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**MENTAL ILLNESS: NEGATIVE PERCEPTIONS OF UNIVERSITY
STUDENTS**

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ABSTRACT

The area of mental illness may be noted as one of controversy and uncertainty both in the South African context and in international communities. Much literature on this subject has surfaced from the international community, although there is a dominant reliance on survey approaches. This study has sought to document the negative perceptions of mental illness in a sample of university students across four faculties at the University of Cape Town. Focus group discussions were conducted with students across faculties. Using an interpretive phenomenological approach to guide the analysis process, the following dominant themes emerged: Definitions of mental illness; causes of mental illness; responses to mental illness; factors contributing to negative perceptions; and interventions.

The results showed that in defining mental illness, participants focused on the experience of extreme and chronic symptoms, limited functioning and abilities, inexplicable and irrational behaviour understood as social deviance and a lack of reality testing. Perceptions of causative factors incorporated a more integrative approach where biological, social and cultural factors were cited. Fear, dangerousness and othering dominated as negative responses toward mental illness and participants believed that the media as well as significant others were the main factors contributing to negative perceptions. The last theme addressed interventions for the mentally ill that included professional mental health services. Public-oriented interventions such as the use of support systems that were known to participants, for example family members, emerged as dominant. However professional services were cited when it was believed that a particular illness was severe. Educating members of the public about mental illness was cited as important in addressing the limited knowledge in this regard. Tolerance and patience towards mentally ill individuals were believed to be important behaviours necessary as an intervention. Participants

also cited early mental health education and intervention as more effective strategies in addressing negative perceptions as well as the limited literacy rate in the area of mental health.

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DECLARATION

The author hereby declares that this whole dissertation is her own work. Each significant contribution to and quotation in this dissertation from the work, or works, of other people has been attributed and has been cited and referenced.

University of Cape Town

Signature

Date

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CHAPTER ONE: INTRODUCTION

According to Grant (1963; 1968) and Sue, Sue and Sue (2003), mental illness or psychopathology describes certain ways of thinking, feeling and behaving which are inconsistent with a society's social norms. Mental illness is characterised, according to the Microsoft Encarta (2008) definition by disturbances within the sufferer's emotions, behaviour and cognitive processes, which implies global disturbances in functioning.

It is important to contextualise the concept of mental illness relation to conceptualisations of health and mental health, as this allows for a broader understanding of the concept. The World Health Organisation (WHO) defines health as a state of wellbeing in several spheres such as physically, mentally and socially; and not merely the absence of disease (WHO, 2008). Mental health is perceived to be integral in defining health and is defined as a state of wellbeing whereby perceived abilities of the self are realised and the individual is able to employ useful coping mechanisms in dealing with normal life stresses in addition to being able to work productively and fruitfully and ultimately contributing positively to one's community (WHO, 2008).

The experience of mental illness challenges this understanding of health because, according to Mermier (1993), the substantial disruptions in the individual's judgment, thought processes, perceptions of reality or emotional processes result in gross impairment of behaviour. In addition to social, psychological and biological interacting factors that contribute to the development of mental disorders, WHO (2008) identifies socio-economic disadvantages as a threat to mental health. It is therefore important to understand that mental illnesses are best understood according to multiple theoretical frameworks and by recognising the interaction of these factors

rather than focusing on the dominance of a particular factor or being limited to one understanding.

A study conducted by Angermeyer, Matschinger and Corrigan (2004) paints a sad portrait of the occurrence and experience of stigma in relation to people with mental illness. This is, however, not a recent phenomenon and the battle of mentally ill individuals against marginalisation and indecent treatment can be traced throughout the ages. Such abusive treatment ranges from trepanning (the process of surgically inserting a hole in the skull), which dates back approximately 5000 years, to the persecutory Renaissance era during which mental illness was associated with witchcraft (Microsoft Encarta, 2008). In more recent times those afflicted with mental illness must endure, among other things, social distance (Angermeyer, Matschinger & Corrigan, 2004). Within the context of this study, a multiple theoretical framework inclusive of biological, psychosocial and cultural frameworks is employed as it serves a more holistic approach in the manner in which mental illness is perceived.

What emerges from the literature is that responses to people with mental illness are influenced by perceptions, beliefs and attitudes that people have about psychopathology. Feldman (1985) defines attitudes as being configured into three major components: an affective, a cognitive and a behavioural component. This theory proposes the following: (1) the affective component includes an individual's evaluation or emotion experienced toward the object of attitude; (2) the cognitive component refers to an individual's belief system regarding the attitudinal object; and the behavioural component refers to actions directed toward the attitudinal object. Beliefs are said to be mental and verbal ideas and assessments that individuals hold about the world, which vary in strength (Babylon, 2008). According to Gould and Kolb (1964), perceptions consist of ideas about the world and are formed through experience. Perceptions denote an altered relationship between an individual and the

external world that results in the assignment of meanings to sensory experiences, which have previously not been processed (Gould & Kolb, 1964). These authors further argue that sensory experiences result in the formation of perceptions when individual interpretations are congruent with one's concepts of the environment (Gould & Kolb, 1964). Perceptions thus denote insight into a particular phenomenon.

It is therefore important to understand the terms attitudes and beliefs as they are encompassed within the definition of the term perceptions. However, perceptions dominate as an all-inclusive term as they shape the manner in which people deal with those suffering from mental illness and how the sufferers understand and manage both the illness and treatment.

Current literature demonstrates worrying findings regarding how societies generally perceive mental illness. There are studies that associate the role of stigma in how individuals perceive mental illness or mental health (Ssebunnya, Kigozi, Lund, Kizza & Okello, 2009; Nyati & Sebit, 2002). The manner in which there is no understanding or incorrect information regarding such has also been found to influence the treatment of individuals with psychiatric disorders. For example, perceiving mentally ill persons as dangerous potentially threatens the wellbeing of psychotic people as the malevolence directed toward them could be justified, based on this stereotype (Olugbile, Zachariah, Kuyinu, Coker, Ojo & Isichei, 2009). Understanding how individuals perceive mental illness may result in shaping help-seeking behaviours. This is useful within this study as the objective is to elicit these perceptions within a framework of university students in a South African tertiary institution. Concurrently, this understanding informs help-seeking behaviours (or lack thereof) and therefore has important implications for the treatment of mental illness. The qualitative approach that this study uses, addresses the gap in literature in the area of mental illness more specifically in the South African context, where studies of this nature are acutely limited.

This thesis is organised into five chapters. A definition of terms is introduced. Chapter Two provides a literature review of studies pertinent to this topic. It looks at the findings of local and international research, on the attitudes and responses to mental illness in the general population and students in particular regarding this issue. Chapter Three explains the methodology followed in eliciting the negative perceptions of mental illness in a sample of students at the University of Cape Town. The chapter is organised under five subheadings, namely: the study design, data collection methods, participants used in the study and data collection procedure. The phenomenological approach employed in analysing the data is described fully. The last section comprises the ethical issues considered in the study.

Chapter Four presents the results and discussion of the study. This involves a critique and comparison of the findings of this study to what is reported in the literature.

In the last section, the conclusion, the limitations of the study and suggestions for further research are discussed.

CHAPTER TWO:

LITERATURE REVIEW

This chapter presents a review of literature that is relevant for this study. The first section will look at cultural issues related to mental illness, followed by a discussion on knowledge about mental illness in the general population and in students' samples. The next section will look at issues related to the stigma attached to mental illness and how such stigmatisation shapes perceptions and attitudes towards the mentally ill. The last sections will discuss the role of stigma in the maintenance of social distance and the manner in which it influences help-seeking behaviour.

CULTURE AND MENTAL ILLNESS

Swartz (1998) illustrates how culture can exert influence on how mental illness is perceived. Western cultures may label an individual as 'schizophrenic', while the African indigenous healing system may view the same individual as having been bewitched (Swartz, 1998). In addition, symptoms experienced by an individual may be seen as resulting from 'ukuthwasa', a process defined as an ancestral calling for one to become a diviner (Edwards, 2000). Cheetham and Cheetham (as cited in Patel, 1995) found that the Xhosa-speaking community of South Africa recognise a range of mental illnesses, but few are perceived to result from abnormalities of the brain.

Cultural differences are perhaps more included in explaining the emergence of the illness and appear to be less effective in ameliorating stigma and negative attitudes within the African continent. While studies that investigate perceptions of mental illness within the African context are not as prevalent as those conducted in Western contexts, Patel (1995) offers an explanatory model of mental illness in Sub-Saharan

Africa. In a review of studies conducted in eleven Sub-Saharan Africa countries including South Africa, it was observed that a diversity in beliefs about mental illness existed, but that shared concepts could be found. For example, a disjuncture between the mind, body and spirit was perceived to result in mental illness, while spiritualism was considered an important component of mental illness in many African countries (Patel, 1995). Spiritualism, according to Hadebe (1986), is a philosophy that understands the soul as eternal or immortal. Mysticism is “a search for a covert truth ... a drive to re-establish harmony or to achieve union in being with the divine” (Hadebe, 1986, p. 3).

While traditional scientific models foreground rationality, spiritualism may be viewed as a different way of conceptualising mental illness that may contribute to a broader understanding by locating culture as a core aspect of mental illness. While accepted that mental illnesses could be inherited, its causation could also be explained by three other factors: supernatural forces, illness resulting from bewitchment by those possessed by evil powers, and behaviours of individuals and/or their families that angered their ancestors, who then inflicted the illness as punishment (De Jong as cited in Patel, 1995). Such beliefs challenge dominant traditional Western ideas and models, which place emphasis on empiricism. However, while the explanatory models may differ between social settings, discrimination is experienced by those afflicted with mental illness. These experiences perhaps result from fear of associating with individuals who have been ‘bewitched’ in order to avoid a similar fate or fear of passing on ‘diseased’ genes to future generations.

