Perceptions of mental healthcare consumers regarding their conditions

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ABSTRACT

Distress is experienced, understood and communicated differently across various cultures. The aim of the study was to investigate the role of culture, religion and spirituality in patients’ understanding of and coping with mental problems. A quantitative survey was done at a psychiatric institution. A questionnaire was designed to explore patients’ cultural and religious beliefs about mental illness, and how these beliefs and perceptions influenced their actions in search for recovery. Questionnaires were completed by 94 patients. The majority of participants were Christian (79.8%), followed by African traditionalists (17.0%). Seventy-two per cent believed that faith in God, and 34.4% that help from religious leaders, could contribute to mental wellness. Approximately a third (29.0%) believed that by keeping their ancestors happy, they would be protected from sickness and bad luck. Mental healthcare providers’ sensitivity to cultural and religious beliefs will translate into a more comprehensive management plan, ensuring a satisfying therapeutic relationship.

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Introduction

Cultural concepts of distress profoundly influence patients’ understanding and communication of their symptoms or problems. The DSM-5 (American Psychiatric Association [APA], 2013a) refers to three main concepts of distress, namely cultural syndromes, cultural idioms of distress and cultural explanations or perceived causes. These concepts are defined as follows:

- Cultural syndromes are clusters of symptoms and attributions of distress that co-occur among individuals in specific cultural communities and are recognised locally as coherent patterns of experience.
- Cultural idioms of distress are the ways in which distress is expressed; it is collectively shared ways of experiencing and talking about social and personal problems.
- Cultural explanations or perceived causes are the culturally recognised aetiology and meaning of distress, symptoms and illness; it is the labels and attributions of an explanatory model (APA, 2013a).
It is of paramount importance to elicit information from mental healthcare consumers (MHCCs)/patients about their views and those of others in their communities. Communicating with patients in terms of their dominant concepts improves rapport and engagement, and is likely to result in greater patient collaboration and satisfaction. Insufficient understanding of an individual’s concept of distress and their behaviour relating to their illness or symptoms may lead to misdiagnosis, ineffective management and possible underestimation of the severity of their distress. They may, ultimately, experience reluctance in engaging in and adhering to prescribed treatment plans and be dissatisfied with the care provided (APA, 2013a).

Individuals grant meaning to their mental health problems from a personal, social and cultural context. For example, a person hears voices and believes them to be communications from the ancestors. Clinicians must seek to understand what sense the person makes of the experience, and to what extent it causes distress and functional impairment. Treatment options must then be discussed from this basis, as the meaning attached to the patient’s experiences will determine the need for intervention, and what type of intervention would be most appropriate (Baumann, 2010).

MHCCs often attribute their symptoms to a cultural or spiritual cause and as a result tend to visit spiritual or traditional healers before attending psychiatric units. Mkize and Uys (2004) studied the pathways patients take prior to their admission to a mental health facility in a South African Province. They found symptom severity to be an important determinant in treatment seeking, as those with markedly disturbed behaviour (such as aggression and violence, undressing in public and self-harm) typically presented earlier to mental healthcare services and were often brought in by the police. The authors noted that the chosen pathway for MHCCs to restore mental health is dependent on a wide range of biopsychosocial and spiritual factors and concluded that the cultural background of patients and how they interpret mental illness influences to whom and where they go for help. Similar findings from a national study concluded that MHCCs often seek the help of traditional healers before consulting western medicine services. Seedat et al. (2008) reported that, compared to the mental health speciality sector, the majority of patients were treated in the Complementary and Alternative Medicine (CAM)/traditional healer sector. In particular, black South Africans were more likely to seek treatment from the CAM sector than other racial groups, while white South Africans were more likely to consult a psychiatrist.

