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# **The Knowledge, Attitudes and Perceptions of General Assistants towards mentally ill patients in Psychiatric Hospitals in Cape Town in the Western Cape**

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UNIVERSITY of the  
WESTERN CAPE

**A mini- thesis in partial fulfilment of the requirements for the degree of Masters in  
Advanced Psychiatry in the Department of Nursing in the Faculty of Community  
Health Sciences**

**University of the Western Cape**

**Supervisor: Dr S. Arunachallam**

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## **Keywords**

Attitudes

Mental illness

Mental health

Basic mental health knowledge

Stigma

Discrimination

Mentally ill patients

Perceptions

Stigmatisation

General assistants

Psychiatric Hospital

Mental health literacy



## **Abstract**

The current debate on knowledge, attitudes and perceptions of medical staff and the broader community towards mentally ill patients across the world is also quite extensive in South Africa. The literature on the subject matter demonstrates poor knowledge of mental illness in the general population and also indicates that people often have stigmatising attitudes towards mental illness. However, while most studies have explored the attitudes, perceptions and behaviour towards mentally ill patients with respect to various staff categories such as doctors, nurses, pharmacists, psychologist and the community globally and particularly in Sub-Saharan Africa, few studies have extended the analysis to include general assistants. Moreover, little research has been carried out on the knowledge, attitudes and perceptions towards mental illness and mentally ill patients of non-medical staff such as general assistants, who on a daily basis spend time with mentally health care users, ensuring hygiene in psychiatric hospitals in South Africa.

This study intended to fill the gap by using a quantitative, descriptive approach encompassing a cross-sectional survey design to identify the level of basic mental health knowledge and determine attitudes and perceptions of general assistants towards mental illness and mentally ill patients in four government funded psychiatric hospitals in Cape Town, South Africa. A random sample of 124 was selected from the general assistants of the four psychiatric hospitals in Cape Town.

The results established that the majority of General Assistants (75.6%) in all four psychiatric hospitals demonstrated fair basic mental health knowledge pertaining to mental illness and positive attitudes and perceptions towards mentally ill patients. Although the attitudes and perceptions are mostly positive, item analysis revealed that there are disparities in the results. One third of the general assistants find it stressful to work with mentally ill people. Others displayed frustration (30,1% ), mistrust (52%) and fear(12%). In addition, 82.9% of the general assistants like working with mentally ill people and the majority of the general assistants are comfortable working with mentally ill patients. The recommendation is that basic mental health awareness programmes or in-service training should be implemented for general assistants especially newly appointed general assistants to improve the knowledge and understanding, attitudes and perceptions of general assistants and to reduce fear and negative perceptions and attitudes in order to enhance positive patient experiences.

## **Declaration**

I declare that “The Knowledge, Attitudes and Perceptions of General Assistants towards mentally ill patients in Psychiatric Hospitals in Cape Town in the Western Cape is my own work, that is has not been submitted for any degree or examination in any order university, and that all sources I have used or quoted have been indicated and acknowledged by complete references.

**Lorraine Theresa Beukes**

15 May 2014



Signed.....

## Dedication

I would like to dedicate my thesis to my Loving Mom, Johanna Beukes who sacrificed herself, and who unselfishly gave her best throughout my upbringing and to the rest of my family as well, especially my nieces Inge, Makyala and Khloee-Lee Beukes.

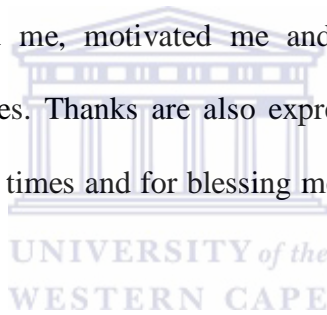


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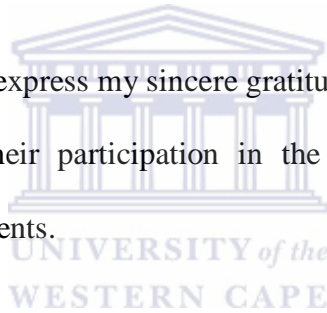
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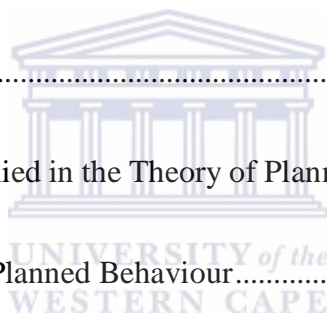
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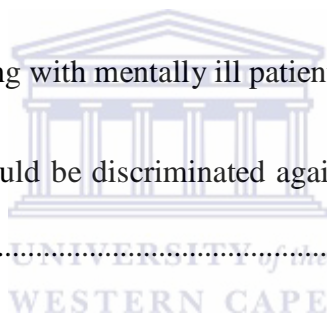
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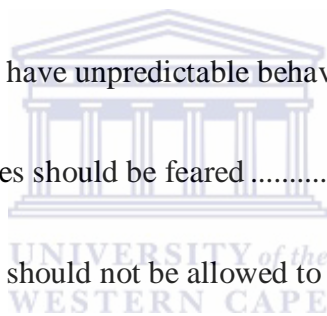




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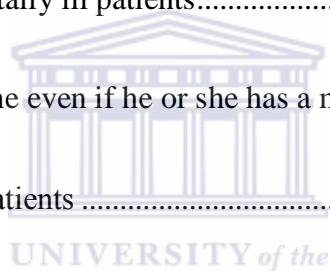
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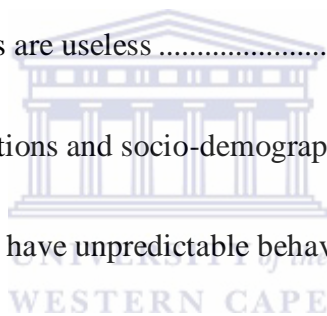
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## Acronyms

A : Agree

ANOVA : Analysis of Variance

D : Disagree

df : Degree of Freedom

F : Fishers Exact Test

KAP : Knowledge, Attitudes and Perceptions

KMO : Kaiser Meyer- Olkin measure

N : Population

n : Sample size, frequency

NAD : Neither agree nor disagree

NCCAH : National Collaboration Centre of Abnormal Health

Pt : Patient

P-value : probability of accepting/rejecting null hypothesis

r : coefficient of correlation

SA : Strongly Agree

SD : Strongly Disagree

VIF : Variation inflation factor

WC : Western Cape





WHO : World Health Organisation

$\chi^2$  : Chi-square test



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# **Chapter I: Introduction**

## **1.1 Introduction**

This introductory chapter provides an overview of the study. It begins with the background and rationale of the study, followed by the research problem statement, aim and objectives, and research questions that the study intends to answer. Thereafter, the significance of the study is discussed and the definitions of key concepts related to the study are provided. The chapter concludes with a chapter outline and remarks.

## **1.2 Background and rationale**

According to the World Health Organisation's report (2001: 5-34), mental and behavioural disorders affect about 25% of the world's population at some point in their lives. The World Health Organization (WHO) also reported that mental and behavioural disorders are present at any time in about 10% of the world's adult population, with the potential of causing massive disruptions in the lives of those affected and their families (WHO 2001: 5-34).

Despite the fact that mental illness and mental health care awareness programmes have been implemented extensively over the past few decades, mentally challenged patients are still mocked, ostracised, labelled, ill-treated and misunderstood by the greater community, family and at times health care personnel (Ukpong & Abasiubong, 2010:56). Stigmatisation, prejudice and alienation are some of the challenges that mentally ill patients face on a daily basis (Ukpong & Abasiubong, 2010:56). In addition, studies indicate that large populations have negative attitudes and beliefs towards mentally ill patients, usually stemming from the fact that lay people, generally, have poor knowledge regarding mental illness (Nordt, Rossler & Lauber, 2009:709; Barke, Nyarjo & Klecha, 2011: 1191; Sadik, Bradley, Al-Hasson & Jenkins, 2010: 26). Due to lack of knowledge, insight, misperceptions, false beliefs and

myths relating to mental illness, some societies believe that mentally ill patients are bewitched; as a result, mentally ill patients are often treated as outcasts or mad people (Bener & Ghuloum, 2011:157; Barke, Nyarjo & Klecha, 2011: 1191; Chikaodiri, 2009:19; Ukpong & Abasiubong, 2010:57). Lack of knowledge also causes people to fear mentally ill patients, regarding them as dangerous and unpredictable (Chikaodiri, 2009:19).

In the past twelve months, various complaints were lodged by mentally ill patients, from different departments in a psychiatric hospital in the Western Cape, that they were being mocked, ridiculed, labelled and discriminated against in the hospital. These complaints are similar to the findings of Botha, Koen and Niehaus (2006: 621) who investigated the perceptions of patients suffering from schizophrenia towards the community's attitudes in Cape Town. The complaints that were highlighted in Botha *et al* (2006:621) include the finding that the clients were discriminated against and that they were stigmatised. The complaints were expressed verbally, in writing and through quality assessment forms. Some mentally ill patients indicated that they were unhappy because of the way they were treated and labelled in the psychiatric units. It is, however, unclear which category of staff display such negative behaviour and attitudes towards mentally ill patients.

General assistants form part of the hospital support personnel and deal with mentally ill patients on a daily basis. They perform supportive functions in the psychiatric hospitals and are responsible for the provision of food and enhancing the cleanliness of the facility. Consequently, they are in direct contact with mentally ill patients on a daily basis.

They mostly work under direct supervision of nurses and registered nurses within the psychiatric hospitals. The post requirements and criteria for general assistants require them to be able to read and write, they must be able to work shifts and consist of good interpersonal and communication skills. The job description of the general assistants does not require any



knowledge of mental illness, but it is advantageous for them to have some form of basic mental health knowledge or mental health literacy.

## **Rationale**

Knowledge regarding mental illness and the symptoms of mental disorders might give participants an understanding of the behaviour and symptoms that mentally ill patients display. Basic mental health knowledge and literacy could enable general assistants to gain an understanding of the behaviour and symptoms faced by mentally ill patients. This might enable them to perceive patients better and ultimately ensure that they display more positive attitudes towards mental health patients. It will also enhance the positive patient care experiences of patients in the hospitals and quality care. Basic mental health knowledge focuses on elementary mental health knowledge and beliefs about mental disorders which aid their recognition of mental disorders.