The role of the media in the creation of negative perceptions within communities cannot be denied. Mass media reports, for example television, newspapers, the internet and movies, tend to sensationalise certain mental illnesses. This may contribute to the alienation and/or marginalisation of mentally ill persons due to

negative labels that already exist as a result of their illness (Diefenbach & West, 2007). This finding is documented in a study by Dietrich et al. (2006), where students who had read a negative article about mental illness expressed more negative attitudes toward mentally ill people as a result. According to Vitello and Durham (2006), mentally ill people tend to be portrayed in the media as dangerous and violent, which fuels negative perceptions.

KNOWLEDGE ABOUT MENTAL ILLNESS

Multitudes of studies have been conducted pertaining to attitudes towards and perceptions of mental illness in members of the general public within the international community (Angermeyer, Matschinger & Corrigan, 2004; Bentz, Edgerton & Miller, 1969; Buckley et al., 2007; Corrigan et al., 2000; Gonzalez, Alegria & Prihoda, 2005; Jacob, 2001; Jorm, 2000; Myers, 1996; Patel, 1995; Segal, 1978). The predominant theme in most of the literature suggests that ignorance or lack of knowledge is pertinent in misunderstanding mental illness. According to Jorm (2000), research on the subject of attitudes towards mental illness indicates that a majority of the public fail to correctly recognise mental disorders and struggle to understand the meaning of psychiatric terms. This suggests an implicit connection between ignorance and fear. The resultant fear may culminate in stigmatising and discriminative behaviour.

It appears as though a lack of knowledge of mental illness may contribute significantly towards how members of the public may perceive and behave towards those afflicted with mental illness. Such findings have been demonstrated in Corrigan et al. (2000), who sought to elicit stigmatising attributions about mental illness. It was found that work and housing opportunities for mentally ill persons are significantly hampered by societal stigma. An investigation of community care for persons with mental disorders in developing countries found that from a community viewpoint,

mental health concerns are lower in priority when compared to physical health needs (Jacob, 2001). An explanation for this trend could be that since developing countries are often burdened with economic constraints, mental health concerns could be viewed as luxuries. Citizens may attribute more importance to basic human needs, such as food and shelter, and may view mental health as secondary to physical health needs. Mental illness is often considered distressing in nature (Sue et al., 2003). Interpersonal difficulties deriving from stigmatisation and discrimination are therefore likely to hamper recovery and increase the challenges faced by the affected persons.

A study using vignettes to investigate community attitudes toward and knowledge of mental illness in South Africa (Hugo, Boshoff, Traut, Zungu-Dirwayi & Stein, 2003) within the Cape Town Metropolitan area revealed three main findings. These researchers reported that most respondents understood the illnesses described in the vignettes as predominantly stress-related or as resulting from a lack of willpower. Talking about the problem was the intervention recommended rather than medication or consulting a mental health professional. Interestingly, medication emerged as the least favourite method of treatment for some cases such as those involving substance abuse, but as useful in those vignettes where the presented symptoms were made more explicit. While this study usefully points out the dearth of knowledge and need for education, a limited number of local and international studies have focused on student populations and their negative perceptions of mental illness.

Viljoen (2005) conducted a qualitative study on the attitudes of students towards suicidal behaviour. Thus far, Viljoen's (2005) study has been the sole study that is wholly congruent to this study due to its qualitative nature and an investigation into attitudes in the area of mental illness, using a student population. Results indicate that students that experienced mental illness were more sympathetic towards those who committed suicide, while having a co-morbid psychological disorder such as depression (Viljoen, 2005). It therefore appears plausible to assume that the

experience of certain mental illnesses elicits sympathy. Sympathy within the context of Viljoen's (2005) study may be closely linked to empathy, as students with a history of mental illness appear to express feelings of sympathy that are on a more semantic level than pity. This could be the result of understanding and the ability to relate to one another due to shared experiences of mental illness. For instance, a covert rationalisation of suicide exists, based on the presence of a co-morbid disorder. The sympathy resulting from this rationalisation breeds the interpretation that those students who committed suicide are not to be blamed for this act and that the act of suicide was a result of mental illness. It is important to note that below the overarching theme of "knowledge of mental illness", the misrepresentations or illiteracy therein is not separate from the role of stigma, but is interconnected. Knowledge of mental illness is chosen as the first emergent theme within the literature as it is particularly the limited knowledge in this area that may be foundationally attributed to the impact of stigma in how mental illness is perceived.

Mental health literacy

In recognition of the problems that a lack of knowledge creates for those affected by mental illness, there have been increasing attempts to increase knowledge in the general population. The WHO (2008) emphasises the importance of mental health promotion, which is aimed at positively impacting mental health through actions that create supportive living conditions and environments that encourage the adoption and maintenance of healthy lifestyles for the purpose of enhancing mental health. The concept of mental health promotion speaks to the underlying illiteracy concerning mental health and mental illness and is seen as a key aspect of mental health literacy in members of the public.

Jorm (2000) lists seven major components of mental health literacy that have been combined into three broad elements, which may be beneficial in addressing the

limited public knowledge of mental illness. These include the recognition of specific disorders or psychological distress, as well as knowledge and beliefs about risk factors and causes, self-help interventions, available professional help and how to seek mental health information. The third element involves attitudes that facilitate recognition and appropriate help-seeking behaviour.

The above components address some core issues in relation to mental illness and point to a more holistic approach in addressing mental health literacy among members of the public. Although helpful in informing mental health literacy initiatives, questions have been raised about the applicability of Jorm et al.'s (as cited in Jorm, 2000) model across different cultures. Some of the criticisms revolve around the study's use of an Australian population and that possible cultural variations were not accounted for. In addition, no steps were indicated for addressing mental health literacy for cultures outside of Australian terrain.

While the above section on mental health literacy relates to the general public, Buckley et al. (2007) investigated the perceptions and concerns of a group of residents of a suburban residential area about educational input on serious mental illness and recovery. The study found that the participants generally expressed concern over the potential for diminishing confidence and support for traditional professional services, in addition to viewing a recovery-oriented model regarding serious mental illness with "cautious optimism". The authors also found that all residents had indicated interest in obtaining more information regarding the recovery model. In the midst of negativity shrouding mental illness and those afflicted with mental illness, the above finding offers a small but powerful message of hope. It shows that communities are capable of actively getting together in the name of a worthy cause such as being educated about a matter in which their knowledge is limited. In review of the above literature and the existence of negative perceptions, the next section will discuss the role of stigmatisation in the area of mental health.

STIGMATISATION

Research has shown the role that stigmatisation plays in the area of mental illness (Angermeyer et al., 2004; Bentz et al., 1969; Gonzalez et al., 2005; Segal, 1978). Stigmatisation is defined as “the process by which an individual or group’s character or identity is negatively responded to on the basis of the individual’s or group’s association with a past imagined or currently present deviant condition, often with harmful physical or psychological consequences for the individual or group” (Dijker & Koomen, 2007, p 6). Discrimination refers to behaviours that are usually of a negative nature, which are directed towards members of different social groups (Baron, Byrne & Branscombe, 2006). Stigmatisation and discrimination are important concepts to understand as both encompass negativity directed toward an individual. This is important to define in understanding negative perceptions of mental illness.

A number of studies have indeed produced evidence for the occurrence of stigma towards mentally ill people in societies, with some of the findings suggesting that negative perceptions were linked to perceptions that people had about mental illness (Angermeyer et al., 2004; Bentz et al., 1969; Gonzalez et al., 2005; Segal, 1978). For example, Angermeyer et al. (2004) investigated the manner in which people related to schizophrenia and major depression sufferers, depending on familiarity with said mental illnesses. They found that weaker perceptions of dangerousness corresponded closely to less fear of the sufferers, which was associated with less social distance and isolation. A study by Gonzalez et al. (2005), which investigated the attitudes towards seeking mental health treatment in a national epidemiological sample, found that young male adults reported the most negative attitudes.

In relation to the stigmatisation of mental illness, a study by Van der Burg (1983) was conducted and sought to document the views of white, Coloured and Indian South Africans on mental illness and the mentally ill. Results indicated that there were

relatively strong negative attitudes toward former psychiatric patients, more especially in the Coloured community. All three racial groups displayed ambivalence regarding the causes of mental illness due to a subscription to a biological concept of mental illness. The Indian community was documented as pessimistic with regards to the cure of mental illness by means of treatment. While the Van der Burgh (1983) study was not fully representative of South Africans because blacks were excluded, it did reveal the presence of negative perceptions in the sampled groups. Similarly a survey conducted by Botha et al. (2006) that involved patients as participants, found that those suffering from schizophrenia felt that they experienced a high degree of stigmatisation and discrimination. In addition those respondents, who suffered from schizophrenia and were in better social standing, felt that the media had a negative influence on perceptions of mental illness.

While many of the studies on attitudes towards mental illness have been conducted on members of the general population, some have focused on students (Cuomo & Ronacher, 1998; Dietrich, Heider, Matschinger & Angermeyer, 2006; Haag Granello & Granello, 2000; Zolar et al., 2007). Zolar et al. (2007) investigated whether psychiatric education affected the display of stigma. They found that when students had completed psychiatric studies their association of mental illness with dangerousness decreased. Feelings such as fear, reluctance and alienation initially directed towards the mentally ill disappeared, although patients were still judged as less capable. This study demonstrated that education does serve an important function in decreasing stigma and eliciting acceptance and understanding (Zolar et al., 2007) thus confirming the findings of many studies on education and mental illness (Segal, 1978; Zolar et al., 2007). However, Zolar et al. (2007) also demonstrated that negative attitudes are not completely eradicated as there were still negative attributions or assumptions made about mentally ill individuals.

In a study on the use of psychological services at the University of Cape Town (UCT) conducted by Flisher, De Beer and Bokhorst (2002), it was found that women and those aged between 20 and 24 years were more likely than men and other age groups, respectively, to receive counselling. Furthermore the authors reported that black students were overrepresented in the service users. However, the overall picture points to an under-utilisation of the services: of the 23 158 students registered at the university, only 932 (4%) presented at the counselling service. The authors suggest that this limited use of the counselling service is likely to be due to negative attitudes towards the counselling service, concerns about confidentiality and problem solving via self-reliance (Flisher et al., 2002). This study thus suggests that negative impressions of mental illness are likely to influence help-seeking behaviours.