The South African Declaration on Mental Health (Department of Health South Africa [DoH SA], 2012) emphasises the key role of culture in the delivery of mental healthcare. The obligations it places on mental health services regarding accessibility, affordability and acceptability (DoH SA, 2012) reaffirm earlier recommendations for the incorporation of traditional and faith-based practices into western modes of treatment to ensure a holistic and “tailor-made” management plan (Ally, 2010; Mkize & Uys, 2004). The declaration states that service delivery should be committed to building and strengthening links with traditional, complimentary and faith-based healers and organisations (DoH SA, 2012). As suggested by Mkize and Uys (2004), health professionals should educate traditional and faith healers in concepts pertaining to mental illness, the need to comply with treatment and follow-up care, as well as the indications for referrals to health professionals, in order to prevent delays and minimise disability.
The implementation of the South African Declaration on Mental Health (DoH SA, 2012) continues, however, to be challenged by poor access to mental health services in the country. The South African Stress and Health (SASH) study (Herman et al., 2009) found that most South African citizens who suffered from a mental disorder in the previous year had unmet treatment needs. This study included 4351 respondents, of which 76.2% were black, 12.9% coloured/mixed race, 7.2% white and 3.7% Indian or Asian (Seedat et al., 2008). It was reported that 16.5% of South Africans interviewed met the criteria for a mental illness in the previous 12 months. Of these, 66.6% had one disorder, 23.6% had two disorders and 8.5% had more than two. Anxiety disorders (15.8%) were the most prevalent class of lifetime disorders, followed by substance use disorders (13.3%) and mood disorders (9.8%). The two provinces with significantly higher rates were the Western Cape and the Free State. The projected lifetime risk of any mental disorder was 47.5% (Herman et al., 2009). This study also reported an alarmingly low treatment rate of 25.5% (Seedat et al., 2008), stressing the dire need for mental healthcare provision (Herman et al., 2009).

In 2003, it was estimated that 87.7% of South Africans depended on public health sector services. Actions flowing from the Mental Healthcare Act to integrate mental health into general health took place before adequate provision was made in the infrastructure of general hospitals. Lack of funding resulted in general hospitals having insufficient beds, seclusion rooms and staff to accommodate the needs of MHCCs (Ramlall, 2012).

The Declaration on Mental Health (DoH SA, 2012) states that the public lack awareness of mental health-related issues. This field of healthcare is insufficiently funded and resourced compared to other health priorities in the country, with only 9.3 human resources working in mental health per 100,000 of the population.

The results of a study by Allers (personal communication, 2017) of the South African Society of Psychiatrists (SASOP), as reported in the media (Daily Maverick, 2015), revealed that of the 320 practising psychiatrists in South Africa, 120 were employed in the public health sector. Approximately 15% of the population then belonged to a medical aid, leaving a ratio of more or less one state psychiatrist per 440,000 people (as opposed to the one private psychiatrist per 33,000 people), indicating the underservice of South Africans as a whole.

Racial differences in seeking mental health services may be partly maintained by problems related to the acceptability of current mental health services to black South Africans. Although the majority (80.7%) of the South African population is black (Statistics South Africa (SSA), 2016a), the mental health treatment models implemented by government hospitals are mainly based on western principles. In addition, the shortage of black psychiatrists often results in users and professional service providers speaking different languages and thinking or believing differently about mental illness.

The Health Professions Council of South Africa (HPCSA) indicated in November 2017 that there are 868 actively registered psychiatrists and 11,960 registered psychologists in the country. However, according to Allers (personal communication, 2017), only 496 psychiatrists are currently working in South Africa, of which only 110 are employed in the public sector. The racial profile of psychiatrists in private sector is approximately 10% black, 69% white, 3% coloured and 18% Indian. Thus, the minority of the workforce (22%) need to provide care for the majority of the people (roughly 85% of the South African population) who depend on the public health sector, with the best part being
black. The racial profile of psychiatrists employed by the government is not currently available.

However, the ratio of black psychologists to black individuals in the South African population is more acceptable than that of psychiatrists. The Health Systems Trust (HST, 2015) indicated that 1238 psychologists worked in the public sector in 2015, of which 723 were black, 353 white, 86 coloured, 69 Indian or Asian and seven other.

