's aim was to gather a deeper understanding of the experiences of the sample population. Therefore, the findings cannot be used to make generalisations about the conceptualisation or understandings of mental distress of all amaXhosa people.

5.5. Reflective comments

The current study has exposed me to the reality of how difficult it is to have dialogues about mental distress amongst some amaXhosa people often owing to the limited understanding of the phenomena and the lack of formal terms to describe the different disorders that people experience. With limited jargon to speak about mental distress in the amaXhosa culture, it was challenging for both myself and participants to strike a balance between falling into the trap of using common, mostly derogatory terms to describe mental distress, derived from our socio-cultural environments. I noticed how careful participants were in speaking about mental distress, which made me aware of the inherent difficulties in constructing this phenomenon amongst amaXhosa people. I as the researcher found myself being careful in the way I would frame the questions to make them easily understood, using more sentences to explain and clarify questions in an attempt to not use language that sensationalises mental distress.

I also discovered while conducting interviews that because of my positionality as a mental health practitioner, perhaps participants became anxious about providing their conceptualisations of mental distress. With the pressure of being interviewed participants also became anxious about needing to maybe provide correct responses as experts in this regard. Hence the observed scepticism in sharing their understandings often treading carefully around their words. This may have been related to their fear of being judged because of the conceptualisations that they reported on. This would lead them to feeling exposed and vulnerable because of the realisation that they do not define distress according to their acquired knowledge, but rather rely on how it is defined by others in their communities. When I noticed this in participants I drew from my own experiences and reflected that mental distress is difficult to define within the amaXhosa culture and that I too sometimes struggle to accurately define the phenomena, especially when with other amaXhosa people. I often use

many words to strive to assist people's understandings, in an attempt to not use the often easily understood but derogatory terms when speaking about mental distress. This approach seemed to help diffuse the sense that I was all-knowing and perhaps scrutinising their responses as wrong or right. As the researcher, I did not anticipate the power dynamics to be so prevalent, because of the stance I held as a trainee intern psychologist going in with the mindset to learn from older more experienced people, since before the interviews I had felt ill- equipped.

The study has taught me that healthcare workers, with formalised training firstly acknowledge the complexity of defining mental distress because of their cultural backgrounds, often relying on socially agreed upon conceptualisations of the phenomena. As a researcher my expectation was to gain enriched perspectives of mental distress to the ones I had. As the investigation progressed I observed the many similarities that exist in thoughts and conceptualisations of the phenomenon that I and my participants shared. I began to question the worthiness of my study and if it would make a valuable contribution to research. Supervision was beneficial in helping me understand that probing and further exploring new insights participants were sharing could assist me in gaining rich and thick descriptions. When I began relying on my probing skills in a bid to enter as far as possible the psychological worlds of participants to gain deeper insights, nuanced idiographic experiences of participants emerged. As I became more flexible in my interview schedule I felt connected to my participants as I explored some of the new insights they were providing. The study has shown that for some populations including many amaXhosa people, there still exists a view of mental distress in which mostly violence and aggression are the perceived indicators.

The decision to also question participants themselves as amaXhosa people about their own constructs of mental distress yielded great insight for me as the researcher. Instead of only requiring participants to report on their observations of how some amaXhosa people

speak about mental distress, asking them about their own constructs helped me perceive that even with formalised knowledge, experience or encounters with mental distress, does not make conversations easier. It exposed me to the potential conflicts that educated amaXhosa healthcare workers face in an attempt to empower their communities, as they often appear to run the risk of being singled out and discriminated against and viewed as peculiar, on the basis of having some understandings of the phenomena contrary to the agreed social conceptions.

My motivation for the study was to provide a space to some amaXhosa people to discuss some of the conceptualisations of the mental distress phenomena that exist among many amaXhosa people. The study was important to me as a trainee psychologist, and as an individual from the amaXhosa ethnic group, to uncover how some of my people understand mental distress. This is likely to be beneficial for me working within the diversity of SA people to be more sensitive when addressing mental distress issues with non-western populations; and to remain open-minded and mindful of other factors that affect the mental distress of people. The study has been rewarding for me in that through participants sharing their experiences, I had the opportunity to reflect back to a time before I become a psychology student and I remembered that I too defined mental distress in similar ways to participants' reports. This reaffirmed that the influence of people's socio-cultural environments in constructing the mental distress phenomena cannot be understated. It made me appreciate the knowledge I have acquired through my training as a psychology student because mental distress may be thought of similar to other illnesses and that chronic conditions affect many people, so those affected should not also need to cope with the stigma that they encounter.