While research findings suggest the existence of negative attitudes in student populations, some studies have also shown that there were variations in the attitudes of students, which may also be linked to their experiences with mental illness. For example, a study on the attitudes towards mental illness of college students of Drury University conducted by Cuomo and Ronacher (1998) found that on average, occupational therapy students displayed the most positive attitudes. It was believed that their least authoritative and socially restrictive, encouraging and positive professional view of treatment was possibly a result of previous interaction with disabled persons through fieldwork experiences. Surprisingly the attitudes of psychology students were more negative, with attitudes of accounting students emerging as the most negative (Cuomo & Ronacher, 1998). This finding somewhat challenges the notion that knowledge is likely to essentially alter negative perceptions of mental illness. Furthermore, the authors believe that formal education may no longer be sufficient to elicit positive attitudes and that interaction with disabled people is more likely to be the crucial feature that contributed to occupational students' positive attitudes (Cuomo & Ronacher, 1998). This suggests that perhaps when

knowledge and education are coupled with social interaction with mentally ill people, attitudes and perceptions are more likely to be altered.

The results of the Cuomo and Ronacher (1998) study, however, should not be viewed as conclusive as other research findings show that individuals that are educated in the realm of mental health hold better perceptions than those that lack such literacy. Haag Granello and Granello (2000) found that in the relationship between college students' beliefs about the definition of mental illness and tolerance, students that had broader and a less restrictive definition of mental illness maintained less socially restrictive attitudes toward the mentally ill. A more inclusive manner of defining mental illness may result in better acceptance and be less pathologising of a variety of behaviours.

Stigma and the maintenance of social distance

Research has consistently shown that negative attitudes had an impact on the lives of mentally ill people. In a review of various studies on attitudes towards the mentally ill, Segal (1978) showed that negative attitudes affected mentally ill people's involvement in communities as well as how interventions aimed at addressing the issue highlighted how these attitudes evolved. Overall, these resulted from insufficient information regarding mental illness as well as a failure to observe and learn about mental illness (Nunnally, as cited in Segal, 1978). While this finding may be linked to people's desires to maintain social distance, as discussed above, it is also hypothesised that those suffering from mental illness tend to limit their involvement within the community due to the manner in which members of the public perceive them. In this way negative attitudes and the resulting negative behaviours that are directed towards and experienced by the mentally ill serve to maintain disequilibrium in society by perpetuating the marginalisation of a socially unacceptable few. According to Dohrenwend and Chin-Shong (as cited in Segal, 1978) members of the

public relied more on the criterion of perceived dangerousness of mentally ill individuals, which may be associated with the desirability of maintaining social distance. Star (as cited in Segal, 1978) demonstrated how the American public attributed unpredictability, impulsiveness, loss of control, extreme irrationality, violent behaviour, incomprehensible speech, delusions or hallucinations to true mental illness. In view of the above findings, knowledge on the subject of mental illness may serve to break down the social barrier that exists between 'normal' and 'abnormal' people. Contact with mentally ill persons has been demonstrated to be beneficial in altering negative attitudes (Cuomo & Ronacher, 1998; Haag Granello & Granello, 2000; Segal, 1978).

Implications for help-seeking behaviour

According to Jorm (2000), stigma associated with mental disorders may hinder help-seeking behaviour. This statement offers some insight into the findings of Gonzalez et al. (2005). Similar sentiments are echoed in Myers (1996) as well. According to Myers (1996) a number of physicians will delay or avoid help-seeking behaviour because of the stigma attached to mental disorders such as depression. It should be noted, however, that physicians, similar to any person predisposed to mental illness, can be mentally ill and simultaneously not be occupationally ill (Myers, 1996). Thus, as long as the respective disorder has not progressed to a state where medical judgment, competence, safety or manner are jeopardised, the physician can function professionally (Myers, 1996).

Stigma is thus an all too real problem encountered when addressing mental health. The occurrence of stigma is also within American judicial systems and is further perpetuated through negative media portrayals (Vitello & Durham, 2006). For example, there is a tendency to portray mentally ill persons as violent, dangerous and susceptible to crime (Vitello & Durham, 2006), contrary to reality. More responsible

depictions of mental illness by the media (e.g. depictions serving an educative purpose and which refrain from confirming stereotypical portrayals to an already misinformed and condemning society) would perhaps aid in deconstructing our society's stigmatising views regarding mental illness. Stigma, which partly results due to the media's dramatisation tactics, is interconnected to varied behaviours that result from its expression, be it discrimination, maintaining social distance from those that are mentally ill or community involvement in the realm of mental health.

It seems plausible that negative evaluations of the mental health domain would limit use of such services. Similar to Flisher et al., (2002) two Australian studies examined the use of university counselling services by students (Raunic & Xenos, 2008; Russel, Thomson & Rosenthal, 2007). Both studies found an underutilisation of university services. Raunic and Xenos's (2008) review cites a few explanations from current literature, which could account for this underutilisation. For example, perceived self-sufficiency, denial as a coping style, unwillingness to discuss personal problems, lack of knowledge about counselling services and the perception of stigma related to receiving counselling are documented as barriers in making use of such services. (Komiya et al. 2000; Surf and Lynch 1999, as cited in Raunic & Xenos, 2008). Interestingly, Russel et al. (2007) found that those that did make use of the services evaluated these in a favourable light. Explanations for failure to seek help were based on perceived insufficient seriousness of problems, lack of information regarding the services and less commonly, doubts and discomfort about the services. The latter study brings about a different understanding, that perhaps a good experience of mental health services positively affects perceptions towards mental illness and appropriate help-seeking behaviours.

The study conducted by Flisher et al. (2002) is also important within the context of perceptions that affect help-seeking behaviour. As mentioned previously, a limited

number of students make use of UCT's counselling service when compared to the overall student population. Flisher et al.'s (2002) study additionally provides valuable insights pertaining to the area of mental health more specifically in relation to the present study, as it is framed within a South African context.

It is important to understand the impact of negative perceptions on mental illness as they have important implications for accessing treatment (Flisher et al., 2002; Raunic & Xenos, 2008; Russel et al. 2007). Treatment is integral in the recovery process and a barrier to this is therefore a barrier to recovery.

SIGNIFICANCE OF THE STUDY

Stigma has repeatedly been encountered as a major challenge in the wake of experiencing mental illness on a global scale. Studies have shown that mental health illiteracy may contribute significantly to the occurrence of stigma.

The dearth of studies on the subject of mental illness in the South African context may partly account for the general negative perceptions about mental illness. Exaggerated or stigmatising views exist and thus public education is clearly a necessity. Given the limited studies focusing on the perceptions of students in South Africa and the dominant reliance on survey approach methods in understanding mental illness, this study attempted to understand the negative perceptions of mental illness in a sample of students at UCT. In understanding these perceptions, it is hoped that barriers to seeking treatment can be identified and that the findings can contribute to formulating solutions to overcome these barriers.

CHAPTER THREE:

METHODOLOGY

This chapter describes the research methodology used in order to ascertain the negative perceptions of mental illness of a sample of students. A section of the chapter presents design of the study, describing the qualitative framework used in the collection and analysis of the data. This is important as the nature of the study is tailored to a qualitative rather than a quantitative understanding in order to bridge the literature gap in this area of research. The use of a qualitative framework in data collection and analysis therefore addresses the objectives of the study and hopes to obtain a more semantic understanding of elicited perceptions and their impact on help-seeking behaviours, as well as implications for future research. The use of a vignette is discussed. A vignette was necessary to facilitate the focus group discussions and serve as an ice breaker. Group discussions directly pertain to the aims and allowed for participants to offer perceptions that were in some instances highlighted by personal experiences. Such a method is therefore important and contributes to the richness of the data. This is followed by the description of participants and how they were recruited for the study. The next section describes the procedures followed in collecting the data and is followed by a description of the interpretive phenomenology approach used to analyse the data and the steps undertaken towards organising the data into themes. The last section presents the processes adhered to in order to comply with ethical requirements for the study.

Study design

The aim of this study is to gain an in-depth understanding of the negative perceptions of mental illness in a sample of university students from UCT. This study is qualitative in nature. According to Babbie and Mouton (2004), qualitative research

refers to a generic approach in social research where the main aim is to gain an insider perspective on the topic of interest. Different qualitative methods use several ways of obtaining data. In-depth individual and group interviews are useful in gaining participant perspectives on topics. This study used a sample of students in focus group discussions in attempting to elicit perceptions of mental illness. Prearranged meeting times were agreed on and snacks were organised for the participants. An audiotape recorder was used to document the discussions. A summary of a case study (vignette) was provided in all group discussions. The vignette fulfilled an icebreaker role, as group discussions began with comments on the case study. This allowed the researcher to gain easier access into prevailing perceptions through the inclusion of a scenario that documented a student's difficulties with anxiety symptoms at university. It also allowed participants to better relate to the topic and assist in bridging the gap between the experience of mental illness and themselves. This therefore served as an appropriate tool to document negative perceptions. The focus groups lasted for an hour and the data that was gathered was transcribed. The data obtained was analysed using an Interpretive Phenomenological approach.