The Declaration on Mental Health recognises the value of respect for culture, acknowledging the “varying cultural expressions and interpretations of mental illness, which should be respected, insofar as they protect the rights of the mentally ill” (DoH SA, 2012, p. 21). In accordance with the Declaration, the aim of the study that was performed at the Free State Psychiatric Complex (FSPC) in Bloemfontein, South Africa, was to determine MHCCs’ perspectives on mental health – what they perceived to be the cause of mental problems and what they believed would be the most appropriate treatment options. Furthermore, the role of culture, religion and spirituality in patients’ understanding of and coping with mental problems was established, and also their preferred primary mental healthcare provider, their preferences and coping mechanisms in dealing with mental problems, and their attitudes toward their treatment and the perceived effectiveness and appropriateness of the different treatment modalities.

Methods

A quantitative survey was done by using a questionnaire designed to explore and analyse patients’ cultural and religious beliefs about mental illness and the actions they take in their search for recovery from mental disturbances. Questionnaires that were available in English and Sesotho were completed by the patients. Participation was voluntary and anonymous.

Patients from different sections and/or wards at the FSPC were included in the study, namely the outpatient department, Mafube (affective ward), Blocks A and C (acute male and female wards for involuntary and assisted mental healthcare users), and Blocks B and D (forensic state patients).

The inclusion and exclusion criteria that were taken into account when the sample of eligible participants was selected are listed below. The target was to include approximately 80 patients in the study.

Inclusion criteria

- Older than 18 years of age;
- An Axis I diagnosis according to DSM-IV or DSM-5 criteria;
- The ability to read and write in English and/or Sesotho;
- Provision of written informed consent for participation;
- Participants from the acute inpatient wards were only interviewed once their psychiatric condition had been stabilised to the extent that they had the capacity to give informed consent.
**Exclusion criteria**

- Patients who were incoherent and answered questions irrelevantly due to a formal thought disorder or prominent active psychotic features;
- Patients who did not want to participate in the study;
- Patients who had completed the questionnaire previously.

The professional nurses at the participating acute inpatient units were informed about the study and were requested to assist with the identification of possible participants. Informed consent documents were handed to participants after which the questionnaires were completed. Participants were given sufficient time during a period when no other formal ward activities were scheduled. The signed informed consent documents together with the completed questionnaires were then returned to ward staff. It took approximately 25 minutes to complete the questionnaire.

The questionnaire was compiled by incorporating demographic information, combined with certain items of the World Health Organization Quality of Life Spiritual, Religious and Personal Beliefs Questionnaire (WHOQOL SRPB; 32 items) (World Health Organization [WHO], 1998), the Cultural Formulation Interview (CFI; 16 questions) (APA, 2013b), the Rating of Medication Influences (ROMI; 20 items) Scale (Weiden et al., 1994) and the South African Traditional Beliefs Scale (SATBS; 41 items) (Beuster & Schwär, 2005). The questionnaire items (29 in total) were adjusted from these scales to be relevant to and appropriate for the objectives of the study. A pilot study was conducted on two MHCCs to test the questionnaire, although their data were not included in the final analysis.

**Results**

Ninety-four patients, of which 55 (58.5%) were male, were included in the study. The mean age of participants was 36 years, ranging between 18 and 85 years. The participants’ demographic data are summarised in Table 1. The distribution of participants with regard to the ward/section at the FSPC from which they were recruited was approximately equal. The majority of the participants \( (n = 71; 75.5\%) \) were black, while Sepedi was spoken by 40% of them \( (n = 38; 40.9\%) \). As shown in Table 1, in the total group of participants, 53 (56.4%) were single.

Table 2 outlines the findings with regard to the participants’ level of education, employment and level of income. Fifty-nine (62.7%) had scholastic training to at least secondary level, and 43 (45.7%) were unemployed and only eight (8.5%) had formal employment. Four (4.3%) participants reported that they had no formal education, while 23 (24.5%) indicated that their source of income was disability grants paid by the government. The vast majority of participants \( (n = 83; 88.3\%) \) had an income of less than R2000 per month, which was equal to less than 160 US$ per month at the time of the study.