5.6. Conclusion

The study offered participants an opportunity to offer their own perceptions of mental distress and share their personal experiences related to this phenomenon. It highlighted the intricate and innate difficulties related to mental health problems in SA and among some amaXhosa people. It also demonstrated the overshadowing and dominant western principles that disregard important African values, which exacerbates the prevalent problems in the understanding and conceptualisation of the phenomena under investigation.

The study has provided adequate responses to the research questions in relation to how mental distress is conceptualised by some amaXhosa people. The findings have revealed what existent attitudes maintain stigma and discrimination and lastly investigated help-seeking methods of some amaXhosa people to facilitate in-depth analysis of areas needing redress. The discussion on the differences between Western and African cultures was explored in the study to facilitate further insights into how differently the two cultures view illness. This provided the opportunity to recognise the need for the development of Afrocentric modes of healing necessary in such a diverse context, so that services are culturally sensitive and can be accessible and rendered to all who require them despite age, race, gender, and culture.

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APPENDIX A: ETHICS APPROVAL

Human Ethics subcommittee
Rhodes University Ethical Standards Committee
PO Box 94, Grahamstown, 6140, South Africa
t: +27 (0) 46 603 8055
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e: ethics-committee@ru.ac.za

www.ru.ac.za/research/research/ethics
NHREC Registration no. REC-241114-045

20/10/2020

Prof Jacqueline Akhurst

Email: J.Akhurst@ru.ac.za

Review Reference: 2020-1353-4751

Dear Prof Jacqueline Akhurst

Re: The perspectives of some amaXhosa healthcare workers regarding mental distress: an Interpretative Phenomenological Analysis.

Principal Investigator: Prof Jacqueline Akhurst

Collaborators: Miss Siphosethu Ngqamfana

This letter confirms that the above research proposal has been reviewed by the Rhodes University Human Ethics Committee (RU-HEC) and
PROVISIONALLY APPROVED PENDING PERMISSION/GATEKEEPER LETTER(S).

Gatekeeper permission is required from:

a) Khulanathi (Together we grow) Psychosocial Rehabilitation Center

Once the Gatekeeper permission letter/s have been received please forward it to the Ethics Coordinator, (s.manqele@ru.ac.za) in order to finalize your ethics approval. Sincerely,

Prof. Arthur Webb

Chair: Rhodes University Human Ethics Committee, RU-HEC cc: Mr. Siyanda Manqele, Ethics Coordinator

APPENDIX B: REQUEST TO ACCESS RESEARCH PARTICIPANTS

RHODES UNIVERSITY
Where leaders learn

ACCESS LETTER REQUESTING PERMISSION TO CONDUCT RESEARCH

Rhodes University
PO Box 94,
Grahamstown,
6140

The Khulanathi Management Board
Victoria Road
Grahamstown
6139

Date:

Dear Ms Mkumatela

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

My name is Siphosethu Ngqamfana a registered Master's student in Clinical Psychology at the Psychology Department at the Rhodes University. My supervisor for the study is Prof Jacqueline Akhurst.

The proposed topic of my research study is: *The perspectives of some amaXhosa Healthcare workers regarding mental distress: an interpretive phenomenological analysis.* The objectives of the study are:

(a) To explore and describe how mental distress (including psychotic phenomena) is conceptualised and understood by some amaXhosa healthcare workers?
(b) To explore the perspectives of healthcare workers regarding existing attitudes that sustain forms of stigma and discrimination towards individuals living with mental distress within this ethnic group?
(c) And to explore the methods of treatment that are generically sought by some people within the Xhosa ethnic group in addressing mental health issues.

I am hereby seeking your consent to conduct a series of semi-structured telephonic interviews with the healthcare workers, working at Khulanathi Centre. To assist you in reaching a decision, I have attached to this letter:

(a) A copy of an ethical clearance certificate issued by the University
(b) A copy of the research questions that I intend using in my research

Rhodes University, Research Office, Ethics
Ethics Coordinator: ethics-commitee@ru.ac.za
t: +27 (0) 46 603 7727 f: +27 (0) 86 616 7707
Room 220, Main Admin Building, Drostdy Road, Grahamstown, 6139

Signature of gatekeeper: [signature]
Name of gatekeeper: LULAMA MKUMATELA
Date: 13/11/2020

Should you require any further information, please do not hesitate to contact me or my supervisor. Our contact details are as follows:

Siphosethu Ngqamfana (Student Investigator)

Cellphone number: 0605587900 , Email address: sethu.nqgamfie@gmail.com

Prof Jacqueline Akhurst (Principle Investigator)

Email address: j.akhurst@ru.ac.za

Upon completion of the study, I undertake to provide you with a feedback summary of the findings obtained.