Participants

Convenient sampling was used to select participants. This method of sampling places importance on obtaining representative opinions of the population being sampled (Baker, 1999). This study required the use of students from different university faculties in order provide a diverse sample and not adhere to a strictly homogenous group, which may confound results (see Appendix 5: Participant Demographic Information). Participants were recruited through directly approaching students at various university venues, who, on agreeing to participate, were invited to focus group discussions. This form of recruitment allowed the author and participants to become acquainted prior to the discussions and therefore begin the process of rapport-building. This process was further facilitated by the author's own status as a student,

which was made apparent during introductions, as it allowed for more equilibrium in the power dynamics between researcher and participant. The author approached students in areas where those registered in their respective faculties were most likely to be found, for example, Commerce students most likely to use the Leslie Commerce building, Humanities students the Leslie Social Science building, Engineering students the New Chemical Engineering building, etc. Other general areas such as the Main Library, where students across faculties may be found, were also used to obtain participants. Four students from each of the four faculties were approached to recruit their peers to participate in the study. This proved to be a more useful approach specifically for the group dynamics during the discussions. Thirteen participants were involved: four registered with the Humanities faculty and the other three faculties (Commerce, Law and Engineering) contributed three participants respectively. The participants overall consisted of three males and ten females. Upon accepting to participate in the study, participants were briefed on what the study entailed: confidentiality and other ethical considerations, the time frame of the interview and the unrecorded debriefing session at the end of the interview. All participants were asked to complete a participant information form. Included information was gender, nationality, faculty and level of study. Participants were also provided with a consent form, which they were required to sign. Four focus group discussions comprising three to four participants were conducted at venues and time slots that were negotiated with the respondents. The only criterion required for participation was that all participants had to be registered as students at their respective UCT faculties.

Data collection method

“Qualitative methods allow the researcher to study selected issues in depth, openness and detail as they identify and attempt to understand the categories of information that

emerge from the data” (Durrheim, 2002, p. 42). Focus group discussions, employing interviewing techniques and guidelines proposed in Seidman (1998) and Esterberg (2002) were used to collect data. According to Glitz (1998) the focus group discussions aim to gather opinions, knowledge, perceptions and concerns of small groups of individuals, pertaining to a particular topic. A copy of the vignette (see Appendix 3) was presented to each individual in order to facilitate a discussion. The researcher’s aims were to obtain negative perceptions of mental illness by asking a series of open-ended questions about what the problem is perceived to be, recommendations for assistance and questions pertaining to personal conceptualisations of mental illness. The use of vignettes in social research is seen as useful for allowing participants’ perceptions to emerge in relation to a hypothetical other (Shabalala, 2004) and thus enabled the sampled students to distance themselves consciously from personal experiences of mental illness. Each focus group interview was approximately one hour in duration. Audio tape recordings were utilised in the group interviews, thus enabling the researcher to capture all that the participants had to offer verbally. The combination of the tape recordings and memo-notes were carefully used to transcribe the findings of the entire interviews.

Data collection procedure

Participants agreed to participate in the study after they were informed that light snacks would be served at the venues. Upon obtaining the necessary participants, times and venues were negotiated. This proved highly challenging as many students within the same faculty experienced numerous timetable clashes with the proposed times. Therefore a 10-minute preliminary meeting for all focus groups was organised between lectures and tutorial meetings, where specific times and dates could be agreed on, which were suitable to all participants. Another challenge was faced when

a seemingly free venue was to be used for academic purposes during the time of the focus group discussions. In one instance, this problem necessitated moving from the chosen venue (after the equipment and snacks had been set up) and travelling to another venue. This was experienced as disruptive to both the author and the group; however, this disruption did not hinder the discussion. As previously stated, audio tape recordings were used to document the discussions.

Data analysis

This study has made use of interpretive phenomenological analysis (IPA), which aims to obtain meanings that particular experiences, events and states hold for participants (Smith & Osborn, 2003). In utilising this approach, Smith and Osborn (2003) suggest that meaning is central in the interviews, and is therefore important to attempt to understand the content and complexity of those meanings. Thus the researcher has to engage in an interpretive relationship with the transcript. The transcripts are thoroughly reviewed in order to familiarise the researcher with the content and to gain new insights resulting from this thorough reading process, as suggested by Smith and Osborn (2003). Themes in all of the transcriptions have been developed by comparing different segments of data. Dominant themes have been prioritised because of richness of particular passages that highlight the themes. The theme aids in illuminating other aspects of that account, as well as the prevalence of certain themes within the data (Smith & Osborn, 2003). This analysis procedure resulted in the emergence of five dominant themes, which addressed various components of the negative perceptions of mental illness in the sample used.

Ethical considerations

Participation in the present study was voluntary and informed consent was obtained from each participant. The purpose of the study was explained to each of the participating groups. Upon agreeing to be part of the focus group participants were provided with a consent form to sign (see Appendix 1 & 2). Negative perceptions of mental illness may be considered a sensitive subject issue for individuals who have had experiences of mental illness. The author perceived that should the study have resulted in distress for some of the participants, the researcher's objective would be to identify and manage potential difficulties by having a thirty-minute debriefing session following the focus group discussion. Those participants that either appeared to be or voiced any distress will have been referred to the UCT Student Wellness Centre: Student Psychological Services. It was hoped that the above steps adequately addressed all ethical considerations.

CHAPTER FOUR:

RESULTS AND DISCUSSION

This section will provide the results and discussion of the data that emerged within the present study. Four group discussions were included in the study. Five dominant themes emerged in the analysis of all discussions, namely: (1) Definitions of mental illness; (2) causes of mental illness; (3) negative responses to mental illness; (4) factors contributing to negative perceptions; and (5) interventions. The above themes form different yet connected components in understanding negative perceptions by addressing various areas pertaining to these and have been organised below.

DEFINITIONS OF MENTAL ILLNESS

The definitions herein are important as the way mental illness is defined may provide insight into the nature of negatively held perceptions. For example, the study conducted by Haag-Granello and Granello (2000) illustrated that students that had broader and more inclusive definitions of mental illness, maintained less socially restrictive attitudes toward the mentally ill. The manner in which mental illness was defined also demonstrated the level of knowledge that participants possessed with

Participants were chosen and coded alphabetically according to which faculty they represent:

Humanities: Group A (A1, A2, A3, A4)

Law: Group B (B1, B2, B3)

Commerce: Group C (C1, C2, C3)

Engineering: Group D (D1, D2, D3)

regards to this area. The emergence of this theme may therefore be useful in drawing out negative perceptions of mental illness. The following ideas captured what participants perceived to be important in defining and understanding the concept of mental illness: The experience of extreme and chronic symptoms, limited functioning and abilities, inexplicable and irrational behaviour regarded as social deviance, and lastly the lack of reality testing. The following quotes show some ideas of what mental illness is believed to be:

“... For me it’s a guy who’s completely lost it ... ja [yes], someone completely in their own world ... they’re not with us (laughs)...” (C1)

“I don’t want to say ‘there’s something missing’, but something isn’t ... ja [yes]... there’s something missing ...” (B3)

Mental illness, according to the above statements is thus defined in terms of a form of detachment from a lived experience of reality as well as an element of a sense of normalcy that is perhaps incomplete.

Experience of extreme and chronic symptoms

The development of this perception was apparent in all groups that participated in the present study. Participants listed the chronic and extreme experience of symptoms as out of the ordinary and as indicative of something “serious”. Sue et al. (2003) included discomfort as one of the definitions of abnormal behaviour (psychopathology) from a behavioural perspective. The experience of discomfort must interfere with an individual’s capacity to function to be considered abnormal (Sue et al., 2003). Thus, the participants’ ability to recognise extremities and chronic symptoms indicates some insight in defining mental illness.

“... For me a mentally ill person, like I said, they can't function properly ... you can't actually get them to integrate properly ... but it's someone who does it all the time ...” (C2)

“... For me it's a guy who's completely lost it ... ja [yes], someone completely in their own world ... they're not with us (laughs) ...” (C1)

An inability to “function”, while supported by literature (Sue et al., 2003) is not fully qualified in the above excerpt. What is denoted in the quote is a sense of a complete lack of functional ability all the time. This finding somewhat contradicts Sue et al. (2003) in that a mentally ill individual needs to be significantly impaired in areas of functioning. It is therefore important to note that experiences of mental illness may vary and should be viewed along a continuum of experiences, severity and chronicity as opposed to a applying what may be a generic set of experiences across all psychiatric disorders.

Limited functioning and abilities

Participants correctly cited problematic functioning in defining mental illness. In defining mental health, the WHO (2008) definition encompasses optimal functioning on various spheres, therefore participants were correct in making such an analysis. It appeared, however, that the participants' definition considered an extreme limitation in functioning and abilities, perhaps even severe debilitation. Although this is true for certain mental illnesses, one cannot generalise this definition to all mental illnesses, as noted in the previous section. This was observed in the following excerpt from one student:

“[If I was told they have] mental illness I think of someone in a chair...”

drooling ...” (A1)

Such a statement hints at the perception of all individuals suffering from mental illness as being severely debilitated. While there may be those that are severely hampered by a psychiatric disorder, it does not necessarily imply a general experience. Another definition arose that incorporated psychological distress, as seen below:

“People who can’t really function on like a day to day basis and interact with people ... because of some psychological issue ...” (A2)

In addition to the impairment in functioning as a result of psychological factors implied above, the last quote also points to perceived helplessness in the mentally ill person. The statement implies that the “drooling” individual is so severely incapacitated by their disorder that they may have no awareness of emitting saliva, the social implications of this and/or an incapacity to act in a socially appropriate manner. The concept of helplessness has been associated with certain disorders such as depression (Sue et al., 2003) and the perception of helplessness may elicit sympathy towards those afflicted with mental illness, as they may not be judged as having brought the illness upon themselves.

Inexplicable and irrational behaviour understood as social deviance

Sue et al. (2003) include deviance in their definition of psychopathological behaviour. A number of individuals attribute the term mental illness or mentally ill to observable behaviour that is regarded as socially unacceptable or deviant from the norm. This definition implicitly reveals the interplay of culture in the construction of societal norms. For example, Swartz (1998) demonstrates the manner in which symptoms of

“ukuthwasa” are regarded as normal in the South African indigenous healing system, whereas the same symptoms would likely warrant a diagnosis of schizophrenia in western cultures. This was also demonstrated in a study, which sought to investigate brain fog symptoms among black South African university students (Peltzer, 2002). Brain fog, a culture-bound syndrome which presents as somatic symptoms, depression and mental exhaustion (Peltzer, 2002), may be recognised as a mental disorder within the South African context. It is not congruent to the DSM IV-TR categorisation of recognised mental disorders, which may be attributed to the cultural manifestations and/or definitions of the illness.