Participants’ religious affiliations and involvement with religious activities are illustrated in Table 3. The majority of participants were Christian \( (n = 75; 79.8\%) \). Of 87 participants who responded to the questionnaire item pertaining to involvement with their religious communities, 36 (41.4%) participants indicated that they were actively involved, while 12 (13.8%) never participated in religious activities.
More than three quarters \( (n = 73; 77.7\%) \) of the participants acknowledged that they had mental health problems, opposed to 10 (10.6\%) who were in denial and 11 (11.7\%) who were uncertain about having a mental illness. Table 4 summarises the findings of actual diagnoses and participants’ perceived diagnoses. In most of the participants \( (n = 40; 42.6\%) \), the actual diagnosis was schizophrenia. Anxiety disorders were the only category

| Table 1. Demographic data of participants. |
|------------------------------------------|
| Demographic variable                      | \( n \) (%) |
| Gender \( (n = 94) \)                     |             |
| Male                                      | 55 (58.5)   |
| Female                                    | 39 (41.5)   |
| Ward/section of FSPC \( (n = 94) \)       |             |
| Acute psychotic                           | 22 (23.4)   |
| State forensic                            | 26 (27.7)   |
| Affective (depression and anxiety)        | 20 (21.3)   |
| Outpatient department                    | 26 (27.7)   |
| Race \( (n = 93) \)                       |             |
| Black                                     | 71 (76.3)   |
| Caucasian                                 | 13 (14.0)   |
| Mixed race                                | 9 (9.7)     |
| Language \( (n = 93) \)                  |             |
| Sesotho                                   | 38 (40.9)   |
| Afrikaans                                 | 19 (20.4)   |
| Setswana                                  | 11 (11.8)   |
| isiXhosa                                  | 11 (11.8)   |
| isiZulu                                   | 7 (7.5)     |
| English                                   | 4 (4.3)     |
| Sepedi                                    | 3 (3.2)     |
| Marital status \( (n = 94) \)            |             |
| Single                                    | 53 (56.4)   |
| Married                                   | 15 (16.0)   |
| Traditionally married                     | 5 (5.3)     |
| Cohabitating or living as married         | 6 (6.4)     |
| Widowed                                   | 8 (8.5)     |
| Divorced                                  | 5 (5.3)     |
| Separated                                 | 2 (2.1)     |

Table 2. Participants’ level of education, employment and monthly income.

| Variable                                           | \( n \) (%) |
|----------------------------------------------------|-------------|
| Level of education \( (n = 94) \)                 |             |
| Tertiary                                           | 23 (24.5)   |
| Secondary                                          | 59 (62.7)   |
| Primary                                            | 8 (8.5)     |
| No formal education                                 | 4 (4.3)     |
| Employment status \( (n = 94) \)*                  |             |
| Scholar/student                                     | 14 (14.9)   |
| Unemployed                                          | 43 (45.7)   |
| Informal employment (stable income)                | 5 (5.3)     |
| Informal employment (variable income)              | 4 (4.3)     |
| Formal employment                                   | 8 (8.5)     |
| Disability grant                                    | 23 (24.5)   |
| Old-age pension                                     | 3 (3.2)     |
| Monthly income \( (n = 94) \)                      |             |
| Less than R500 (<38.61 US$*)                       | 50 (53.2)   |
| R500 to R1999 (38.62–154.36 US$)                   | 33 (35.1)   |
| R2000 to R4999 (154.42–385.97 US$)                 | 4 (4.3)     |
| More than R5000 (>386.05 US$)                      | 7 (7.4)     |

*Six participants selected more than one option.

Rand/dollar exchange rate when preparing the article: R1 = US$ .08.
in which no discrepancy between the actual and perceived diagnoses was observed. Cumulative percentages in Table 4 exceed 100% as co-morbidities were also included.

Table 5 portrays participants’ beliefs of biological factors and substances (cannabis and alcohol) being contributing factors to the development of mental illness. Both cannabis and alcohol were regarded as causative of mental illness. However, the participants mostly disagree that these two substances could play a role in the cure of mental illness.

Participants’ beliefs regarding the role of psychological, social and spiritual factors are shown in Table 6. It was clear that substantially more participants regarded stress as a cause of mental illness compared to those who did not, while a notable percentage of participants indicated that changing the way one thinks would be curative to mental illness.