The principal objective of psychiatric institutions is to enhance patient-centred care approaches to achieve positive patient experiences. Nevertheless, based on the complaints filed by patients against staff of various psychiatric hospital indicate that this goal is far from being achieved. This study was set in the Western Cape because a study exploring the knowledge, attitudes and perceptions of general assistants in psychiatric hospitals in the same region was not found after an extensive literature search.

In order to enhance positive patient experiences and to combat complaints such as negative attitudes in psychiatric facilities, it is essential that I explore the knowledge, attitudes and perceptions of general assistants towards mentally ill patients. The results emanating from this study could enable me to determine if general assistants are displaying negative attitudes towards mentally ill clients since it is not known who displays negative attitudes towards mentally ill patients as reported in some of the feedback from clients.

### **1.3 Research problem statement**

In Sub Saharan African countries few studies have been conducted in recent years on the knowledge, attitudes and perceptions of community members and health care workers towards mentally ill patients (Barke *et al.*, 2011:1191-1202; Chikaodiri, 2009:19-26). The aforementioned studies indicated that people with higher education tend to have more knowledge and positive attitudes towards mentally ill patients (Ndetei, Khasakhala, Mutiso & Mbwayo, 2011: 234). A large group of health care providers, hospital staff as well as support staff have been included in past and recent studies on knowledge and attitudes of health care workers towards mental illness, yet there are no published studies that explore the knowledge attitudes, perceptions or behaviour of general assistants working in psychiatric hospitals in South Africa (Kapungwe, Cooper, Mayeya, Mwanza, Sikwese, Lund & Mental Health Poverty Project Research Consortium, 2011:290; Minas, Zamzam, Midin & Cohen, 2011:317).

Furthermore, the outcomes and results of recent patient satisfaction surveys and patient complaints reveal that some patients experience labelling, discrimination, negative attitudes as well as stigmatisation in one of the psychiatric hospitals. It is, however, not clear whether the general assistants have negative attitudes towards mentally ill patients. In addition, little is known regarding knowledge, attitudes and perceptions of general assistants. This study, therefore, is aimed to identify and determine the knowledge, attitudes and perceptions of general assistants in four selected psychiatric hospitals in Cape Town.

### **1.4 Research Aim**

The aim of the research was to investigate the level of basic mental health knowledge, attitudes and perceptions of general assistants towards mentally ill patients in four tertiary Psychiatric hospitals in the Western Cape.

## **1.5 Objectives**

The objectives of the research were to:

- 1.4.1 Evaluate the level of basic knowledge of general assistants pertaining to mental illness.
- 1.4.2 Explore the attitudes of general assistants about mentally ill patients in psychiatric hospitals.
- 1.4.3 Explore the perceptions of general assistants towards mental illness and mentally ill patients.
- 1.4.4 Apply and test the theory of planned behaviour to the study to determine the suitability of the framework within this current study.

## **1.6 Research questions**

- 1.5. 1 What is the level of basic mental health knowledge of general assistants regarding mental illness?
- 1.5.2 What are the perceptions of general assistants on mentally ill patients and mental illness?
- 1.5.3 What are the attitudes of general assistants towards mentally ill patients in psychiatric hospitals in the Western Cape?

## **1.7 Significance of the study**

Various studies have indicated that negative attitudes, prejudice, stereotyping and discrimination towards persons with mental illness occur globally (Barke *et al.*, 2011:1191; Arvaniti, Samakouri, Kalamara, Bochtsou, Bikos & Livaditis, 2009:658; Nordt, Rössler & Lauber, 2009:709). It is, however, important that the current situation be changed in order to enhance and embrace positive patient care experiences and to reduce the prevalence of the

negative attitudes towards mentally ill patients. Studies have also shown that lack of knowledge regarding the manifestation of mental illnesses has a role to play in the perception of individuals towards mentally challenged patients. It is expected that provision of basic mental health knowledge regarding mental illness will improve knowledge, attitudes and perceptions of general assistants regarding mental illness and mentally ill patients. This indicates the need for in-service training for general assistants regarding mental health literacy.

The results of the study could contribute to the body of knowledge on the general assistants' attitude towards mental illness. Moreover, it might enable policy-makers to formulate training guidelines on the management of mentally ill patients and mental illness, and might also contribute to the implementation and initiation of relevant study programmes. Furthermore, the results of the study might enable nurse managers to implement training programmes for general assistants regarding basic mental health literacy in the psychiatric hospitals and psychiatric nursing units.

### **1.8 Research methodology**

A quantitative descriptive research method was used in the study employing survey method and a cross-sectional design to explore knowledge, attitudes and perceptions of general assistants towards mental health service users. The sample size constituted of 124 participants and a semi structured questionnaire was used to gather data on knowledge, attitudes and perceptions of general assistants towards mentally ill patients. The data were analyzed using Excel and SPSS version 21. The findings were presented by means of tables, frequency tables, and graphs. More details can be found in Chapter 3 of the study.

## 1.9 Definition of keywords

**Attitudes:** Refers to a quality or characteristic which might be viewed as a positive or negative evaluation of people, objects, event, activities and ideas (Das & Phookun, 2013:98).

**Mental illness:** Refers to a positive diagnosis of a psychiatric illness and disease as classified by the International Classification of Disease (ICD 10) and the Diagnostic and Statistical Manual of Mental Disorders (DSMVI) criteria for psychiatric disorders (Yeap & Louw, 2009:1169).

**Mental health:** This is the state of complete physical mental and social well being, in which a person is simultaneously successful at working, loving and resolving conflicts by coping and adjusting to the recurrent stressors of everyday living (Yeap & Louw, 2009:1169).

**Basic Mental health knowledge:** This describes knowledge and beliefs about mental disorders, which aid in their recognition, management or prevention.

**Stigma:** This is an attribute of an individual that makes him different from others and of a less desirable kind-in the extreme, a person who is quite thoroughly bad, or dangerous, or weak (Das & Phookun, 2013:99).

**Discrimination:** Is defined as the prejudicial or distinguishing treatment of an individual based on his or her membership - or perceived membership - in a certain group or category. It is also seen as the manner in which a person is treated intentionally and unintentionally as a result of stigma (Dako- Gyeke & Asumang, 2013:1).

**Mentally ill patients:** Refers to patients who suffers from a mental illness and who receive mental health care, rehabilitation, treatment and support.

**Perception:** Is the organisation, identification and interpretation of sensory information in order to represent and understand the environment (Das & Phookun, 2013:99).

**Stigmatisation:** Is viewed as the assignment of negative perceptions to an individual due to perceived differences from others on the basis of physical appearance or various other qualities. Stigma is also defined as an unpleasant phenomenon and sign of disgrace or dishonour in which a person is perceived different from other. (Dako- Gyeke & Asumang, 2013:1).

**General assistants:** Refers to the category of workers that are responsible to fulfil general tasks such as cleaning, cooking and promoting hygiene in the various departments, including the wards in the psychiatric hospitals.

**Psychiatric Hospital:** Refers to hospitals that provide specialised psychiatric, care, treatment and rehabilitation for mentally ill clients.

**Mental Health literacy:** Mental health literacy consist of (a) the ability to recognise specific disorders; (b) knowledge and beliefs about risk factors and causes (c) knowledge and beliefs about self-help interventions; (d) knowledge and beliefs about professional help available; (e) attitudes which facilitate recognition and appropriate health seeking and (f) knowledge of how to seek mental health information(Jorm, 2000:396).

## **1.10 Chapter outline**

The study consists of six chapters. Chapter 1 constitute the Introduction. Chapter 2 contains the literature review while Chapter 3 consists of the theoretical framework. Chapter 4 and Chapter 5 deal respectively with the methodology and the results of the study, while Chapter 6 contains discussions, conclusion and recommendations.

## **1.11 Conclusion**

This chapter has provided a brief overview of the background and rationale as well as the research problem statement, aims, objectives, research questions, the significance of the study and definition of keywords. Furthermore, the outline of the study has also been provided. The following chapter provides the literature review in relation to knowledge, attitudes and perceptions towards mental illness.



## Chapter 2: Literature Review

### 2.1 Introduction

Extensive research has been conducted in developed countries on the attitudes of staff members working in psychiatric and general hospitals towards mental illness, disability; and knowledge, attitudes and perceptions of health care workers towards mentally ill clients. The findings of the research displayed that the attitudes and knowledge of health workers in psychiatric hospitals are better compared to the counterparts in general hospitals (Des Courtis *et al.*, 2008:503-509; Sui *et al.*, 2012:18-24; Stone & Merlo, 2011:134). Researchers explored knowledge, attitudes and perceptions of different staff categories: doctors, nurses, psychologists, medical students, case managers and pharmacists (Arvaniti, Samakouri, Kalamara, Bochtsou, Bikos & Livaditis, 2008:658; Chikaodiri, 2009:1; Bellver, Martinez-Raga, Moreno & Salar Ibanez, 2010:1; Howard & Holmshaw, 2010:882).

In a comparative study between mental health and non mental health personnel in Lincolnshire- UK, Gateshill *et al.* (2011:101) found that non mental health care workers regard mentally ill patients as being dangerous and unpredictable. However, the emotional empathy and attitudes displayed by both mental and non mental health care workers are similar. Similarly, a host of studies have also emphasised community and public attitudes towards mental illness and mentally ill clients in both developing and developed countries (Ndeti *et al.*, 2011:225; Ewhrudjakpor, 2009:24; Kapungwe *et al.*, 2011:290). After a comprehensive search of various databases such as Medline, Pub med, Ebscohost, websites, library and inter-library searches, between 2011 and 2014, it was found that there is a paucity



of information, and studies conducted around knowledge, attitudes and perceptions of general hospital assistants towards mental illness and mentally ill. The words mental illness, knowledge, attitude, perception, mental illness and work, general assistants and support staff were employed during the literature search.

This chapter provides an overview of the prevalence of mental illness and explores literature around knowledge, attitudes and perceptions of health care workers; support staff and the general public towards mental illness and mentally ill patients.

The literature review is discussed under the following headings:

- An overview of the prevalence of mental illness
- Knowledge about mental illness
- Attitudes towards mental Illness and mentally Ill Patients
- Perceptions towards mental Illness
- Stigmatisation of mentally ill patients
- Discrimination against mentally ill patients
- Beliefs and myths regarding mental illness
- The relationship between knowledge, attitudes and perceptions (KAP) of mental illness and work experience
- Mentally ill patients and work
- Conclusion

## **2.2 An overview of the prevalence of mental illness**

Mental illness is currently one of the greatest burdens of diseases globally, affecting almost every society. Despite the level of awareness creation about mental illness around the world, research conducted on mental illness demonstrates that its acceptance among the general

population still remains a challenge (WHO, 2013:6-50). This chapter provides an overview of the prevalence of mental illness globally.