“Eish, I don’t think I can answer that question ... What comes to mind? Schizophrenia ... crazy ... what I perceive to be not normal ... is crazy ...”
(D3)

“... Acting strangely for no apparent reason.” (A1)

Participants referred to such deviance as “craziness that is out of context”, with some belief that all individuals experience momentary episodes of deviance. The distinction was perceived to be established when that deviance is generalised to multiple contexts and is regarded as strange and/or unacceptable by onlookers. Similar sentiments were expressed when respondents explained mental illness as partly “talking to oneself”.

Interestingly, although the term craziness was regarded as a euphemism for mental illness, it appeared that the latter was viewed as encompassing less pessimistic experiences than the former, which was regarded with greater pessimism. For example, dangerousness and severity of symptoms were associated with what was termed as “higher classifications”, such as schizophrenia, which participants regarded as craziness. Craziness was seen to be related to more negative recovery related

outcomes, an issue that has particular implications around stigmatisation as participants felt that witnessing a 'recovered' person was a rare occurrence. The following quotes highlight an implicit distinction between craziness and mental illness while still acknowledging some similarity:

"... Not necessarily crazy, but umm...not having the full capacity to make decisions without the influence of emotions, but like the hectic emotions. I think it's sort of ... it's sort of ... umm ... where [there is] like, that conscious inability to make decisions for yourself ..." (D1)

"They both deal with the brain." (A4)

Lack of reality testing

The issue of an individual's ability to distinguish between what is real and imagined, reality testing, which has been associated with disorders such as schizophrenia (Sue et al., 2003), was mentioned by some participants as key in defining mental illness.

"... More like having a double personality ... so mental illness would probably be, like living in another world ... losing the clear mind between what's real and what's not." (D2)

Once again, the severity of experiences appears to be relied on as in citing a lack of reality testing in mental illness, there appeared to be a belief that all disorders exhibit this symptom. As can be seen in the above example, there may be confusion and conflation of symptoms in lay understandings of mental illness. Mental illnesses vary in types and severity and a lack of reality testing may not be generalised to be symptomatic of all mental illnesses. The manner in which mental illness has been

defined above assumes the experience as one in which the umbrella of psychiatric disorders is perceived as encompassing psychosis.

CAUSES OF MENTAL ILLNESS

Participants cited three main factors that they believed cause mental illness, namely biological, social and cultural. The present theme was the result of various ways that participants saw certain factors to impact on how they perceived mental illness to be caused. This is important as the manner in which mental illness is thought of on a broader spectrum (e.g. causes, influences etc.) serves to play a role in how mental is perceived and hence influence behaviours towards those that are mentally ill. It was therefore important to note that in understanding mental illness, it was necessary for participants to elicit factors, which they perceived to result in mental illness. Biological, social and cultural factors were identified as playing a causative role in the development of mental illness in individuals.

Biological factors

Sue et al. (2003) state that psychopathology may be understood from a multiple theoretical framework, which is inclusive of biology as a perspective. The biological causes should, therefore be considered as important in understanding mental illness. The participants agreed that this view was effective in influencing their perceptions of mental illness. Participants cited the interplay of genetics as being influential in causing mental illness, with reference to certain individuals as being “born crazy“, as commented by one particular student. Chemical imbalances were also included in their explanations. This finding provides evidence that western ideology does shape perceptions, as citing biological factors may be understood to be an adherence to such ideology. One only needs to consult the DSM IV-TR to confirm the aforementioned

statement, where much emphasis is placed on biological causes of mental illness. Two quotes have been included to elaborate on the emergence of this viewpoint:

“I think there are varying degrees of it [mental illness]. Some mental illnesses are chemical imbalances, which then make you react differently or make you react differently to different situations. But then again, it’s not just the chemical imbalances, you know... your situation, your environment will sort of dictate or inform the way in which you view a situation.” (B1)

“It can be biological ... where you’re born with it ... you’re just born crazy ... stuff like that. If you’re not sleeping or you drink too much ... you smoke, you’re not looking after your body ... that kind of thing ... life is hectic as well. Like, you’ve had a rough life ... that can contribute to it as well.” (C1)

Social factors

In understanding the phenomenon of mental illness, it is useful to adopt a multiple theoretical framework as the channels of understanding are better extended (WHO, 2008). Importance is thus placed on the interaction of the various factors, as opposed to the reliance of one major factor. One group in particular cited social factors as the sole cause of mental illness:

“... Social experiences ... personal disappointments ...” (D2)

“I mean I also think the lack of support from family as well ... like if you’re going through something as well and you don’t get the support.” (D3)

Social factors were heavily emphasised by this group, while the remaining groups demonstrated an adherence to the interplay of multiple factors in causing mental illness, including an emphasis on social factors. Included in the category of social causes were the experience of abuse, stress, suppressed emotions, lack of familial support, anxiety, regrets not dealt with and death. The above examples were believed to play a significant role in the development of mental illness.

Cultural factors

The emergence of this as contributory to causing mental illness demonstrates the powerful influence of culture (Hadebe, 1986; Patel, 1995; Swartz, 1998). Spiritualism was cited as an example by some participants, while others expressed being “open minded” to cultural factors such as witchcraft and inexplicable causes. This approach provides a different dimension of understanding how people understand mental illness and it forms a weaker argument. This is perhaps due to the mysterious and non-empirical nature of this perspective. Such limited knowledge on the subject may lead to the dismissal of supernatural causes such as witchcraft. However, it should be noted that ideas of spiritualism should not be discarded too hastily, as they bring about a particular observation. Psychology incorporates the study of the ‘psyche’. Others may view the psyche as the spirit and any disruptions affecting this psyche may negatively affect an individual’s functioning.

“Ok ja [yes], the locals there [in Namibia] I think see it [the causes of mental illness] as very cultural, like South Africans see culture as playing a role, in fact even more so there than here, the whole supernatural ... then you get the German side of Namibia, which is scientific, they don’t - they’re very narrow minded people, if I do say so myself - and they don’t even know at all ... it’s all very scientific.” (A2)

This participant's view demonstrates an understanding of the role of culture in how mental illness is perceived. Two contrasting cultures are pitted against each other, one of dominant western ideologies (for example, what is cited as German-Namibian) versus third world ideologies ('native' Namibians and South Africans), science versus the supernatural. Largely, participants regarded ideas from the Western world (e.g. USA and Europe) as having logical explanations of mental illness.

The process of Westernisation has affected individuals on a global scale and due to such acculturation, adopting Western ideologies may be the norm. While acknowledging the role of culture, they also emphasised the importance of western perspectives in shaping their views. In this instance, they were deemed as offering more rational and logical explanations of mental illness. The following quotes capture these viewpoints on culture:

"I think culture does play a role, but I think for us, we've been exposed to a lot of reasoning and like, you'll always find a logical reason as to why that person would be going through that. Personally, I wouldn't say like, ancestral calling and that kind of thing...so...I wouldn't say they're going crazy. I'd try and find a logical reason." (C1)

"It's different because when you come from like the rural townships and whatever, you're drilled into this whole, 'ok it's your ancestor', but if you go to like a model C school, white school, its scientific, its logical..." (A4)

The experiences of an individual are documented as differing across contexts, such as in the last quote above. Here the participant highlights the contradictions between her "white" scholarly experience that contributes to logical explanations and her rural/township knowledge offering a spiritual understanding.

Participants perceived one's racial group, religious and spiritual beliefs as impacting one's perceptions of mental illness. Largely, they viewed black communities as holding strong stigmatising views of mental illness and the mentally ill, which may be compared to the findings of Van der Burg (1983) as seen in the following statement,

“I think it [culture] can make some situations worse, like if you do have a problem, like I know being Black, it's not even a problem ok - that thing [mental illness] needs to beaten the hell out of you and then it would be sorted out ...” (A3)

Although the black community was excluded in Van der Burg's (1983) study, similar results were found in all sampled racial groups, especially in the Coloured community. It is possible that different racial groups conceptually define mental illness in varied ways. Cheetham and Cheetham (as cited in Patel, 1995) demonstrated how the explanatory model of mental illness according to the Xhosa community may cause problems. For example, if mental illness is attributed to witchcraft, which is negatively perceived, this may result in the negative associations to mental illness.

“I think the understanding in different cultures of what it means to be mentally ill is socialised, because I know in some cultures it's an illness, its treatable, it's a disease, its scientific; others it's more of a supernatural thing ...” (A4)

“I think it [culture] can make some situations worse, like if you do have a problem, like I know being Black, it's not even a problem ok - that thing [mental illness] needs to beaten the hell out of you and then it would be sorted out one time, whereas if you're white then, “it's ok my love, we'll take you to the best facility, we'll sort it out, or take you away to like France or somewhere and like sort it out” just like, under the rug, on camp or something, there's always excuses, always alternatives whereas if you're

Black then...you're told we don't have money to deal with these things so just get better.” (A3)

The inclusion of religion as a factor shaping conceptualisations of mental illness was an unexpected finding; however no literature makes reference to religion. The emergence of religion is important as it demonstrates the importance of using a qualitative approach, which has brought to light a finding, which perhaps would not have emerged had a different approach been utilised. Cultural influences, for example religion, witchcraft and spiritualism were viewed as important, as shown in the excerpt below:

“Or it's like a witch doctor situation, kind of sangoma thing, you know it's not an illness, it's an evil spirit kind of thing ... A gift of the Gods, that kind of thing ...” (A2)

The quotes encompass strong perceptions of what is experienced as cultural factors. Participants felt that there are supernatural versus scientific explanations and religious experiences (as seen in the third quote where the participant noted how some people may not necessarily view a set of symptoms as mental illness, rather a gift from God or else as a spiritual experience).