### Table 3. Participants’ religious affiliation and involvement with religious activities.

| Variable                          | n (%)   |
|----------------------------------|---------|
| Religious/spiritual affiliation  |         |
| Christian                        | 75 (79.8) |
| African traditionalist           | 16 (17.0) |
| Other                            | 3 (3.2)  |
| Involvement in religious community |         |
| Actively involved                | 36 (41.4) |
| Sometimes                        | 15 (17.2) |
| Once in a while                  | 10 (11.5) |
| Rarely                           | 14 (16.1) |
| Never                            | 12 (13.8) |

Table 4. Actual and perceived diagnoses of participants’ (n = 94) mental health problems.

| Diagnosis                        | Actual n (%) | Perceived n (%) |
|----------------------------------|--------------|-----------------|
| Bipolar disorders                | 27 (28.7)    | 20 (21.3)       |
| Depressive disorders             | 22 (23.4)    | 20 (21.3)       |
| Anxiety disorders                | 6 (6.4)      | 6 (6.4)         |
| Substance use/induced disorders  | 8 (8.5)      | 4 (4.3)         |
| Schizophrenia                    | 40 (42.6)    | 23 (24.5)       |
| Personality disorders            | 5 (5.3)      | 1 (1.1)         |
| Poor insight*                    | 0 (0)        | 29 (30.9)       |

*Poor insight was not an option on the questionnaire and was concluded from the patients’ perception of the reason for their hospitalisation, e.g., headache and stomach ache.

### Table 5. Participants’ beliefs regarding biological factors and mental illness.

| Causal factors                  | Agreed n (%) | Disagreed n (%) |
|---------------------------------|--------------|-----------------|
| Bodily dysfunction              | 37 (39.8)    | 24 (28.5)       |
| Dysfunction of the brain        | 61 (65.6)    | 6 (6.5)         |
| An unhealthy lifestyle          | 45 (48.4)    | 15 (16.1)       |
| Substances                      |              |                 |
| As a cause                      |              |                 |
| Cannabis                        | 66 (70.2)    | 10 (10.6)       |
| Alcohol                         | 55 (58.5)    | 13 (13.8)       |
| As a relieving factor           |              |                 |
| Cannabis                        | 18 (19.4)    | 48 (51.6)       |
| Alcohol                         | 14 (15.0)    | 49 (52.7)       |
| Western medicine is required to cure mental illness | 71 (76.3) | 7 (7.5) |
Also displayed in Table 6 is that the majority of participants (80.7%) believed in the curative value of good relations with friends and family, while more than half believed that support from church members would contribute to curing their mental illness.

Although most participants believed that faith in God (72.0%) and help from religious leaders (34.4%) could contribute to their mental wellbeing (Table 6), Table 7 shows that 29.0% of participants reckoned that keeping ancestors happy would protect them from sickness and bad luck. Approximately one quarter (23.4%) specifically deemed the help of religious leaders for being bewitched to be more effective than Western medicine.

Seventeen per cent of the study population viewed themselves as African traditionalists. In particular, 20% reported that traditional healers could be of assistance, while 6% deemed traditional healers to be the most readily accessible of all possible helpers. Views concerning the outcome of Western medicine on African traditionalism are delineated in Table 7. With regard to bewitchment and mental illness, 21 (22.3%) participants believed that traditional medicine could be the only cure, while 33 (35.5%) believed that...
Table 8. Participants’ preferences with regard to seeking mental wellness.

| Preference                                      | n (%*) |
|------------------------------------------------|--------|
| Psychiatrist                                   | 47 (50.0) |
| Medical doctor                                 | 37 (39.4) |
| Psychologist                                   | 36 (38.3) |
| God in prayer/church/religious worker          | 30 (31.9) |
| Community or social worker                     | 19 (20.2) |
| Clinic nurse                                   | 17 (18.1) |
| Trusted friend/family member                   | 16 (17.0) |
| Sangoma/traditional healer/traditional medicine| 12 (12.8) |
| Pharmacy / over the counter western medicine   | 11 (11.7) |

*Total exceeds 100% as some participants selected more than one option.