According to WHO (2001:5-8), approximately 1 out of 4 (25%) of the adult population globally is exposed to mental illness some time during their lifespan. WHO (2001:5-8) states that there are four principal mental illnesses associated with years lived and disabilities. These illnesses include amongst others; depression, alcohol abuse disorders, schizophrenia and bipolar mood disorder. Interestingly, in America 81.6 million people present with a mental illness per year while in Sub-Saharan Africa the data is unknown due to the application of inappropriate statistical methods to investigate the phenomenon (Funk, Drew & Freeman, 2010: XXI-XXII).

Bradshaw, Norman and Schneider (2007:438), suggested that neuropsychiatric disorders are the third greatest burden of diseases in South Africa. The same study indicated that one out of every six South Africans present with signs or symptoms of depression, anxiety or substance abuse. Furthermore, it is stated in a Mental Health Atlas report that neuropsychiatric disorders that contribute to the global burden of disease in South Africa are approximately 5.9% (WHO, 2011:4).

In line with Bradshaw, Norman and Schneider's (2007:438) observations, Herman, Stein, Seedat, Heeringa, Moomal and Williams (2011:399) further indicate that the lifetime prevalence of any mental illness in South Africa is 30.3%. Furthermore, they discovered that the most prevalent disorder in South Africa was anxiety disorders with 8.1% of the population affected, followed by substance abuse disorders (5.6%) and thirdly mood disorders with 9.8%. The findings also indicate that the most common disorders were depression, alcohol abuse and agoraphobia.

In comparing the prevalence of mental illness among the nine provinces of South Africa, the Western Cape Province reported the highest prevalence with 42% of the inhabitants affected, whilst the Northern Cape recorded the lowest prevalence with only 29% (Herman *et al.*, 2011:399). These figures have the potential of rapidly increasing in the Western Cape due to the high incidence of drug, substance abuse, on-going gang violence, gender-based violence and poverty.

Vices such as drug and substance abuse, gang violence and gender-based violence undeniably increase the burden of mental illness on the society as a whole. Not only do mental illnesses place a burden on the carers, family, community, health, social sector and the national health care budget, they also weigh on the psychiatric institutions (Patel, Flisher, Hetrick & McGorry, 2007:1302). Mental illnesses also affect people regardless of their ethnicity, colour, gender, socio-economic status and age.

Despite the progress that have been made towards the treatment and management of mental illnesses over the years; people who suffer from mental illnesses are still ostracised, discriminated against and ill-treated. Literature also identifies that, in most instances, people display negative attitudes towards mentally ill patients (Minas; *et al.*, 2011:317; Ewhrudjakpor, 2009:19).

Moreover, it is evident that the mental health knowledge or mental health literacy amongst the general population is still poor (Bener & Ghuloum, 2011:157). Despite the fact that various methods and strategies have been implemented to enhance mental health awareness such as awareness campaigns, mental health promotion activities through the media and television as well as anti- stigmatisation programmes, significant change has not been observed in the situation. In light of the above, this study aimed to shed light on knowledge,

attitudes and perceptions of general assistants towards mentally ill patients, in the Western Cape.

The following sections explore knowledge, attitudes and perceptions of general assistants in relation to their socio-demographic variables. This is because knowledge, attitudes and perceptions can be influenced by factors such as ethnicity, religion, age, gender, work experience and culture (National Collaboration Centre of for Abnormal Health, 2009:1; Chaudhury & Minas, 2011:1; Adewuya & Oguntade, 2007:931).

## **2.3 Knowledge on mental illness**

### **2.3.1 Knowledge on mental illness in Asian Countries**

Research conducted in Qatar indicates that the level of mental health knowledge and mental health literacy amongst members of the public is very poor (Kabir *et al.*, 2004:3; Bener & Ghuloum, 2011: 157). The findings in the aforementioned studies indicate that the knowledge of the public regarding the aetiology of mental illness is poor. The study conducted by Bener and Ghuloum (2011:157) focused on ethnic disparities in knowledge, attitudes and beliefs towards mental illness. This study, however, does not indicate whether the participants in the studies received some form of training related to mental illness. Bener and Ghuloum (2011:164) support the claim that ethnicity has an impact on the knowledge, attitude and practices of the general population of Arabs. Furthermore, they also proved that Arabs in Qatar have very poor knowledge about mental illnesses. This could be attributed to the various myths about mental illnesses among various ethnic groups indicating why different communities would perceive mental illness differently.

Van der Ham *et al.* (2011:574), in an explorative study conducted in Vietnam, found that the participants in the study were unable to identify and name the different mental illness and the

results also attribute stress and studying to be causes of mental illness. Lack of knowledge in terms of mental illness was also discovered and it was suggested that this might have been influenced by cultural and moral views pertaining to mental illness. Furthermore, the study also demonstrated that the perceptions of the adults in this study is negative, related to lack of knowledge and cultural beliefs. Negative attitudes were displayed towards persons with alcohol disorder but interestingly the results in this study indicated that the participants who practiced Buddhism as a religion and those who were found to have less knowledge had positive attitudes towards mentally ill persons.

Some investigators concluded that negative attitudes, discrimination and stereotyping are related to lack of knowledge relating to mental illness (Gateshill *et al.*, 2011:101; Gureje, Olley & Kola, 2006:104).

Pande, Saini and Chaudhury (2011:17) support the view that higher literacy levels are associated with more positive attitudes towards mental illness. They found that participants who were literate had positive feelings towards mental illness while those who were less literate expressed negative feelings towards mental illness. Pande *et al.* (2011:18) reported that despite the fact that the non-psychiatric health professionals in Chandigarh possess high awareness levels of mental illness, they still perceive mentally ill patients as less significant than others and they also express a lot of bias towards mental illnesses.

Wolff *et al.* (1996) in Pande, Saini and Chaudhury (2012:18) indicated that although the Hong Kong population are well informed and knowledgeable about mental illness, they still displayed negative attitudes towards mentally ill patients. Based on the evidence gathered from the literature, the investigator is of the opinion that irrespective of the level of education, people still possess the propensity to stigmatise and discriminate against mentally ill patients.

A study conducted in West India in Jalgaon, Maharashtra, which focused on knowledge and attitudes of adults in the rural and urban areas of Jalgaon, suggested that there is a distinct difference between the rural and urban adults as 78% of the rural participants demonstrated poor knowledge while their urban counterparts 82% indicated that they have good knowledge pertaining to mental illness. The study showed a strong correlation between knowledge and attitudes of the participants in the study and also a strong association between knowledge and demographic variables: education and economic status. This study however does not indicate whether the participants in the study underwent previous training regarding mental illness (More, Jadhav, Puranik, Shinde & Pakhale, 2012:5).

In addition, More *et al.* (2012:5) supports the view of Ganesh (2011:178) and suggested that the knowledge on mental illness amongst the general public in South India was poor. Some of the participants in the study conducted by Ganesh could mention a few mentally ill disorders. However, the knowledge pertaining to the causes of mental illness was poor and many of the participants alluded mental illness to punishment from God. Furthermore, knowledge regarding treatment modalities was also poor. Male counterparts had better knowledge than their female counterparts (Ganesh,2011: 178).

A study conducted in Malaysia by Yeap and Louw (2009:1169) involving 720 participants revealed that the knowledge of the participants pertaining to mental illness was very low but the study also revealed that there are statistical significant differences between knowledge and variables such as ethnic background, religion, educational background and their geographical location.

The findings of research studies are mixed because some researchers support the view that high levels of education result in knowledge in mental illness while other researchers indicate

that regardless of the level of education, knowledge of mental illness remain poor (Yeap and Louw, 2009:1169, Pande, Saini and Chaudhury, 2011:17).

A study conducted by Cowan, Raja, Naik and Armstrong (2012:21) in India that explored knowledge and attitudes of doctors in Karnataka revealed that a third of the 58 participants never had training relating to mental health and some of the participants in the study who had training indicated that the training they received was less than two weeks. Interestingly, the doctors in the study were able to identify signs and symptoms of depression and the majority of the participants could only name 2 out of 3 symptoms of schizophrenia. Interestingly, the majority of the doctors who never had training related to mental illness, those doctors in private practice and those who did not feel competent to treat mentally ill patients, expressed negative attitudes towards certain aspects and felt that mental health problems is a sign of personal weakness and that it is difficult to work with mentally ill patients.

Das in Phookun (2013:100) revealed that caregivers in rural areas had better knowledge while the urban caregivers revealed better attitudes towards mental illness. Studies in Japan indicated that the participants in Japan had lack of knowledge concerning schizophrenia. Furthermore, the majority of the studies indicated that the public participants attributed mental illness to interpersonal relationships, problems with relations, nervousness and weakness rather than biological factors. The study was conducted as a literature review in the studies conducted in Japan that focused on mental health stigma. The researchers reviewed 19 studies which were retrieved from Medline and PsycINFO since 2001, and the studies either focussed on the public's stigmatisation as well as knowledge, attitudes and behaviour of the public towards mental illness. A study conducted in the Qatar, indicate that the level of mental health knowledge and mental health literacy amongst members of the public is very poor (Bener & Ghuloum, 2011: 157).

Therefore, it cannot be conclusively said that there is a clear relationship between literacy levels and knowledge of mental illness because the majority of the studies conducted focused on the general public's knowledge pertaining to mental illness.

### **2.3.2 Knowledge on mental illness in America**

Research conducted in America, to determine knowledge, attitudes and perceptions of various groups of people towards mental illness and mentally ill patients, demonstrate that the general public attribute mental illness to stress, family related matters and biological factors such as trauma to the brain, illicit drug use, dysfunction of the brain and vulnerability to mental illness (Gateshill *et al.*, 2010:104). These findings were found amongst mental- and non mental health professionals. However, a study which involved African American woman postulates that the participants attribute the causes of mental illness to stress, family and work related matter (Ward & Heidrich, 2009:482). According to the 2010 Mortality and Morbidity Weekly Report conducted in 35 states in the district of Columbia and Puerto Rico, the Behavioural Risk Factor Surveillance System (BRFFS) report conducted in 2007, revealed that 88.6% of the participants agreed that treatment can help mentally ill patients to live normal lives and the majority of the participants are of the opinion that treatment for mental illnesses is effective.