Overall, the results in the first two sections suggest the presence of both positive and negative elements in how mental illness and its causes are understood. The next section will look at some attitudinal issues that emerged from the data.

RESPONSES TO MENTAL ILLNESS

The central question in this study was to explore students' perceptions and attitudes towards mental illness. These were derived through listening to and observing how all participants responded to the vignette, verbal and non-verbal expressions in mental illness discourse during the focus group discussions. Although fear, dangerousness and othering emerged as the major themes within this section, not all associations were of a negative nature. All participants had known at least one person who has been afflicted with mental illness, with one of the participants having had an immediate family member suffer from a certain mental illness and two thirds of the participants knew a relative suffering from a mental illness at the time of the focus group discussions. Some of the participants demonstrated empathy when they imagined the disposition of the vignette character and were able to identify key experiences that they believed the character had on a regular basis. This is in line with Viljoen's (2005) finding that students who had experienced mental illness were more sympathetic to those students who had committed suicide while having a co-morbid disorder such as depression. Although none of the participants had personally experienced mental illness, it seemed that knowing someone who had was sufficient to elicit more positive associations. While all of the groups did demonstrate positive associations, a review of the transcripts presented the existence of the following three results across the groups as having dominated.

Fear

Fear was generally covertly expressed in association to individuals with mental illness. All participants expressed fear, although different types of fear emerged. For example, some students expressed fears of being "seen" as utilising UCT psychological services such as the Wellness Centre, while one said that she

occasionally experiences fear in the presence of a mentally ill relative.

“... She’s my aunt but sometimes I’m scared of her ... I’m not always comfortable being around her...” (D1)

Thus there exists a fear of association due to the stigma attached to mental illness and this negatively affects help-seeking behaviours (Jorm, 2000; Myers, 1996). Other respondents admitted to be likely to initially express fear upon being confronted with mentally ill individuals. The experience of fear was captured in the following quote:

“... You watch movies and it’s all a bunch of crazy people and the environment is just really ... I mean I would never want to go to Valkenberg [Psychiatric Hospital], because I think it’s like that, I’m just scared.” (A2)

The fear was attributed unpredictability associated with mentally ill individuals, a finding that is consistent with a study conducted by Star (as cited in Segal, 1978), which illustrated how the American public attributed unpredictability as one of the symptoms of “true” mental illness.

Dangerousness

Dangerousness is closely linked to the previous finding of fear. Society fears mentally ill individuals because of associated dangerousness and as a result, such reliance has been said to be associated with the desirability to maintain social distance (Dohrenwend & Chin-Shong, as cited in Segal, 1978). The same may be observed in the following statement made by one participant:

“I think that, because I think that ‘crazy’ is a person jumping around in a little

cell and just all of a sudden has, like, an outburst of violence, I think of very aggressive behaviour, but generally I don't feel very comfortable around crazy people.” (A3)

Literacy within the area of mental health would serve to educate the public and perhaps assist individuals in relying less on the criterion of dangerousness. Therefore, education appears to address a number of challenges concurrently.

Othering

A combination of the previous two perceptions ultimately culminates into the present view of othering. This idea emerged due to repetitive distinctions made between “us” and “them”, with the outside group (mentally ill individuals) possessing negative associations due to their mental health status. This finding does not necessarily refer to mentally ill individuals being referred to as ‘them’. This was observed in statements such as:

“Someone who’s completely lost it ... they’re completely in their own world”.
(C1)

The most direct form of othering was observed when one participant expressed that he did not believe that any UCT student was presently suffering from any mental illness. This may be attributed to identification with the UCT community and thus desiring to weaken mental illness associations with that group. The Commerce group comprised a majority of male participants (two out of three) and the negative views generally expressed in this group are linked to the findings of Gonzalez et al. (2005). The study found that in the investigation of mental health attitudes, young adult males reported the most negative attitudes. Thus far, this finding has been echoed in the present study

as the male participants have demonstrated the most negative perceptions when compared to their female counterparts. Limited knowledge and lack of exposure may account for this finding as what emerged was unlike other groups, as none of the Commerce students had known someone afflicted with a mental illness.

“My experience is ... they’re almost not part of the society at all ... it’s like a ‘them and us’.” (C3)

The above statement further emphasises the existence of othering in perceiving those that are afflicted with mental illness. Literature focusing on attitudes and beliefs toward mental illness either directly and/or indirectly addresses this finding, more especially in studies where stigma and/or discrimination are cited.

FACTORS CONTRIBUTING TO NEGATIVE PERCEPTIONS

Participants felt particular factors contributed to the shaping of how they understood and responded to mentally ill people, particularly the negative perceptions that prevail. An apparent implicit message was that these develop after various interactions with our social environment and are not necessarily completely self-generated.

The media

The media were cited as having a vast impact on how each respondent perceived mental illness. It was agreed that the media (e.g. movies, television, etc.) contributed significantly to negative perceptions of mental illness as the basis of their conceptualisations has largely been shaped by the images of mentally ill people that have been portrayed. Movies such as ‘Hannibal’ were believed to further fuel

negative perceptions and confirm existing stereotypes. Vitello and Durham (2006) echo this sentiment when they demonstrate the vital role that the media play in sensationalising (Diefenbach & West, 2007) and as a result construct negative perceptions of mental illness (Dietrich et al., 2006). This is seen in the following quote:

“... They’re [mentally ill individuals] perceived as dangerous as well and unpleasant to be around and I mean you watch movies and it’s all a bunch of crazy people and the environment is just really ... I mean I would never want to go to Valkenberg because I think it’s like that, I’m just scared.” (A4)

The participants were, however, able to view the positive and powerful role of the media. For example, movies such as ‘I am Sam’ were said to have played a positive role by educating individuals and eliciting sensitivity, sympathy and understanding of some of the experiences of mentally ill individuals. This is seen in the following excerpt:

“I think a movie like I am Sam was very sad, but you’re left with the message that like “Oh, they are actually people, they do really feel like we feel” ... and we must exercise more tolerance ...” (A2)

Thus the media may be seen as having a dichotomous role in shaping perceptions of mental illness. On the one hand, continuously sensationalising the experiences of mentally ill individuals breeds further stigmatising views, while concurrently (however to a lesser extent) provides insight into these experiences. All participants agreed that more responsibility had to be exercised through the provision of realistic depictions of mental illness, as well as promoting mental health and reducing stigma by enlisting the assistance of influential figures (e.g. Oprah Winfrey). Similar to

findings in literature, the media (e.g. movies) were deemed an equally important factor influencing perceptions as seen in the following quotes:

“Well I know that like the media can be used as a good thing to spread a good message. Movies like ‘I am Sam’, it teaches people, but like some people won’t go and watch a movie without a big name ...” (A3)

“... And more shows like Oprah, when she like interviews people, people actually do listen, even when she has shows about bipolar situations, people do listen ...” (A2)

However, the media were also perceived as a factor that simultaneously largely shapes negative perceptions, as seen in an earlier quote. Thus media depictions of an individual’s experience of mental illness are shown to have a largely negative effect on shaping perceptions.

Significant others

Participants noted the impact, which may occur at different times or simultaneously, that certain individuals have in shaping their ideas of mental health. They perceived primary (e.g. family members) and secondary (e.g. friends, school and community) groups as highly influential in shaping an individual’s perceptions and that particular beliefs are constantly reinforced within these groups. One participant expressed this view in the following statement:

“... You can’t say it’s just one factor, I think your family creates a foundation to base on it, but secondly ... you know... learning as well from friends ...” (B2)

The above statement suggests some form of mutual connectedness between both primary and secondary groups. Therefore, for example, the primary group may provide the first exposure to certain attitudes and predispositions but these are further developed within secondary social interactions.

INTERVENTIONS

For the mentally ill

Participants identified a number of possible resources and interventions that can be used to deal with mental illness and both positive and negative attitudes to some of the formal structures emerging. Most participants showed a preference for relying on established support systems such as family, usually prior to consulting professional services. A likely explanation for this preference may be attributed to culture. Participants generally viewed psychologists and psychological services as western phenomena, to which they became exposed during the different levels of education (school and university).

The reliance on established support systems (e.g. family, friends, pastors) was deemed to be of significance for someone afflicted with mental illness. In some cases, reliance on such support systems was preferred over utilising UCT services in dealing with crises. This was observed in the following quote:

“... I’ve got certain systems in place in my own life [for] how I deal with certain situations ... Like death in the family, that kind of thing. I’ve got friends, I’ve got pastors ... so I feel I’m in a position, where that side of my life is sort of sorted.” (C1)

“I wouldn’t [use UCT Student Wellness Centre]... OK look, I’d use it for academic purposes like, I don’t know ... you get extra time for exams or what not, but it’s personal stuff. I think ... I trust my parents ... my mother and father enough about stuff to take it to them and then if she [mother] recommends it, I’d make use of psychologists ... I’d go to the UCT psychologists, had she recommended that I go.” (D3)

Both statements show how participants preferred interventions with people that were known to them and with whom they perhaps share a closer relationship as opposed to an unknown mental health professional. There may be an element of this preference involving a sense of trust toward someone well known rather than a stranger. This is echoed particularly in second statement, where such services would be used only if referred by somebody trusted. While the majority of participants preferred seeking alternative methods for assistance before seeking professional intervention, almost all participants were still receptive to seeking professional assistance. This suggests that professional intervention, even in the midst of negatively perceiving the consultation of such services, is still considered to be a viable option, particularly in cases where it was felt that professional intervention was necessary in “severe” cases. While some participants expressed a preference for private services than UCT services, as UCT students who required mental health service interventions, students were assumed to be in the financial position to afford such services. The UCT psychological services, referred to as the Wellness Centre or Student Health, were largely the first form of assistance that was offered to the person in the vignette, as shown in the following statements:

“... Student health as well ...” (D3)

“Wellness Centre [in unison] ...” (A1, A2, A3, A4)

Although the character in the vignette was referred to UCT psychological services by participants, it does not necessarily imply that the respondents would have made use of these services themselves. Citing the centre however, displays an awareness of the importance of the Student Wellness Centre. All groups demonstrated having some knowledge pertaining to the existence and location of UCT psychological services, as demonstrated in the following statement:

“Everyone knows where Student Health is ...” (D1)

The knowledge of the existence of these services suggests a general acceptance of the Student Health and Wellness facility as an important structure at the university due to the knowledge of the location of these services. Although students were aware of the centre’s whereabouts, it does not necessarily simultaneously imply accessibility to students. This aspect may also be necessary in understanding perceptions of mental illness and the utilisation or under-utilisation of such services. Flisher et al. (2002) reported that general negative perceptions towards using university services were due to confidentiality concerns and self-reliance.