Western medicine cannot cure this type of mental problems and 27 (29.0%) deemed Western medicine to worsen mental problems caused by bewitchment. Approximately one-third of the participants (30.9%) were of the opinion that Western medicine cannot cure mental illness caused by angry ancestors.

Table 8 recounts participants’ preferences with regard to seeking help for mental illness. Up to 50% of the participants in the study preferred mental healthcare practitioners (psychologists 38.3%; medical doctors 39.4%; psychiatrists 50.0%), followed by spiritual practices (praying to God; going to church; consulting a religious worker).

Discussion

Disease has been defined as a deviation from medical norms. In contrast, illness has been formalised as the experience of disease. Illness is strongly influenced by culture, and describes how impairment or distress is experienced and how disease is perceived and coped with. Different cultures therefore have different explanations for the cause of illness, which may include social and spiritual causes, an explanation that goes beyond the borders of the biomedical model (Ally, 2010). The World Health Organization (WHO, 1998) acknowledges that

[the health professions have, until recently, largely followed a medical model, which seeks to treat patients by focusing on medicines and surgery, and gives less importance to beliefs and to faith – in healing, in the physician and in the doctor-patient relationship. This reductionism or mechanistic view of patients as being only a material body is no longer satisfactory. Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process. The value of such “spiritual” elements in health and quality of life has led to research in this field in an attempt to move towards a more holistic view of health that includes a non-material dimension (emphasising the seamless connections between mind and body) (p. 7).

Hence, the difference that exists between treating disease and treating illness, which focuses on a person’s experience of disease, needs to be addressed. Consequently, healthcare providers in multi-cultural and multi-religious environments should attempt to understand, diagnose and treat patients with cognisance of their personal perspectives and belief systems (Ally, 2010).

Practising medicine in South Africa entails working in a multi-cultural and multi-religious environment. According to the 2011 national census, the total population was 51.8 million people, of which 79.2% was African, 8.9% coloured (mixed race), 8.9%
white and 2.5% Indian. The study subjects were a very good representation of the South African population.

According to the South African General Household Survey that was done in 2015 (SSA, 2016b), most South Africans (86.0%) professed to be followers of the Christian faith, followed by Muslims (1.9%), Hindus (0.9%), Jews (0.2%) and other religions (0.04%). This survey found that 5.4% of South Africans indicated they were African traditionalists, including ancestral, tribal, animist or other traditional African religions, and 5.2% had no religious affiliations (SSA, 2016b). Our findings with regard to African traditionalism (17.0% of participants) differed from the 2015 General Household Survey (5.4%), showing that the patients included in the study, who were followers of this religion, were not representative of the general population in the country.

The study sample mirrored the South African population in that nearly all participants identified with a religious community. The majority of participants believed they lived connected to a spiritual realm, which might exert a definite influence on their natural world. In addition, slightly more than 40% of participants reported active participation in religious activities. The findings suggest that MHCCs might feel more positive toward an environment in which the opportunity exists to engage in their religious or cultural practices, further enhancing the acceptability of the mental health services provided to them.

Since the significance and meaning of mental symptoms are interpreted from a personal, social and cultural context, clinicians ought to enquire about patients’ concepts of distress. Accordingly, patients will conclude whether or not help is needed and what type of intervention will be most appropriate (Baumann, 2010). This explains why MHCCs often first visit traditional healers before making use of mental healthcare services.

The Traditional Health Practitioners Act (THPA), No. 22 of 2007 (South African Government, 2008) defines traditional health practice as a “service based on a traditional philosophy that includes the utilisation of a traditional medicine or traditional practice … to diagnose, treat and prevent physical or mental illness … to maintain or restore physical or mental health or function” (p. 6). The Act describes traditional medicine as “medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not” (South African Government, 2008, p. 6).

Stott and Browne defined a traditional healer as “one who gained his diagnostic abilities from psychic powers granted by the ancestors, his knowledge of treatment from dreams, and is one who exorcises evil” (Stott & Browne, 1973, p. 334). Traditional and faith healers are often consulted first when mental illness is interpreted as bewitchment, as they are seen as experts in dealing with African magic. Grobler, Weiss, Lebelo, and Malerotho (2011) found that these alternative healers are more readily accessible and available for continuity of care and are respected by most members of the community.