According to the CDC (2012:3), about 26.2% of the adult population in America present with mental illness in their lifetime. Furthermore, the CDC (2012:3) also indicated that the attitudes and beliefs about mental illness are often related to people's knowledge pertaining to mental illness, cultural stereotypes, media and also other factors. Various other factors that might influence knowledge include peoples' age, religion, ethnicity and familiarity with mental health and health services. The report also affirms that the behaviour displayed



towards mental illness can be related to their attitudes and perceptions; and it also links the findings to Ajzen and Fishbein's theory of planned behaviour (CDC, 2012:5).

Besides the studies that involved general public, studies were also conducted on the knowledge, attitudes and perceptions involving church members and pastors. Studies involving Vietnamese American Buddhist leaders postulate and attribute mental illness to daily stressors, karma, mind- body stressors, mind body imbalance, virtuous deeds and spiritual possessions. However, in contrast with the Buddhist leaders, Stanford and Philpot (2009:284-185) in their study involving pastors in Texas, America revealed that the pastors displayed moderate knowledge on mental illness, they also have moderate exposure to mentally ill people and attribute the causes of mental illness to biological factors as well as psychological and even some spiritual factors. The pastors involved in the study were in the possession of honours, master's and doctoral degrees and this could be due to the fact that the pastors appeared more knowledgeable and also had better attitudes towards people with mental illness (Quinn, Laidlaw & Murray, 2009:33-45; Barke *et al.*, 2010:1191; Des Courtis *et al.*, 2008:505).

Barke *et al.* (2010:1191) revealed that knowledge and understanding pertaining to mental illnesses results in more positive attitudes toward mental illness and mentally ill patients in some instances. Studies conducted by Des Courtis *et al.* (2008:505) and Gatheshill *et al.* (2011:104) indicate that familiarity of patients with mental illness and knowledge about mental illness does imply that more positive attitudes are displayed towards mental illness (Barke *et al.*, 2010:1191). These views are in contrast with the views of other researchers who revealed that despite the participants' knowledge regarding mental illness, participants' attitudes are still negative (Bener & Ghuloum, 2011: 157).

Gateshill *et al.* (2011:104) in a study that focussed on the attitudes of health workers and mental health workers revealed that the participants attribute biological and psychological factors to the causes of mental illness.

### **2.3.3 Knowledge on mental illness in studies conducted in European and Australian countries**

According to Reavley and Jorm (2011: 1-175), a national survey and systematic review in Australia which investigated mental health literacy and stigma, revealed that surveys have been conducted on national level to investigate mental health literacy and stigma. Community members, psychiatrists and psychologists have been included in these studies and vignettes have been presented with different mental health care problems which participants had to identify. The results of the survey reveal that the majority of the participants would seek help if they present with mental health problems such as depression and PTSD. Furthermore, the results also reveal that the majority of the participants perceived mentally ill people as unpredictable and the majority of the participants were also able to identify the different mental illnesses described in the vignettes. However, the recognition of schizophrenia was substantially lower. With regards to treatment, the participants indicated that they'll seek help from a GP, psychologists, family and friends. Participants also viewed relaxation and physical activity as well as medication as treatment options. The participants in this study can be regarded as having mental health literacy.

A survey conducted by Nordt *et al.* (2006:709) which explored the attitudes of the general public and mental health care professionals in Switzerland found that even though there is a distinct difference between health professionals and the general public with regards to their knowledge, attitude and perceptions on schizophrenia, there is no difference in their responses relating to keeping social distance towards patients with schizophrenia. The results

of the study revealed that both the health professionals and general public reported the same level of social distance which is one of the greatest components of stigmatisation. However, the results also demonstrated that members of the general public with higher education levels displayed positive attitudes towards treatment possibilities. Interestingly, the study revealed that psychiatrists displayed more negative stereotypes than the general public and the rest of the participants despite their wealth of knowledge pertaining to mental illness. The study also revealed that the mental health care professionals have three times less restriction pertaining to mental illness than the general public which, in essence, means that their attitudes pertaining to social restrictions are better towards mental illness than the attitudes of the public (Nordt *et al.*, 2006:709). Despite the fact that health care professionals are highly expected to have more positive attitudes and less stigmatising behaviour towards mentally ill patients, it is hardly the case.

A mixed method study conducted by Quinn, Laidlaw and Murray (2009:40) in the United Kingdom suggests that older people have a more positive perspective towards mental illness. Quinn *et al.* (2009:40) were of the view that empirical research has suggested inconsistencies in terms of the results pertaining to the attitudes and perceptions of older people, hence the reason why they conducted a mixed method study to explore the attitudes of 79 elderly people from Old age psychiatry services and elderly forums. Their results indicated that negative attitudes toward mental illness were associated with negative attitudes towards aging. However, due to the small sample size, the results in this study cannot be generalised and regarded as all the views of older people. The knowledge of older people pertaining to mental illness was also not explored and it is, therefore, unknown as to whether or not the participants in this study have knowledge and or training regarding mental illness.

#### **2.3.4 Knowledge on mental illness in African Countries**

Sub Saharan Africa is known for its strong cultural beliefs which have the ability to influence the knowledge of people regarding mental illness (Ewhrudjakpor, 2009:19; Adewuya & Oguntade, 2007:932). Ewhrudjakpor (2009:19), in his study on knowledge, beliefs and attitudes, observe that despite the fact that the healthcare providers possessed a wealth of knowledge relating to mental illness, they still held on to their cultural beliefs. Furthermore, Adewuya and Oguntade (2007:932) also proved, in their study, that Nigerian doctors also had strong cultural beliefs, and the participants in the study regarded mentally ill patients as dangerous, unpredictable, and aggressive; and that mentally ill patients have a poor prognosis. Even though doctors in Karnataka possessed knowledge regarding mental illness, they are also of the opinion that mental illness is a sign of personal weakness, and they also have other negative attitudes towards mental illness. What is interesting in the last mentioned study is the fact that the results indicated that 30 percent of the PHC doctors never had in-service training regarding mental illness. Studies conducted in the Nigeria indicate that the level of mental health knowledge and mental health literacy amongst members of the public is very poor (Kabir *et al.*, 2004:3).

However, other studies that focused on the general public's knowledge revealed that the knowledge of community members are poor and researchers recommended that mental health promotion should be implemented (Chikaodiri, 2009:19; Kapungwe *et al.*, 2011:290). In addition, studies that identified similar gaps recommended programmes of enlightenment in which mental health literacy promotion and training should be established. (Chikaodiri, 2009:19; Kapungwe *et al.*, 2011:290).

Previous studies conducted in Cape Town also revealed poor knowledge about mental illness (Hugo *et al.*, 2003:715). Furthermore, both Hugo *et al.* and Botha *et al.* found that there are stigmatising attitudes towards mentally ill patients (Botha *et al.*, 2006: 622). Both studies

focussed on the broader community and, therefore, do not represent the views of general assistants or other health care workers.

It is often expected that people with higher levels of education would display more knowledge regarding mental illnesses and are, therefore, expected to have more positive attitudes toward mentally ill people and mental illness. This expectation is supported by the findings of Kabir *et al.* (2004:5) who discovered that there is a strong correlation between the level of education of people and their knowledge, attitudes and perceptions towards mental illnesses.

## **2.4 Attitudes towards mental illness and mentally ill patients**

An extensive amount of research has been conducted in developed countries on the attitudes of staff members towards mental illness and disability as well as on the knowledge, attitudes and perceptions of health care workers towards mentally ill patients (Des Courtis *et al.*, 2008:503-509; Sui *et al.*, 2012:18-24; Stone & Merlo, 2011:134). Some of these studies focus on the attitudes of various healthcare workers. The different health-care workers that were included in these studies ranged from nurses, doctors, students, support staff, case managers, pharmacists, students, and psychologists. A scrutiny of the literature shows that limited studies have been conducted on knowledge and attitudes of general assistants.

### **2.4.1 Attitudes towards mental illness in Asian Countries**

Cultural beliefs in Asian countries often attribute to the negative attitudes participants have towards mental illness and mental illness. Similar attitudes were also found amongst some studies conducted in Sub Saharan African countries where people have a strong cultural background and aetiological beliefs (Kapungwe, 2011:209; Chikaodiri, 2009:19; Li, Li, Thornicroft & Huang, 2014: 233). A study conducted by Li, *et al* (2014: 213) supports the

fact that Asian people have high levels of stigmatisation towards mental illness. This is even the case with the mental health care practitioners who were the target population within the study. They also argue that the Asian people may express greater stigma than their cultural counterparts in western countries. Sui *et al.* (2012:18-24) are of the opinion that the stigmatisation displayed towards mentally ill patients among the Chinese population is generally negative and discriminating. In Chinese societies, stigma related to schizophrenia is often associated with aetiological beliefs and it is also associated with cultural beliefs. Sui *et al.* (2012:18-24) are of the opinion that the attitudes displayed towards mentally ill patients among the Chinese is generally negative and discriminatory. In addition, a comparative study between the Australian and Japanese populations revealed that the Japanese show more negative attitudes towards mentally ill patients than Australians (Griffiths, Nakane, Christensen, Yoshioka, Jorm & Nakane, 2006:4).

In addition, Hamdan –Mansour and Wardan (2009:705) argued that the mental health nurses in Jordan demonstrate fairly negative stigmatising views towards the mentally ill patients and mental illness in general. The results indicate that Jordanian nurses perceive mentally ill patients as dangerous, unpredictable, dirty and pessimistic.

#### **2.4.2 Attitudes towards mental illness in American Countries**

According to the Centre of Disease Control (CDC, 2012:3), a person's perception and attitude towards mental illness influences how they treat, support and interact with mentally ill people. Furthermore, the Mental Health report of the CDC (2012:3) also indicate that the attitude and beliefs about mental illness are shaped by an individual's knowledge about mental illness, interaction with mentally ill people, cultural stereotyping and various other factors (Centre of Disease Control, 2012:3).

In a study conducted in the UK by Gates *et al.* (2011:103-105), it was found that both non-mental health professionals as well as mental health professionals have positive attitudes towards mentally ill patients. However, non-mental health professionals are of the opinion that mentally ill patients are unpredictable and dangerous.