Your permission to conduct this study will be greatly appreciated.

Yours sincerely,

Signature: S.Ngqamfana
Name: Siphosethu Ngqamfana

Rhodes University, Research Office, Ethics
Ethics Coordinator: ethics-commitee@ru.ac.za
t: +27 (0) 46 603 7727 f: +27 (0) 86 616 7707
Room 220, Main Admin Building, Drostdy Road, Grahamstown, 6139

APPENDIX C: CONSENT FORM FOR PARTICIPATION IN RESEARCH

I ………………(participant's name) have been informed about the proposed research study entitled: *The perspectives of some amaXhosa Healthcare workers regarding mental distress: an interpretive phenomenological analysis*, conducted by Siphosethu Ngqamfana under the supervision of Prof Jacqueline Akhurst

I have understood that:

1. The researcher is a student conducting a research project in partial fulfilment of the requirements for a Master's degree in Clinical Psychology at Rhodes University (RU). The research project has been approved by the relevant ethics committee and is under the supervision of Prof Jacqueline Akhurst in the Psychology Department at RU.

2. The researcher is interested in understanding how mental distress is conceptualized amongst some amaXhosa people, by interviewing healthcare workers who (a) have directly worked in mental health institutions with individuals who meet a diagnosis/ and are living with mental distress, to obtain deeper insight into their understanding of mental distress as amaXhosa. The researcher also hopes to learn about attitudes that contribute to stigma and discrimination against people experiencing mental distress firstly a) any stigma prevalent within the individual themselves (self-stigma) observed by these healthcare workers; b) stigma observed by healthcare workers from the public (public stigma) referring primarily to generic attitudes/ stigma which emanates from the communities these individuals come from. Lastly the researcher also hopes to investigate the methods of help seeking generally sought by some amaXhosa people. This research is to contribute to the gap in literature that exists in reporting on the varied experiences and understandings of mental distress among non-western populations, specifically amaXhosa for the present study. I will be invited to at most

two one- on-one semi-structured telephonic interviews with the researcher. The interview days and times will be arranged with me prior to the date, and each interview should take approximately 1 hour.

3. I have understood the purpose and procedures of the study and that my participation may involve answering questions of a personal nature and of my lived experiences. I have also been made aware that it is not mandatory to answer any questions about aspects of my life that I am not willing to disclose.
4. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation and to have these addressed to my satisfaction. The Rhodes University Psychology Clinic may also be contacted for further support on 046 603 8502.
5. I declare that my participation in this study is voluntary and that I may withdraw at any point in time.
6. I have been made aware that there is no monetary compensation available for my participation in this study, and that the results of the study will contribute to inform policy and practice pertaining to mental healthcare.
7. The research report may contain information about my personal experiences, but the report will be designed so that I will not be identified by any information provided.

Should you have any questions, please do not hesitate to contact me or my supervisor on:

Siphosethu Ngqamfana (Student Investigator) Email address: sethu.ngqamfie@gmail.com

Cellphone number: 0605587900

Prof Jacqueline Akhurst (Principal Investigator) Email address: j.akhurst@ru.ac.za

Signed on (date):

Signature of participant:

Signature of Researcher:

Signature of Witness:

APPENDIX D: INFORMATION SHEET FOR PARTICIPANTS

Dear Participant

My name is Siphosethu Ngqamfana, currently studying towards a Masters in Clinical Psychology degree at Rhodes University in Makhanda. The following document seeks to provide you with information pertaining to a research study I will be undertaking in partial fulfilment for the requirements of my degree. The title of my research is: The perspectives of some amaXhosa healthcare workers regarding mental distress: *an interpretative phenomenological analysis*. I am thus inviting you to be part of this research study and will provide you with all the necessary details about the proposed study.