Based on the findings of this study, and similar to suggestions by previous authors (Ally, 2010; Mkize & Uys, 2004), it may be important to incorporate traditional and faith healing practices in the treatment of mental illness in African traditionalists. In South Africa, provision for this type of inclusion has been made possible by the THPA.

On the contrary, access to mental healthcare continues to be a problem, largely due to the locality of services and the cost of transportation. In addition, earlier studies indicated a lack of information regarding the availability of mental healthcare services and a shortage of resources in these centres (Grobler et al., 2011).
However, this study provided evidence that MHCCs are receptive to seeking professional mental health treatment. Acknowledgement of mental health problems among the participants was high and participants regarded substance use and stress as potential causative factors in their mental illness. Given that 50% of participants indicated that they preferred to seek help from a psychiatrist, 39.4% from a medical doctor and 33.3% from a psychologist, these findings indicate a greater need for the South African Declaration on Mental Health (DoH SA, 2012) to increase the availability and accessibility of mental healthcare services to this population.

In addition to religious involvement, a large majority of participants considered supportive relationships as important in regaining mental health. Mobilising MHCCs’ natural support systems may therefore facilitate the recovery process.

**Limitations**

Mainly inpatients were used in this study (72.3%), and as symptom severity might have influenced treatment patterns, the findings cannot be generalised to psychiatric outpatients. The receptivity to professional mental health treatment might differ for MHCCs whose symptoms do not warrant inpatient treatment.

This study was performed in an urban setting, and as it was not established whether participants resided in urban or rural areas, the findings cannot be generalised to MHCCs in rural settings.

**Conclusion and recommendations**

The availability and accessibility of mental healthcare services in South Africa has been validated as essential. Expansion of current services is therefore of utmost importance.

The impact that cultural and religious belief systems has on MHCCs’ perceptions of mental illness has been demonstrated and appeal to the availability of acceptable mental health care services. To that end, clinicians need to remain open minded, be sensitive and seek to understand, affirm and validate MHCCs’ concepts of distress. Proper engagement with patients will assure management plans considered to be applicable and authentic. Accordingly, healthcare providers should receive more education and training focusing on the impact that cultural and religious belief systems have on patients’ perceptions of mental illness.

Likewise, findings of the current study suggest a need for the incorporation of complementary and alternative treatment strategies in the rendering of mental healthcare services. This view is also supported by the South African Declaration on Mental Health (DoH SA, 2012). Such inclusion acknowledges MHCCs’ preferences, and may reduce the time required to reach remission and recovery. Although its application has limitations, future research may provide useful insight for the formulation and implementation of interventions that MHCCs believe to be effective. Knowledge of religious and cultural systems is of critical importance to mental healthcare providers, as its prudent and appropriate incorporation may contribute towards a more fulfilling therapeutic interaction to both patient and practitioner. Furthermore, the findings support the importance of psychosocial interventions and strengthening of family and social support structures of the mentally ill.
The implementation of a conceptualisation model that comprises biological, psychological, social and spiritual factors, and integrates recent biomedical advances, patients’ perceptions, social support systems and cultural and religious beliefs, will ensure the development of management plans suitable for specific individuals.

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References

Ally, Y. (2010). Somatic and psychological influence of bewitchment and spirit possession: Exploring differing health beliefs with South African Muslim medical practitioners. *New Voices in Psychology, 6*(1), 17–33. Retrieved from http://journals.co.za/content/unipsyc/6/1/EJC112610

American Psychiatric Association (APA). (2013a). *Diagnostic and statistical manual of mental health disorders* (5th ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association (APA). (2013b). *Cultural formulation interview*. Retrieved from https://www.psychiatry.org/ ... /DSM/APA_DSM5_Cultural-Formulation-Interview.pdf

Baumann, S. (2010). The problematic neglect of phenomenology in contemporary psychiatry. *South African Journal of Psychology, 16*(4), 114–116. Retrieved from https://www.sajp.org.za/index.php/sajp/article/download/279/233