A study conducted by Gray (2001:71-72) involving church attendees in the UK suggested that the participants s/he studied had less stigmatising attitudes towards mentally ill patients when compared with the general population in the UK. The study also revealed that the church congregation expressed concerns about the gravity and unpredictability of mentally ill patients. In contrast with the above, other religious groups perceive mentally ill people as demon possessed and in some instances religious people also interpret mental illness as a result of sin (Morrison & Thornton, 1999:443). In addition, religious beliefs may affect and impact negatively on knowledge, attitudes and perceptions people may have on mental illness and towards mentally ill patients.

Quinn *et al.* (2009:40-45) revealed that older people had more favourable perceptions towards mental illness. This finding is espoused by various other studies. For instance, Yamawaki, Pulsipher, Moses, Rasmuse and Ringger (2011:104) suggest that age is a predictor of the attitudes of Japanese toward mental health services. The study showed that older participants had more negative views and attitudes towards mental illness compared to their younger counterparts. This result is however in contrast with the findings of Currin, Hayslip and Temple (2011:317) because they found that the older people's perception was significantly positive.

Interestingly, another study conducted by Gateshill *et al.* (2011:101) shows that both mental health care workers and non-mental health care professionals display positive attitudes towards mentally ill clients. However, the same study indicates that even though the non-

mental health care professionals have positive attitudes towards mentally ill clients, some perceive the mentally ill clients as dangerous. These findings are similar to the findings of Nordt *et al.* (2006:709) which suggests that health care workers in the study showed more positive attitudes including empathy towards mental illness.

In a study conducted by Currin, Hayslip and Temple (2011:317), which investigate the relationship between age, gender, historical change and adult perceptions on mental health, the authors found out that the female participants in their study had more positive attitudes towards mental illnesses than their male counterparts. Yamawaki *et al.* (2011:103) supported the fact that women generally have more favourable and less stigmatizing attitudes towards mentally ill patients.

#### **2.4.3 Attitudes towards mental illness in European and Australian Countries**

A comparative study conducted in Brazil and Switzerland indicated that Brazilian mental health professionals had much more positive and favourable attitudes towards community psychiatry and mental illness. The Switzerland participants reflected and displayed more negative attitudes, stigmatisation and social distance towards mentally ill patients, but they also displayed more positive attitudes towards psycho-pharmacology (Des Courtis *et al.*, 2008:503). The study concluded that there are major differences in the attitudes of the Brazilians and the Switzerland health professionals towards mental health care users (Des Courtis *et al.*, 2008:503). Contrary to Des Courtis *et al.* (2008:503), Lauber, Nordt, Braunschweig and Rössler (2006:51) suggest that the mental health professionals in Swiss displayed stereotyping and indicated that in comparison with the general Swiss population, the mental health care professionals didn't have consistent negative nor positive stereotypes towards mental illness. Stereotypes that were displayed in this study were the fact that mentally ill patients are regarded as “dangerous”, “mad”, “unpredictable”, “weird”,



“bedraggled”. However, despite the negative stereotypes, there were also positive stereotypes such as creative, healthy, highly skilled. Lauber *et al.* (2006:55) also suggested that the stereotyping about mental illness is predicted or influenced by the professional background and it is also influenced by demographic details such as age, gender, professional and work related experience, to a lesser extent.

Bellver *et al.* (2010:1) conducted a study in which they explored stigmatising attitudes towards patients with mental illnesses amongst pharmacists and health care students and they uncovered that both groups had stigmatising attitudes towards mentally ill patients.

A national survey conducted in France which involved 1000 adults that explored knowledge, attitudes and perceptions towards schizophrenia, bipolar mood disorder and autism revealed that 95 % of the participants were able to name the different diseases while 70% were able to describe the characteristics of the illnesses. Furthermore, the same study revealed similar results than most studies which explored attitudes and perceptions of participants towards mental illness. Prejudice as well as stigmatisation was found; participants also viewed mentally ill people as dangerous and labelling of mentally ill patients was also prevalent in this study (Durand-Zaleski, Scott, Rouillon & Leboyer, 2012:128)

#### **2.4.4 Attitudes towards mental illness in African Countries**

Research in Sub Saharan African countries that explored knowledge, attitudes and perceptions of health care workers and health professionals indicated that negative attitudes are displayed by various health care staff categories including nurses, psychologists, pharmacists, academicians and students (Kapungwe, 2011:290; Chikaodiri, 2009:19). This could be due to the fact that cultural beliefs and myths regarding mental illness often have an impact on how mentally ill patients are perceived.

Chikaodiri (2009:19) states that in Nigeria, health care workers fear mental health users so much that they expressed fears about treating mentally ill patients in a general teaching hospital. These fears may also be related to the aetiological as well as cultural beliefs of the participants. Participants in this research study expressed fear and negative attitudes towards mentally ill patients and often viewed mental ill patients as dirty, worthless, dangerous etc. and from time to time they also associated mental illness with witchcraft and the works of evil machines (Ewhrudjakpor, 2009:24; Chikaodiri, 2009:19).

In contrast, Adewuya and Oguntade (2007: 934) investigating social distance found that the age groups of the participants were significantly associated with social distance, which implies that there is a relationship between the age of the participants and the variables that tested social distance. A significant number of the participants in the last mentioned study indicated that they would not marry someone with mental illness, would not want a fully recovered mentally ill patient to be a teacher and they also indicated that they would not hire a former mentally ill patient to look after their children.

A study conducted in South Africa by Botha, Koen and Niehaus (2006:619) revealed that the community members had a lot of negative attitudes towards mentally ill patients that suffered from Schizophrenia. The study only focussed on mentally ill patients.

## **2.5 Perceptions towards Mental Illness**

Cultural beliefs have a great impact on mental health care, treatment and mentally ill patients. Cultural beliefs often influence people's general knowledge of mental illness (NCCAH, 2009:1). According to Dalky (2012:486), cultural beliefs and norms shape and influence the perceptions of people regarding mental illness. Dalky (2012: 486) also support the view of Choudhury and Minas (2011:42) and indicated that cultural beliefs and perceptions cannot be separated from each other. Research conducted amongst health care professionals indicated

that despite the knowledge people have on mental illnesses, cultural beliefs often outweigh the mental health literature as society tend to hold on to cultural beliefs more ( Bener & Ghuloum, 2011:162; Adewuya & Oguntade, 2007: 935; Kapungwe *et al.*, 2011:295). This phenomenon is more prominent in African communities especially in Sub Saharan Africa because various authors attributed the causes of mental illness to cultural aspects such as punishment by supernatural powers and witchcraft (Adewuya & Oguntade 2007: 935; Kapungwe *et al.*, 2011:295; Chikaodiri, 2009:19).

Despite the fact that most mental health professionals and some non-mental health professionals have positive attitudes towards mentally ill patients, non-medical personnel are still reluctant to help mentally ill patients who are in crises (Gates *et al.*, 2011:103).

Hallet, Klug, Lauber and Priebe (2012:226) indicate that in most instances volunteers have a very positive view of their work with psychiatric clients. The study also suggest that various scholars and researchers who have investigated the opinions/attitudes of volunteers who assist patients with mental illness are of the opinion that volunteers are very satisfied with their work and had their expectations fulfilled and ‘never or rarely’ thought about quitting. Hallet *et al.* (2012:226) conducted a literature search with regards to studies that involved volunteers in mental health areas and reviewed 14 studies from various databases.

A French electronic survey conducted by Durand-Zeliski *et al.* (2012:28) revealed that French people have more prejudice towards Schizophrenia. The participants are of the opinion that psychiatric patients are a danger to themselves and others. Furthermore, the study reveals a significant amount of fear and mistrust exhibited towards patients suffering from schizophrenia. An interesting aspect that came out of this study is that participants have more positive views about bipolar mood disorder and autism compared to schizophrenia.

In Nigeria, it is evident that health care workers fear mental health users. This fear has caused unwillingness among them to treat mentally ill patients in a general teaching hospital (Chikaodiri, 2009:19).

Residents in Cape Town, South Africa are not known for strong cultural beliefs because traditionally Capetonians were predominantly coloured and white while Africans and Indians were the minority (Louw, 2010:1). Previous studies conducted in Cape Town, South Africa revealed that participants in the study had more western views and attributed mental illness to stress, personal weakness and lack of willpower (Hugo *et al.*, 2003:715).

## **2.6 Stigmatisation of mentally ill patients**

Having a mental illness is one aspect in society that is still highly stigmatised regardless of the successes that have been recorded in treating mental illnesses and the awareness that are raised globally in order to combat stigma, prejudice and bias.

The stigmatisation of mentally ill people is a global phenomenon that spans throughout history and it is evident in most societies, cross-culturally and even amongst the most educated people in the general public (Barke, Nyarko & Klecha, 2011:1192; Siu, Chow, Chan Tang & Chui, 2012:18). Studies that investigate this phenomenon reveal that in various countries the degree of stigmatisation differs. In most instances, the results demonstrate that most often than not, negative stigmatising behaviours are projected towards mentally challenged people and mentally ill patients (Barke *et al.* 2011:1192; Siu *et al.* 2012:18).

A study carried out in Ghana revealed that Ghanaians demonstrate high degrees of stigmatisation towards mentally ill patients as they tend to keep greater social distance, and impose restrictions towards mentally ill patients. In the same study, some Ghanaians expressed their unwillingness to marry people with mental illnesses (Barke, *et al.* 2011:1191-

1202). In a comparative study involving mental health professionals, Nordt *et al.* (2011: 709) demonstrated that psychiatrists showed more negative stereotypes towards mentally ill patients.

As a result of the discrimination and stigma associated with mental illnesses, people suffering from mental illnesses tend to seek professional help only at the most advanced stages of the sickness. Mental health facility users often develop a low self-esteem as a result of the stigmatisation and some studies indicate that the life satisfaction of these patients is very low (Dalky, 2012: 487; Stormwall, Holley & Kordrad, 2012: 406 ). There is also evidence that the study participants believe that psychological trauma, stress and even brain trauma are attributed to mental illnesses. This is considered as a positive view of mental illnesses and mentally ill patients.

Contrary to the findings of Quinn *et al.*(2009:44)., Crabb *et al.* (2012: 543) found that the younger Malawian participants in his study attributed mental illness to illicit drug and alcohol abuse, and Gods punishment while the older Malawians considered mentally ill clients a public nuisance.