“I must say I never used to believe in that kind of stuff, but I’ve seen it work on someone and the result was brilliant, so I would definitely recommend it to anyone who needs it.” (D2)

“I don’t think a UCT student would necessarily use a UCT psychological facility. I think if they know they have a mental problem, I think they would much rather use an outside facility ... I think people are worried because you never know who’s going to see you, and then “Oh, look who came out of the psychiatrist’s ward”...” (A1)

The last quote highlights the fear associated with being seen to be utilising the services, thus showing that some negative perceptions related to mental illness and seeking assistance from professionals exist. Being “seen” to use these services may be experienced as shameful. The statement also implies an understanding or perception that all who use psychological services somehow require admission into a psychiatric ward rather than other systems operating externally from this. In addition to concerns around confidentiality, there may be anxieties about the service user’s socio-economic status although this was not explicitly expressed. For example, students using UCT’s free services may be categorised as being of low social standing as this may imply an inability to afford private services.

“And also I think that UCT students would be in a financial position to go to more expensive, like, where you have to pay for private things like therapy and whatever ... things like that.” (A1)

A perception that free services are of poorer quality when compared to private services may exist and thus affect the preference for external resources.

Public-oriented interventions

The issue of listing interventions in order to address negative perceptions of mental illness arose through a need that participants construed to be pivotal in challenging stigma. Numerous studies have placed importance on various methods of reducing stigma directed towards mentally ill individuals (Cuomo & Ronacher, 1998; Hugo et al., 2003; Segal, 1978; Zolar et al., 2007). Participants perceived mental illness as generally portrayed in a negative light, which is important in shaping subjective perceptions. Therefore public mental health education emerged as integral in addressing negative perceptions due to the belief that an understanding of mental illness would reduce stigma and negative stereotypes.

Continuous public awareness, social exposure and mental illness awareness were themes that emerged consistently in relation to education. Some participants saw the need for education in this area sooner as opposed to later. This may be that providing the correct information at an earlier age could equip members of the public with knowledge that would not provide an opportunity for negative perceptions to become engrained.

“For me, I’d say making an awareness that there’s treatment, like for some people they do take treatment. Like, I know my aunt now; she’s fine as long as she’s taking her medication. It comes from the support of the family. They make sure that she takes her medication otherwise ... and err ...I think that the second thing would be making people aware that... like, you have problems ... like earlier on ... like say if you have symptoms get yourself checked out...Some people would take depression to be a light thing ... it’s actually a problem, it actually builds up to something, like much stronger you know? So that you know, like how ... the way the problem starts before you actually like,

attack the big problem.” (D1)

“... Public awareness, you know, some kind of forums where you come and teach people ... but the problem with that is ... people are approached in masses, like first years and then you’re sent for like a two week thing. By the end of the two weeks, people just aren’t interested anymore. I think it takes more than just a two-week programme to rid people of their misconceptions ... but it could help, but I think it has to be something that happens every single month...” (B3)

Education in the realm of mental illness was in all instances, cited as the most effective method of addressing stigma and thus reducing negative perceptions. This view is strongly linked to the findings of a number of studies (Cuomo & Ronacher, 1998; Hugo et al., 2003; Segal, 1978; Zolar et al., 2007). In as much as education was emphasised as being integral in reducing stigmatising views, so too was social exposure. The maintenance of social distance from mentally ill people is recognised as detrimental in the treatment and recovery of affected individuals. Studies conducted by Cuomo and Ronacher (1998) and Zolar et al. (2007) have demonstrated the importance of pairing mental health literacy with exposure to mentally ill individuals in disconfirming negative stereotypes. Angermeyer et al. (2004) demonstrated in their study, the more familiarised members of the public are with mental illness, the less likely they are to maintain social distance.

Participants expressed that having only one week in the entire calendar dedicated to mental illness awareness is not sufficient to address public literacy. It was felt that, although useful, having a “mental health week” continued to position mental illness as an othered phenomenon, something thought of only at a certain period in the year. This is noted by one respondent’s statement:

“I think they could have more information on the campus ...” (B1)

“I think it has to be consistent you know, it’s like ... it’s one of those things where like ... if it’s for public awareness, it has to be like, something that becomes public knowledge. It’s not something that we told about, or taught about or informed about, one month out of the year, or in two weeks, because then it still makes it something abnormal.” (B1)

Early mental health education and intervention

The emergence of this viewpoint sought to address negative perceptions of mental illness by implementing certain strategies at an earlier stage as participants believed that such interventions might be more effective. Participants believed that early education and intervention should be prioritised to address challenges in this area, such as stigma surrounding help-seeking behaviour (Gonzalez et al., 2005; Jorm, 2000; Myers, 1996). Tolerance and patience were positive attributes that participants believed to contribute positively in addressing negative perceptions of mental illness. Exercising tolerance and patience may be linked to a large proportion of the literature that addresses the issue of stigma (Angermeyer et al., 2004; Bentz et al., 1969; Botha et al., 2006; Corrigan et al., 2000; Gonzalez et al., 2005; Segal, 1978; Van der Burg, 1983). Once again knowledge of this area emerges as a powerful entity. The study conducted by Haag Granello and Granello (2000) showed that college students who defined mental illness less restrictively maintained less socially restrictive attitudes toward the mentally ill.

“I think a movie like ‘I am Sam’ was very sad, but you’re left with the message that like oh, they are actually people, they do really feel like we feel...and we must exercise more tolerance ...” (A2)

This chapter has discussed and analysed the results that emerged in focus group discussions documenting the negative perceptions held by students at the University of Cape Town. Five dominant themes emerged which looked at ways of defining mental illness, causative factors, ways in which mental illness is responded to, factors that contribute to negative perceptions and interventions.

The above findings were important as each area contributes in assisting to better understand how, which and why negative perceptions exist in the realm of mental health. In defining mental illness in order to better understand how negative perceptions are shaped in a layperson's idea of what mental illness is, four results emerged: The experience of extreme and chronic symptoms, limited functioning and abilities, inexplicable and irrational behavior understood as social deviance and a lack of reality testing.

Participants believed that biological, social and cultural factors played a causative role in mental illness. These results were important as an analysis of the transcripts showed that understanding the role of culture, for example, shapes negative perceptions. This included racial groups that incorporate spiritual understandings in causing mental illness, which may be perceived negatively within such communities.

Within the theme of responding to mental illness, participants felt that the dominant responses included fear, perceiving individuals with psychiatric disorders with dangerousness and othering. Such responses may result from negative perceptions. Two important factors, which were cited in contributing to negative perceptions, were the media as well as significant others.

Lastly, this chapter looked at interventions necessary in order to successfully address negative perceptions and participants believed that there needed to be interventions directly aimed at the mentally ill, as well as those that are publicly oriented. Early mental health education and intervention was also cited as important in addressing negative perceptions.

University of Cape Town

CHAPTER FIVE: CONCLUSION

This study sought to adequately explore the objectives by reflecting the negative perceptions of mental illness in a sample of university students, according to an interpretive perspective of the researcher. A qualitative approach was used in order to facilitate an in-depth analysis of the results. Thirteen participants from four respective faculties volunteered to participate within the present study. The necessary ethical considerations, such as informed consent were adhered to. Five dominant themes emerged from the results and these facilitated the interpretation of the participants' negative perceptions of mental illness by providing separate yet interconnected components in shaping negative belief structures.

It was important for respondents to define what they believed mental illness to be to gain more insight into how negatively they may have viewed mental illness. The emergence of this theme was also useful in documenting the literacy level of mental health within the student population. In defining mental illness, participants listed the experience of extreme and chronic symptoms and failed to view mental illnesses as occurring along a continuum rather than being categorised in the extremities. It was also believed that the term mental illness is a euphemism for craziness, therefore having less negative associations and believed to be manageable. Definitions included an experience of limited functioning and abilities, inexplicable and irrational behaviour understood as social deviance and a lack of reality testing. While these definitions were not incorrect, the analysis overall, showed more narrow definitions which literature has shown to contribute towards influencing negative beliefs in the area of mental health. The emergence of this theme suggests that in defining mental illness, the importance of providing a broader definition surfaces. Results clearly showed that narrow definitions contributed to students negatively perceiving mental

illness. This understanding can therefore assist in focusing interventions such as education in public mental health literacy. Broader definitions would actively challenge such perceptions.

The causes of mental illness as a theme were also discussed. There emerged a multi-factorial perception of the causes of mental illness such as biological (genetics and heredity), social (abuse and stress) and cultural (spiritual) causes. In South Africa cultural explanations were deemed particularly important, for example the manner in which individuals are raised and perceptions of family, peers and community, religion, spiritualism, witchcraft and Western perspectives. The role of culture arose in different contexts, not merely in an aetiological sense. Participants discussed the nature in which stigma may be embedded in cultural understandings of mental illness. It was expressed that members of the black community are socialised to solve their own problems, which symbolises strength and thus affects the negative perceptions toward mental illness. The role of witchcraft was also deemed influential in molding such perceptions as well as race, for example black communities were perceived to view mental illness more harshly than white communities did. The implication of this finding is that listing biological, social and cultural factors facilitate a broader understanding of mental illness. A multi-factorial understanding may serve to decrease blaming mentally ill individuals for their psychiatric disorders, therefore challenging stigma. The emergence of culture facilitates an understanding as to why students do not fully utilise the university's psychological services. Explanations such as self reliance or reliance on established support systems are viewed more favourably. These results can assist UCT Health and Wellness Centre to perhaps market their services in ways that incorporate an understanding of such factors.