Beuster, J., & Schwär, G. (2005). The South African Traditional Belief Scale as an instrument to aid culture-congruent health care. *Health SA Gesondheid, 10*(4), 29–40. Retrieved from https://www.ajol.info/index.php/hsa/article/view/10320

van der Merwe, M. (2015, July 15). Psychiatry in distress: How far has South Africa progressed in supporting mental health? *Daily Maverick*. Retrieved from https://www.dailymaverick.co.za/article/2015-07-15-psychiatry-in-distress-how-far-has-south-africa-progressed-in-supporting-mental-health/#.WikVjkqWblU

Department of Health, Republic of South Africa. (2012). *National mental health policy framework and strategic plan 2013–2020*. Retrieved from http://www.health.gov.za/index.php/shortcodes/2015-03-29-10-42-47/2015-04-30-08-29-27/mental-health?download=612:national-mental-health-policy-framework-and-strategic-plan-2013-2020

Grobler, C., Weiss, E. A., Lebelo, E., & Malerotho, E. (2011). Culture, religion and psychosis – A case study from Limpopo province, South Africa. *African Journal of Psychiatry, 14*(3), 239–240. doi:10.4314/ajpsy.v14i3.8

Health Systems Trust (HST). (2015). Health systems trust health indicators: Health personnel – number of psychologists. Retrieved from www.hst.org.za/healthindicators

Herman, A. A., Stein, D. J., Seodat, S., Heeringa, S. G., Moomal, H., & Williams, D. R. (2009). The South African Stress and Health (SASH) Study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal, 99*(5 Pt 2), 339–344. Retrieved from https://www.ajol.info/index.php/samj/article/view/50764

Mkize, L. P., & Uys, L. R. (2004). Pathways to mental healthcare in KwaZulu-Natal. *Curationis, 27*(3), 62–71. http://www.rhap.org.za/wp ... /04/Pathways-for-mental-health-care-in-Kwa-Zulu-Natal.pdf
Ramlall, S. (2012). The Mental Healthcare Act no. 17 – South Africa. Trials and triumphs: 2002–2012. *African Journal of Psychiatry, 15*(6), 407–410. doi:10.4314/ajpsy.v15i6.49.

Seedat, S., Stein, D. J., Herman, A., Kessler, R., Sonnega, J., Heeringa, S., … Williams, D. (2008). Twelve-month treatment of psychiatric disorders in the South African Stress and Health Survey (World Mental Health Survey Initiative). *Social Psychiatry and Psychiatric Epidemiology, 43*(11), 889–897. doi:10.1007/s00127-008-0399-9.

South African Government. (2008). No. 22 of 2007: Traditional Health Practitioners Act, 2007. *Government Gazette, 511*(30660), 1–25. Retrieved from http://www.gov.za/sites/www.gov.za/files/a22-07.pdf

Statistics South Africa (SSA). (2016a). Mid-year population estimates 2016: Statistical release P0302. Retrieved from https://www.statssa.gov.za/publications/P0302/P03022016.pdf

Statistics South Africa (SSA). (2016b). General Household Survey 2015: Statistical release P0318. Retrieved from https://www.statssa.gov.za/publications/P0318/P03182015.pdf

Stott, N. C., & Browne, W. M. (1973). Do witchdoctors practice clinical pattern recognition? *South African Medical Journal, 47*(8), 334–335. Retrieved from http://archive.samj.org.za/1973%20VOL%20XLVII%20Jan-%20Jun/Articles/02%20February/4.26%20DO%20WITCHDOCTORS%20PRACTISE%20CLINICAL%20PATTERN%20RECOGNITION%20Nigel%20C.H.%20Stott.pdf

Weiden, P., Rapkin, B., Mott, T., Zygmunt, A., Goldman, D., Horvitz-Lennon, M., & Frances, A. (1994). Rating of Medication Influences (ROMI) Scale in schizophrenia. *Schizophrenia Bulletin, 20*(2), 297–310. doi:10.1093/schbul/20.2.297

World Health Organization (WHO). (1998). *WHOQOL and spirituality, religiousness and personal beliefs (SRPB): Report on WHO consultation*. Geneva: WHO.