## **2.7 Discrimination against mentally ill patients**

The literature on mental health suggests that mentally ill patients often encounter discrimination on a daily basis. Widespread discrimination against mentally ill patients is a global phenomenon and it has a huge impact on sufferers of mental illnesses. What is evident in some studies is that even health care professionals display bias and discriminatory behaviours towards mentally ill patients (Linden & Kavanagh, 2011:1359; Thornicroft, Rose & Kassam, 2007:114).

In various health-care facilities, the tendency of prejudice and discrimination towards mentally ill patients is very often evident (Hamdan-Mansour & Wardan, 2009:705-709; Kapungwe *et al*, 2010:195-196). Stereotyping, bias and prejudice are some of the aspects that mentally ill patients have to deal with on a regular basis (Hansen, Jormfeldt, Svedberg & Svensson, 2011:52-54). Due to this type of behaviour, the progress of mentally ill patients is often affected (Bjorkman, Angelman & Jönsson, 2008:175). Some studies also suggest that as a result of discrimination and stigmatisation, mentally ill patients and their families often delay seeking treatment and some patients even become non-compliant to their treatment regime (Thornicroft, Rose & Kassam, 2007: 119).

Furthermore, mentally ill people often encounter discrimination and stigmatisation when they seek employment and apply for work although the Bill of Rights and Patient's Rights Charter discourages discrimination towards disabilities, mental illnesses and AIDS (McDaid, 2011:5-6). Stigmatisation towards mentally ill people in Cape Town is also rife despite the fact that South Africa has an established constitution and Mental Health Care Act of 2002 that stipulates that every person and mentally ill client has the right to respect and privacy. According to the Bill of Rights of South Africa, all people including people with disabilities and mentally ill people have the rights to equal education, work and employment and decent housing; adequate health, standard of living and social protection. Mentally ill patients also have the freedom of speech, to make decisions related to marriage and parenthood. However, research on mental illness and attitudes and perceptions towards mental illness often suggests that participants indicate that mentally ill patients should not be allowed to have children and social distance with regards to a relationship/marriage to a mentally ill person is also common. In many instances, mentally ill people are discriminated against and people are often prejudice and bias towards mentally ill people with regards to children, sterilisation,

marriage (Adewuya & Oguntade, 2007:934; Barke, Nyarko & Klecha, 2011:1196; Ukpong & Abasiubong, 2011: 58-59).

## **2.8 Beliefs and myths regarding mental illness**

Various myths, beliefs and misperceptions about mental illness are prevalent globally. A study conducted by Bener and Ghuloum (2011:157) suggested that Arabs believe that mental illnesses are caused by the possession of evil spirits. The results of this study confirm that the majority of the general population believe that possession by evil spirits cause mental illness. Crabb *et al.* (2012:541) also showed that the majority of the Malawian participants expressed similar views with regards to mental illness.

In a study conducted in China by Sui *et al.* (2012: 21-22), the authors indicated that some participants are of the opinion that mental illnesses are a punishment from God. According to the study, some Chinese believe that mental illnesses occur because people are being punished for the mistakes of their ancestors. This study also showed a strong presence of traditional and cultural myths regarding the aetiology or precipitating factors attributed to mental illnesses. As a result of the above, Sui *et al.* (2012:22) suggest that it is important to educate the general population on mental illnesses. Likewise, the study conducted by Bener and Ghuloum (2011:164) revealed that the Arab participants also believe that mental illnesses are as a result of Gods punishment.

Various studies in Western and Sub-Saharan countries reveal that there is a common belief that mental illnesses are a result of drug abuse/addiction. Drug abuse and addiction are a common phenomenon that patients present with in clinical settings (Crabb *et al.*, 2012:541; Ukpong & Abasiubong, 2010:16:2). Contrary to the above argument, in Sub-Saharan African countries there is a strong belief that mental illness are a result of witchcraft or the possession by evil spirits.

Studies conducted in Sub-Saharan Africa expose various types of myths and misperceptions about mental illness. Participants in such research studies often express fear and negative attitudes towards mentally ill patients and they often view mentally ill patients as dirty, worthless, dangerous etc. Sometimes people also associate mental illnesses with witchcraft and the works of evil machines (Ewhrudjakpor, 2009:24).

The aforementioned beliefs might be due to the fact that many Sub-Saharan African communities have very strong cultural belief systems (Chikaodiri, 2009:19). Contrary to these findings, studies conducted in South Africa by Hugo *et al.* (2003:719) revealed that participants indicated that stress and lack of will power are associated with mental illnesses. In light of the above studies, we can conclude that despite the fact that a significant number of studies conducted in Africa indicated that some people firmly believe that sangoma's and traditional healers can heal mental illness, the results in the present study dismiss the assumption that sangoma's can heal mental illness. Furthermore in Sub Saharan Africa mental illness is mostly associated with witchcraft while in Cape Town mental illness is associated with stress and will power.

## **2.9 The relationship between knowledge, attitudes and perceptions (KAP) and work experience**

Evan-Lacko, Henderson and Thornicroft (2013:51-57) suggested that familiarity with mental illness often result in the fact that participants have a greater understanding and attitude towards mental illness. They also argue that people who are exposed to mentally ill patients will be more knowledgeable and show a greater understanding towards mentally ill patients or mental health care users. This assertion is supported by CDC (2011:3) which states that familiarity and association or contact with mentally ill people often contributes to positive perceptions, knowledge and attitudes towards mentally ill people.



Jorm and Wright (2008:1) also reported similar findings and indicate that exposure to mental disorders remarkably reduced stigma in adults. This result is supported by and it is in line with Gatheshill *et al*, (2011:104) who found that mental health care professionals who have worked in a health care setting often display more knowledge and understanding towards mental illness and these mental health care workers often display more favourable attitudes towards mentally ill patients.

A Comparative study conducted by Crabb *et al*. (2012:541) between mental health care workers and health care workers in general hospitals revealed that the health care workers in general hospitals often fear mentally ill people and often perceive them to be unpredictable and dirty while many of the mental health care workers are more tolerant, and view mentally ill people in a more positive way.

## **2.10 Mentally ill patients and work**

Mental illness places a great burden on workplaces and has an impact on any organisation on both human and financial resources. According to a systematic review, which involved 11 studies conducted by Crowther, Marshall, Bond and Huxley (2001:204) in America, the majority of the mentally ill patients were unemployed; but despite being unemployed they had the desire to obtain a job. The purpose and aim of the systematic review was to explore the efficiency and effectiveness between prevocational training versus supported employment for severe mentally ill patients, and concluded that supported employment was the most suitable and effective method to assist severe mentally ill patients in obtaining a job (Crowther, Marshall, Bond & Huxley, 2001:204). However, despite the desire and willingness of mentally ill people to work and be employed, mental illness impacts on the individual itself and it also affects the company and fellow employees because mental illness often result in long periods of absenteeism which places a burden of fellow colleagues

(Stuart, 2006:522) Furthermore, mental illness also affects the productivity within a workplace due to the fact that mental illness is associated with absenteeism and the inability of the mentally ill patients to function optimally in some instances. However, adverse working environments and culture also have a negative impact on common mental illnesses such as depression, schizophrenia, anxiety disorders and bipolar mood disorders (Stuart, 2006: 522).

According to the Sainsbury Centre for Mental Health (2007:2), every organisation in Britain is affected by mental illness and they also indicated the huge impact mental illness has on the finances of the organisation. The report also states that on average, employees stay out of work for 7 days per year and from those 7 days forty percent of the time, it is due to mental illness. The Sainsbury centre for mental health also reported during 2005/2006 survey that 30.1 percent (%) working days are lost as a result of mental illness. According to Sinclair and O' Regan, the increased absenteeism related to mental illness is costly for the employers and this view is also in line with the findings of the Sainsbury centre for mental health (Sinclair & O' Regan, 2007:5).

With regards to work (employment), related literature shows that mental illness affects the lives of people as well as their employment and attendance (Chopra, 2009: 5). Consequently, scholars found that mental health problems cause just 25% of absences in less than seven days, and they account for 47% of long-term absences (Lelliott, Tulloch, Boardman, Harvey, Henderson & Knapp, 2008: 7-10)

In comparison with various common physical conditions, mental health problems are often gradual in onset and long lasting. Apart from trying to conceal the problem from their employers, people with mental health problems might delay seeking help until the problem is severe, becoming difficult to treat (Lelliott, Tulloch, Boardman, Harvey, Henderson &

Knapp, 2008: 9-12). It was also noticed that people with a common mental disorder also often have a physical illness, but even though it might be the mental health problem that cause the patient to taking a sick leave, it may not be recognised. This may lead to a delay in receiving effective treatment and thus a delay in returning to work (Lelliott, Tulloch, Boardman, Harvey, Henderson & Knapp, 2008: 7-10).

In contrast to the above studies, Boardman, Grove, Perkins and Shepherd (2003: 467-468) state that work is something that many people take for granted, but many people with mental illness are excluded from work and are unlikely to gain or sustain open employment. This is despite the fact that the majority of people with mental illness wish to be engaged in meaningful activities; considering that being at work has important implications for the personal well-being, social status and civil rights of those with mental illness as well as for their use of health and social services. Work offers consolidate the personal economic benefits for users of mental health services. People with mental illnesses are sensitive to the negative effects of unemployment and loss of structure, purpose and identity which it brings (Chopra, 2009: 5).

Work is important both in maintaining mental health and in promoting the recovery of those who have experienced mental health problems. However, mentally ill patients often experience prejudice and employment related discrimination and stigma within the workplace and when applying for work. According to Stuart (2006:522-526) the employer and often also the employees often holds discriminating views pertaining to mental illness and it often result in employment inconsistency and inequality for mentally ill patients.

## **2.11 Conclusion**

In this chapter the existing literature on knowledge, attitudes and perceptions of mental illness and mentally ill patients has been explored. Despite that a plethora of studies have

investigated mental illness and KAP of various health care workers, the general public and various religious groups in relation to mental illnesses, no studies were found that examined knowledge, attitudes and perceptions of general assistants in the psychiatric context, especially in Sub-Saharan Africa and South Africa specifically.

This study, therefore, was aimed at investigating KAP of general assistants because researchers have tended to focus on trained health care professionals and rarely include janitors, general assistants and some support staff like porters in research studies. However, these people are in contact with mentally ill patients for the greater part of their day while fulfilling their various duties in psychiatric facilities. The following chapter presents the theoretical framework that was employed to address the objectives of the study. This is followed by chapter four which presents and discusses the research methodology.