The third theme to emerge was the manner in which individuals respond to mental illness and the three important categories that were discussed were fear,

dangerousness and othering. The three results are connected and influence one another, for example, there existed a sense of othering, where those that are afflicted with mental illness were perceived to be strange, helpless and feared as a result of an association with dangerousness. This in turn results in negatively perceiving the mentally ill, which is the central focus of this study. What was observable in discourses describing mentally ill individuals were terms such as “not with us” and others as being “born crazy”. One participant expressed that no UCT student suffered from a mental illness. This perception may have been shaped by the idea that mentally ill individuals are extremely observably debilitated and therefore much further removed from the UCT community. Although othering of mentally ill individuals emerged during the interview process, it should be noted that a sense of empathy was elicited, as the participants were able to identify with the experiences of the mentally ill. This was done when participants provided insightful accounts of the experiences of individuals afflicted with psychiatric disorders. In other words, the participants were able to bridge the gap between the self and the other through empathically visualising the daily experience of the vignette character. There were conclusively, largely negative responses although participants incorporated aspects of positive ones. The effect of such responses may rationalise malevolent behaviours toward mentally ill individuals, thereby creating a barrier toward addressing negative perceptions of mental illness. This perpetuates the cycle of othering and may result in further narrowing views of mental illness (e.g. that all people with psychiatric disorders are dangerous).

The fourth theme to emerge was the consideration of factors contributing to negative perceptions. Primary (family) and secondary (peers, community) groups were believed to be influential in negative perceptions of mental illness, including narrow perceptions, misperceptions and fearing the unknown. The media were also cited as influential in shaping negative perceptions of mental illness, through the

reinforcement of negative stereotypes across multiple mediums (television, movies etc.). Interestingly, however, although negative portrayals of the mentally ill were seen to dominate in this sphere, participants also felt that there were instances where the media played a positive role by serving as an educative platform (for example, television programs, which serve to publicise individual experiences in the realm of mental health). The emergence of this theme suggests that the prevalence of negative perceptions will continue to be difficult to manage and eradicate. Primary and secondary factors have shown that they are important in influencing the decision making process of participants as well as shaping their beliefs about mental illness. This was seen in quotes where participants preferred relying on people known to them for assistance (as opposed to mental health professionals). The media too, is an important factor in shaping perceptions and this means that so long as mental illness is disproportionately negatively portrayed, challenging these portrayals and consequent perceptions will be hugely difficult.

The final theme looked at interventions aimed at addressing prevalent negative perceptions documented in the present study. Three categories emerged including interventions for the mentally ill, public-oriented interventions and early mental health education and interventions. Participants preferred making use of their own support systems, including parents, friends and religious leaders due to associating trust to people known to them. Professional intervention in the form of mental health professionals was, however cited as an intervention, particularly for individuals perceived as severely mentally ill. Mental health services such as those offered by the university were included, although fears of what it means to utilise these as a current UCT student surfaced and therefore provided insight into existing negative perceptions when seeking professional assistance. Lastly, negative perceptions were believed to be best addressed through prioritising mental health education and

awareness at an early age and early intervention with regards to psychiatric disorders. The implications of the listed interventions are important as they raise and address the problems resulting from negative perceptions (e.g. delaying help seeking due to stigma shrouding mental illness). The provision of strategies aimed at individuals with psychiatric disorders as well as members of the public, allows insight into what participants, who require literacy in this realm, would be better able to respond to should these strategies be employed.

The utilisation of UCT Psychological Services was important, because while participants displayed a good awareness of these services, there was a preference for private services. This view may be result from the belief that private institutions are better facilitated and offer more discretion than UCT services, where fears of being exposed when using this facility was prevalent. This was a clear indication that negative perceptions toward mental illness in the student population exist. Negative perceptions therefore indicate a low usage of these services. This would ultimately negatively impact students and their quality of life, especially after the finding that professional services were considered only when a problem was viewed as serious. If professional assistance were only sought as the last option, areas of functioning (e.g. academics) may be significantly impaired.

A noted limitation of this study is the small sample size. The sample used richly contributed to the qualitative nature of the study using the participants' voices. However, a larger sample inclusive of all faculties (as opposed to four as was the case in the present study), racial groups and perhaps an inclusion of an equal amount of male and female participants (see Appendix 5) may have provided a more representative population. Future studies can therefore address this limitation using a larger sample that is inclusive of more diverse groups.

Documenting the negative perceptions of mental illness is an important task in helping mental health professionals better understand the lived experiences of everyone affected. This understanding may perhaps help us to be better clinicians in the long run. It is hoped that by conducting the present study, a platform will be established whereby the academic community and members of the general public, more specifically in a South African context, will actively challenge the concerns of that have been raised. Culture has emerged as a powerful entity that influences not only attitudes and beliefs about mental illness, but also help seeking behaviour at UCT. How students define mental illness is equally important as narrow definitions serve to perpetuate negative ideas and may thus result in a rippling effect on others. The study has shown the prevalence of negative perceptions of mental illness and hopes to assist in providing a more 'user friendly' guide for university to address these by considering more effective methods of intervention. Education, for example, plays a role in addressing literacy concerns in this area, however its implementation and focus needs clarity. Using a qualitative approach has aided in providing some clarity as it showed that students need to be able to better define mental illness subjectively in a manner that is broader. This may decrease prevalent ideas of associated fear and dangerousness and facilitate viewing mental illnesses along a continuum of experiences, rather than extremes. In summary, the university may need to consider the following in developing policies, programmes and mental health services:

- (1) In addressing the problem of low literacy in the area of mental health, basic education in this realm should include clear and broader definitions of mental illness;
- (2) continuous education through advertising and incorporating interactive platforms (e.g. speakers on mental health issues faced by students, debates) more especially during the orientation programme and in university residences;
- (3) given the impact of the role of culture in shaping negative perceptions and hence being a barrier to appropriate help-seeking, information from trusted sources (e.g.

mental health professionals) should be provided.

The result may be a decrease in stigma associated with appropriate help-seeking and this process may begin to be more normalised. Dedicating future research within this area, while being mindful of the participants' voices, may therefore be an important stepping-stone in addressing negative perceptions of mental illness.

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APPENDICES

APPENDIX 1

University of Cape Town, Department of Psychology Participant Consent Form

I _____ hereby agree to be a participant in this research study, conducted by Joy Hyde from the University of Cape Town, Psychology Department.

I am aware that the researcher is a Psychology Masters Student.

I agree to participate in one interview, dealing with the “perceptions of mental illness in a sample of university students”.

The researcher has informed me of the following:

The aims of the study.

Confidentiality and anonymity will be maintained.

I have the right to withdraw my consent to be interviewed should the need arise.

Participation in the study is voluntary.

Audio-tape recordings will be included in the data collection process.

I understand the importance of my participation as well as my honesty within the study.

Participant: _____

Researcher: _____

Signature : _____

Signature : _____

Date: _____

Date: _____

APPENDIX 2

PARTICIPANT INFORMATION SHEET

Dear Participant

Kindly provide the researcher with your basic personal information. Provision of such information will be of benefit to the study, more especially in the “Data Analysis” phase. Please be aware that all information provided is within strict compliance with the ethical standards brought forth in the participant consent form.

Thank you for your participation.

Regards,

Joy Hyde (Researcher)

GENDER::

NATIONALITY:

FACULTY (e.g. Commerce):

.....

LEVEL OF STUDY (e.g. Undergraduate, 3rd year):

.....

APPENDIX 3

VIGNETTE

Joanne W. was known by her varsity friends as a worrier. She was apprehensive about anything and everything: failing in school, making friends, eating the right foods, maintaining her health, and being liked. Because of her concerns, Joanne was constantly tense. She often felt short of breath, which was accompanied by a fast heart rate and trembling. Joanne also had difficulty making decisions. Her insecurity was so great that even the most common decisions – what clothes to wear, what to order at a restaurant, which movies to see – became major problems. Every night Joanne reviewed and re-reviewed every real and imaginary mistake she had made during the day or might make in the future. This produced another problem, sleeplessness.

APPENDIX 4

INTERVIEW GUIDE FOR FOCUS GROUP DISCUSSIONS

1. What do you think of what you have just read?
2. Do you think there is a problem? Explain.
3. How would you respond if this were a friend? What can be done to help this person?
4. Where would this person go to receive help? Are you aware of any services said person may utilise here at UCT? Do you know where they are situated? Do you think that they are easily accessible?
5. Do you think psychological services are made use of by UCT students? Explain.
6. What about the general public, do they utilise these as well?
7. Would you make use of these services? Explain.
8. What do you think mental illness is?
9. What do you believe contributes to and/or causes mental illness? Explain.
10. Put yourself in the shoes of the person in the vignette. What do you think they experience, within themselves and how others respond to them?

APPENDIX 5

PARTICIPANT DEMOGRAPHIC INFORMATION

| NATIONALITY | GENDER | RACE | YEAR OF STUDY |
|------------------------------|---------------|-------------|----------------------|
| South African | Male | Black | Honours |
| South African | Male | Black | Third |
| South African | Female | Black | Third |
| South African | Female | Black | Fourth |
| South African | Female | Black | Fourth |
| Democratic Republic Of Congo | Female | Black | Fourth |
| South African | Male | Coloured | First |
| South African | Female | Black | First |
| South African | Female | Black | First |
| Namibian | Female | Coloured | First |
| South African | Female | Black | Masters |
| South African | Female | Black | Masters |
| South African | Female | Black | Masters |