This research study aims to explore the understanding, knowledge, practices and attitudes of some amaXhosa healthcare workers regarding mental distress. In South Africa mental distress is thought of differently by different people, depending on their backgrounds. I would like to explore how mental distress is conceptualized by some people belonging to the Xhosa ethnic group, as a young trainee psychotherapist who identifies with this ethnic group, to understand how people seek help and what behaviours prevent them from seeking that help. The study also aims to especially highlight prevalent stigma and discrimination pertaining to mental distress, to provide information for psychotherapists to find measures to ameliorate these barriers to mental healthcare in their practice. To address the objectives of the study, I would like to recruit participants who (a) have worked in institutions providing aid to individuals who have been diagnosed and are living with mental/psychological distress, (b) who are part of the Xhosa ethnic group and (c) who are over the age of 18 years.

This research study will be conducted by means of an exploratory qualitative research design, utilising an interpretative phenomenological (IPA) framework. The primary aim for the use of this design is to meet the researcher's objectives, as it explores in detail how people make

sense of their personal and social worlds to gain thick descriptions about the phenomenon under investigation. An understanding of people's perceptions of mental distress, practices and attitudes is crucial to uncovering the magnitude of barriers that continue to exacerbate people's susceptibility to suffer in silence and isolation when faced with mental distress.

Participation in the study is entirely voluntary and participants have the right to choose whether to participate or not. Participants may change their minds at any point concerning their involvement in the study, with no consequences to them at all. Should you choose to participate in the study, you will be invited to at most two one- on- one semi-structured telephonic interviews with the researcher on different occasions where information pertaining to your experience working in mental health institutions, lived experiences, attitudes and beliefs may be discussed. However, if you do not wish to answer any questions asked you are welcome to make that clear to the interviewer. The interviews will be conducted with healthcare workers, working at the Khulanathi centre. The interview times and dates will be arranged with the participants individually and each interview is expected to take up to an hour.

The study involves a degree of risk in that the information shared by the participants may be of a personal nature. There is the risk that sharing information may evoke emotional reactions. As a registered student Clinical Psychologist the researcher will take precautionary measures to ensure that participants are taken care of at all times; and that any distress is addressed. The Rhodes University Psychology Clinic may also be contacted for further support on 046 603 8502.

Because the interviews will be audio-recorded you will be asked to sign a further consent form. These audio-recordings will be securely kept, so that confidentiality will be ensured. Your rights to confidentiality and privacy will respected at all stages of the research.

There will be no monetary benefits as a result of participating in the study and the information subsequently generated from the interviews may be used to inform policy and practice. The information will be maintained confidentially and will not be shared with any people other than with my supervisor.

In the event of any questions/concerns you may contact the researcher, or the supervisor contact details as follows:

Siphosethu Ngqamfana (Student Investigator)

Cellphone number: 0605587900, Email address: sethu.ngqamfie@gmail.com

Prof Jacqueline Akhurst (Principle Investigator)

Email address: j.akhurst@ru.ac.za

APPENDIX E: INTERVIEW SCHEDULE

Research title: *The perspectives of some amaXhosa healthcare workers regarding mental distress: an interpretative phenomenological analysis.*

INTERVIEW SCHEDULE FOR HEALTHCARE WORKERS

1. Please provide me with a brief history about who you are and your work at the Khulanathi centre?

Prompts: what would you say encouraged you to work in this kind of environment?

2. What would you say your understanding of mental distress is and where is it derived from? Prompts: how do the people around you speak about mental distress (e.g. psychosis)?
3. How would you describe the way some amaXhosa people you've come across understand mental distress and which methods of seeking help do they ascribe to?
4. Would you say there is an understanding or explanation for depression, anxiety, PTSD or OCD within the Xhosa ethnic group? Prompts: Is there a generic manner in which the manifestation of distress within the Xhosa ethnic group is perceived to occur?
5. Would you say there are any prevalent attitudes of stigma and discrimination experienced by individuals living with mental distress?

Prompts: have you observed any stigma individuals with mental distress impose on themselves? Are you aware of any discrimination that patients report to experience in their communities as a result of living with a mental diagnosis? How would you say the attitudes held by the general community impute on individuals progress and recovery process?

6. From some of your encounters with the patients at the Khulanathi centre, what kind of help or support do they mention/ do you feel they benefit most from?
7. How would you describe your experience of working at the center?

Prompt: Has your work at the center in any way altered/ influenced the way you view people experiencing mental distress from how you prior viewed them?

8. Is there anything in particular that you wish to see change in the public/ in communities and the way they interact with people experiencing mental distress?
   Prompt: Have you been involved in or do you know of any outreach or public education programmes about mental distress?