## Chapter 3: Theoretical Framework

### 3.1 Introduction

Mental illness is one of the illnesses which are regarded as one of the greatest contributors to the global burden of disease. Despite the advances made in mental health care globally, mentally ill patients are still faced with discrimination, prejudice, bias and ill-treatment. This study, therefore, aimed to identify the level of basic mental health knowledge of general assistants pertaining to mental illness; to determine the attitudes of general assistants towards mentally ill patients and to determine the perceptions of general assistants towards mental illness and mentally ill patients.

According to Pickens (2005:44), a person's attitude is a combination of various factors including an individual's feelings, beliefs, personality and behaviour. Furthermore, he postulates that an individual's attitude is also influenced by his/ her environment. Pickens also indicated that a person's attitude often determines how one behaves towards a certain object or person. Perceptions on the other hand, depends on how a person views stimuli and things around him to make it meaningful (Pickens, 2005: 46) In the light of the above, the Theory of Planned Behaviour which was formulated by Ajzen in 1980 (2005:117) was employed to determine the knowledge, attitude and perceptions of general assistants towards mentally ill patients.

The application of the Theory of Planned Behaviour was tested in the studies that determine behaviours towards health interventions e.g. the attitudes of participants towards condom usage. The limitations of the theory are that it does not regard past experiences and environmental controls as predictors of behaviour.

This chapter describes the application of the Theory of Planned Behaviour as formulated by Ajzen in 1980(2005:117-119). This chapter deals with the theoretical framework that guides the exploration of the KAP of the general assistants towards mentally ill patients. The theoretical framework deals with a theory related to behavioural patterns of humans and how they are shaped and guided.

### **3.2 Concepts and Definitions applied in the Theory of Planned Behaviour**

For the purpose of this study, the concepts of the theoretical framework are defined by means of operational definitions that will clarify and simplify the variables that pertain to the theoretical framework.

The following operational definitions are used to guide the theoretical concepts which form part of the theoretical framework. Ajzen and Fishbein (2005:117-120) suggested that certain concepts contribute to behaviour. The Theory of Planned Behaviour asserts that a person's behavioural beliefs, attitude, normative beliefs, subjective norms, control beliefs as well as a person's perceived behavioural control form that person's intention to perform or execute certain behaviour. These different components of the planned behaviour are defined below for a comprehensive understanding of the concept of planned behaviour.

**Behavioural beliefs:** refers to the beliefs or perceptions a person hold towards certain behaviour. Behavioural beliefs also refer to the subjective probability that the behaviour will produce an expected outcome. These include the beliefs they have on mentally ill behaviour as well as their own behaviour towards mentally ill people (Ajzen, 2005:91-92).

**Attitude:** Attitude toward behaviour refers to the degree to which a behaviour is positively or negatively valued, with reference to the study, it refers to how the person feels and perceive mentally ill clients (Ajzen, 2005).

**Normative beliefs:** refers to the beliefs and views that the society has on mental illness and mentally ill clients. Ajzen also describe normative beliefs as the perceived behavioural expectations of important references such as friends, colleagues, family members or colleagues depending on the population and behaviour that is being studied. The normative beliefs and the motivation of a person's motivation to comply with the references' expectation determine the subjective norms (Ajzen, 2005:118).

**Subjective norms:** refers to the perceived social pressure to engage or not engage in certain behaviour. With reference to knowledge, attitudes and perceptions of general assistants, it refer to the person's inherent norms, perceptions and beliefs regarding mental illness which either enable them to engage or not engage in a certain behaviour (Ajzen, 2005:118).

**Control beliefs:** refers to the probable beliefs people have regarding their ability to control or managed their behaviour and it contributes to a persons' perceived behavioural control (Ajzen, 2005:118).

**Perceived behavioural control:** refers to the perceptions that a person can control their performance towards certain behaviour (Ajzen, 2005:118).

**Intention:** refers to the measure/ extent to which a person feels or wants to enforce a behaviour that is initially planned or intended (Ajzen, 2005:118).

**Behaviour:** refers to a person's actions towards mentally ill people.

The concepts defined above have been used to formulate questions to measure the efficacy and applicability of the theoretical framework pertaining to the study.

### 3.3 Description of the Theory of Planned Behaviour

Various scholars have investigated the KAP of various health care staff categories on mental illness. However, only few scholars investigated KAP towards mental illness with respect to

support staff and general assistants. Some authors applied theories such as Heider's Attribution Theory. This study focuses on Ajzen's Theory of Planned Behaviour (TPB). Ajzen (1991:188) asserts that human behaviour is influenced by various factors such as a person's attitude, perception and intention to act or react in a certain manner or to express certain behaviour. Even though the concept of knowledge is not clearly defined or included within the theory, knowledge is implicitly defined and it also influences behaviour. For instance, if somebody has knowledge on the purpose and benefits of condom use during sex, like knowing that using condoms reduces the risk to contract sexually transmitted diseases and HIV/AIDS, they might be prompted to use condoms whereas if they did not have any knowledge with regards to the above, they might engage in unprotected sexual intercourse (Fisher, Fisher, Bryan & Misovich, 2002: 178)

A limitation of the Theory of Planned Behaviour is the fact that it does not consider aspects such as past experiences or fear which may impact on the intention to perform certain behaviour. It also does not take into consideration environmental factors and exposure to certain aspects which may also impact on the intention to behave a certain way (Boston University of Public Health, 2013:1).

Moreover, Ajzen and Fishbein (2005:118) support the statement that knowledge on a certain phenomenon impinges on the behaviour one displays towards aspects related to the phenomenon. This is in line with Fisher and Fisher's Information- Motivation- Behavioural (IMB) Model which suggests that information/knowledge about a certain phenomenon influence and motivates a person to perform certain behaviour (Fisher *et al.*, 2002:178). Considering that attitude, perception and knowledge have an impact on a person's behaviour; this study is theoretically founded on the Theory of Planned Behaviour as formulated by Ajzen and Fishbein (1991:179). Following this theory, therefore, the investigator intended to



explore to the knowledge, attitudes and perceptions of the general assistance in relation to the behaviour reported by the mentally ill patients.

Ajzen and Fishbein (1991:179) postulated that a person's behavioural beliefs and attitudes influence their intention to perform certain behaviours. Further, the same theory predicts that a person's normative beliefs and subjective norms lead to the intention to behave in a certain way or display a particular behaviour. This study, therefore, intended to test the relationship between the behavioural beliefs, attitude, subjective norms, normative beliefs and the intention. Consequently, the investigator aimed to determine whether the intention to perform discriminatory and stigmatising behaviours resulted in the behaviour being actually displayed by the general assistance.

The theory also suggests that the normative beliefs, which is a representation of the norms and beliefs of the society and the subjective norms of an individual, also lead to intention. A person's subjective norms on the other hand is influenced by his or her beliefs regarding certain phenomena but it is also subjected and influenced by the knowledge he/she has with regard to the behaviour/ phenomena in question.

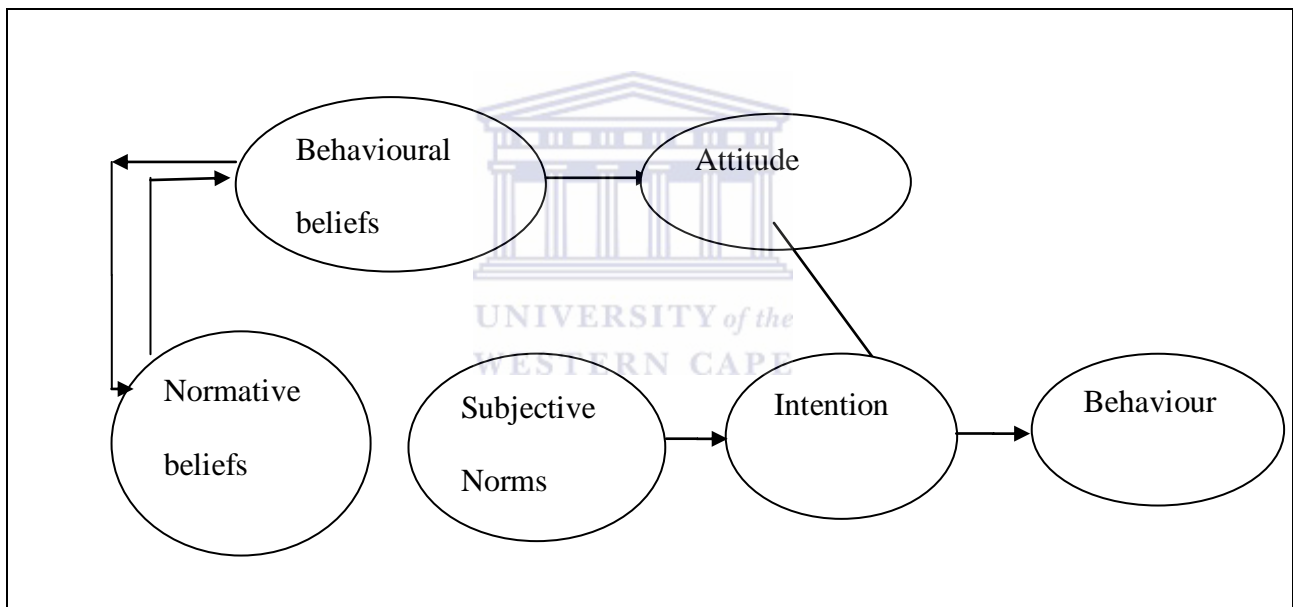
According to Ajzen and Fishbein (2005:118), the theory of planned behaviour indicates that only specific attitudes towards the behaviour in question can be expected to influence and predict that behaviour. The theory also suggests that when we measure a person's attitude we also need to monitor the subjective norms as well as their beliefs.

Although the framework also consists of two other concepts that directly influence the intention to behave in a certain way and to perform the actual behaviour, this study did not focus on those phenomena. The concepts that were not explored or investigated are the control beliefs and perceived behavioural control.

Against this background, the study explored the KAP of the general assistant within the framework of the model of planned behaviour. Hence, the behavioural beliefs, normative beliefs and the intentions of the general assistants were explored. This information provided a scaffold on which the exploration of KAP of the general assistants toward mentally ill clients was based (Armitage and Conner; 2001:471-499). The figure illustrating the theoretical framework is presented below.

### 3.4 Adapted Theory of Planned Behaviour (model)

This study updated the Theory of Planned Behaviour as following:



**Adapted Theory of Planned Behaviour (model), Ajzen and Fishbein (2001)**

The application of the aforementioned framework suggests that an individual's behavioural beliefs are related to the attitude towards the intention to behave a certain way. For instance, if an individual believes that mentally ill people are rude or difficult then it will affect the attitude of the individual by influencing his intention to behave in a certain manner. If, however, the individual does not understand the reaction of mentally ill patients and are disturbed by it then it can lead to the patients in question being perceived in a negative way and negative behaviour due to negative attitude towards the patient could be the result.

Since society often perceives mentally ill people as dangerous and aggressive, the general assistants could also share those beliefs and it would influence the general assistants' norms or beliefs regarding mental illness (Kapungwe *et al.*, 2011:295). Strong cultural views and beliefs could affect the perceptions that the general assistant have towards mental illness and mentally ill patients and it can ultimately result in the person not wanting to be associated with mentally ill patients (Linden & Kavanagh, 2011:1359; Thornicroft, Rose & Kassam, 2007:114). They might even perceive the patients as bewitched and it may affect their attitude and also the individual's behaviour towards mentally ill patients (Choudhury & Minas, 2011:42; Adewuya & Oguntade, 2007: 935; Kapungwe *et al.*, 2011:295).

An individual's subjective norms and beliefs contribute to the intention of an individual to perform certain behaviours. In the light of the above, it can be concluded that a person or general assistant's behaviour towards mental illness and mentally ill people is influenced by their perceptions and beliefs about mental illness. This will in turn affect the attitude they have towards mentally ill patients and also result in behaviours which are related to the attitudes of the person. This is congruent with the CDC report that attitude and knowledge about mental illness is dependent on the individual's knowledge about mental illness, cultural stereotypes (normative beliefs), interaction with mentally ill people and media stories (CDC, 2012:3).

Should people maintain positive views and beliefs about mental illness, then it is most likely that the attitudes and behaviour towards mental illness and mentally ill patients will be positive as well. Should negative perceptions be held towards mental illness and mentally ill patients, then the probability that negative attitudes and behaviour towards mental illness and mentally ill patients will be displayed will be great (CDC, 2012:3). This view is supported by the CDC (2012:3) that suggested that a person's attitude and perception often attribute to how they behave or react towards mentally ill patients.

### **3.5 Conclusion**

In this chapter the Theory of Planned Behaviour has been discussed. The various components that make up this theory have also been explored. The theory and the various concepts that make up the theory have also been conceptualised with the framework of the study exposing how they can be used to explore the KAP of the general assistance with regards to mental illness and mentally ill patients. Further, the same theory also predicts that a person's normative beliefs and subjective norms lead to the intention to behave in a certain way and the behaviour in particular.

The following chapter, chapter 4, describes the research methodology that was applied in the study.



## **Chapter 4: Research Methodology**

### **4.1 Introduction**

This chapter describes the research methodology that was used to achieve the study's objectives. The rationale of the chapter is to explain the methodology and research design that were applied to determine knowledge, attitudes and perceptions of General Assistants in the four government psychiatric hospitals in the Western Cape. A detailed description of the research setting, population, sampling method, data collection instrument and data collection processes that were followed during the study are also expounded in this chapter. In order to ensure that the research instruments and process are valid, the investigator discusses in greater detail, the face validity, content validity and reliability in this chapter. A description of the pilot study is also provided, followed by ethical considerations of the study.

### **4.2 Research design**

Research designs provide a layout of the logical steps taken by the researcher to answer the research questions (Brink, 2001:100). Brink succinctly describes a research design as the blueprint for the study, explaining that it determines the methods used by the researcher to select participants, as well as describes the methods employed to collect, analyze and interpret the data. Kothari (2004:32) asserts that a research design also aims to enhance the smooth flow of the research process by ensuring that the research is conducted in the most efficient and effective way, in a minimal period of time, yet producing the best and most effective results in a financially conducive manner.

In this quantitative descriptive study, a cross-sectional survey design was applied to explore knowledge, attitude and perceptions of general assistants towards mentally ill patients in the four psychiatric hospitals in Cape Town.

### **4.3 Type of research**

To investigate knowledge, attitudes and perceptions of the general assistants in the four government psychiatric hospitals in the Western Cape, a quantitative descriptive study was conducted. Quantitative descriptive studies refer to studies that examine or explore what the current status of a phenomenon is. They also indicate how participants perceive a certain/specific variable and how they respond to the aspects/objects they perceive (Holland & Reese, 2010:41).

This study utilised a quantitative approach as its goal was to explore knowledge, attitudes and perceptions of general assistants towards mental illness and mentally ill clients. The descriptive design was selected for this study because it has the ability to produce the most suitable results. It can, thus, provide the investigator with a relatively accurate account of the current knowledge, attitudes and perceptions of the general assistants towards mentally ill clients, in the four government psychiatric facilities of the Western Cape. Furthermore, the design also enabled the researcher to describe the possible relationships between knowledge, attitudes and perceptions and the demographic variables of the sample population (Burns & Grove, 2011:34).

Tappen (2011:97) postulates that cross-sectional designs are used when you study one or more variables of a certain population at one point in time. In cross sectional design studies, data are collected at one point in time. The cross-sectional research design was used during this study because it can be used to describe certain aspects about the population at one point in time. Cross sectional designs are also useful to determine the frequency of a specific attribute or health related phenomena in a population at a specific point in time. In this study, the design was useful in assessing attitudes, knowledge and perceptions of participants on mental illness and mentally ill patients. An advantage of cross-sectional designs is that the

data can be collected in a small space in time with minimal resources (Holland & Reese, 2010:119). It is also beneficial because multiple variables/outcomes can be measured simultaneously.

The method that was applied within this research study was a survey because surveys potentially minimise interviewer bias. Furthermore, surveys also provide an accurate portrayal or account of the characteristics, for example, behaviour, knowledge, attitudes and beliefs of a particular individual. According to Burns and Grove (2011:550) surveys are also used to describe a phenomenon by collecting data using questionnaires. The survey method was also applied to meet the objectives of the study, namely to determine knowledge, attitude and perceptions of the general assistants towards mental illness and mentally ill clients. (Burns & Grove 2011:550).



#### **4.4 Research Settings**

The research study was conducted in four government psychiatric hospitals in the Western Cape, one of the nine provinces of the Republic of South Africa. The Western Cape is situated in the most Southern end of Africa and has a population of 5 822 734 (Statistics South Africa, 2012: 14).

##### **4.4.1 Hospital A**

Hospital A is situated in the Tygerberg Eastern Health District of the Metro Region of the Western Cape. The hospital consists of 12 wards; 1 daycentre facility, an occupational therapy section, a psychology and outpatient section as well as two residential facilities which form part of New Beginnings (which is recognised as an intermediate psychiatric facility). It has a bed capacity of 318 patients and renders services to patients with acute psychosis. It also provides services for alcohol rehabilitation and other recreational drug, especially heroin

detoxification. The hospital also has a therapeutic ward which caters for clients with depression, obsessive compulsive disorder, suicidal ideation, acutely suicidal patients and clients with personality disorders. Hospital A has an assertive community treatment team (ACT) and a day centre programme where clients are seen post discharge for reasons such as; enhancing client's skills, monitoring the progress of mentally ill clients and providing a support service to discharged clients. It also has a step-up facility running a step-up programme and a residential facility which caters for the needs of long term clients. The acute services cater for clients with the following diagnosis: Substance abuse / drug related psychosis, Schizophrenia and bipolar mood disorder.

#### **4.4.2 Hospital B**

Hospital B is located in Mitchell's Plain which forms part of the Mitchell's Plain sub-district of the Metropole. Mitchell's Plain is situated about 20 kilometres from the City of Cape Town. Mitchells Plain is one of the coloured communities notorious for drug abuse and gang violence and it falls under the Mitchells Plain health district in the Metro Region (DoH website: <http://westerncape.gov>). The hospital provides services to clients with acute psychotic disorders and has a therapeutic ward that caters for depressed and suicidal clients. There is a special section that caters for intellectually disabled clients. A child and adolescent section and a child and family unit also render services to adolescents and children with psychiatric disorders.

#### **4.4.3 Hospital C**

Hospital C is a tertiary specialised psychiatric facility located in Observatory in the Western Cape, providing mental health services to the mentally ill population in the Cape Peninsula and the surrounding areas. The catchment area covers a population of over a million people.



Hospital C provides general psychiatric treatment, care and rehabilitation on both inpatient and outpatient bases to mentally ill clients. A forensic unit provides services to clients who have been sent by the courts for psychiatric observation. The hospital also has admission wards which are used to treat, combat and stabilise mental illness.

The bed capacity of the hospital is 370 and 45% of these beds are allocated for general psychiatric patients whilst 39% of the total beds are reserved for forensic observation. The remainder of the bed capacity is used for medium to long term psychiatric clients (DoH website: <http://westerncape.gov>.)

#### **4.4.4 Hospital D**

Hospital D is a secondary hospital which provides treatment, care and rehabilitation to intellectually disabled mental health care users/clients in the Western Cape. The hospital is situated in Maitland, Cape Town. Hospital D has a bed capacity of 320 beds. Two of the wards, however, cater for the intellectually disabled clients with psychiatric co-morbidities.

Hospital D also provides comprehensive packages of care, treatment and rehabilitation to various people with varying degrees of intellectual disabilities, with or without co-morbid psychiatric illnesses. The comprehensive services rendered at Hospital D include the following: inpatient and outpatient programmes that screen, assess and follow up approximately up to 400 clients on a monthly basis.

### **4.5 Population and sampling**

#### **4.5.1 Population**

The target population constituted all general assistants at the four government psychiatric hospitals in Cape Town. There are a total of 58 general assistants in Hospital A; 80 in Hospital B, 40 in Hospital C and 68 in Hospital D. This gave a total population of 246

General Assistants. Although Hospital D has 68 general assistants working at the institution, only 3 were included in the total population because the remaining 65 are working in the hospital wards rendering services to the intellectually disabled clients. This brought down the total number of the population of general assistants considered in the study to 181.

#### **4.5.2 Inclusion and Exclusion Criteria**

4.5.2.1 The criteria considered for inclusion into the sample was that:

- The general assistant should be employed in one of the four government psychiatric hospitals.
- The general assistants who gave voluntary written consent.

4.5.2.2 Exclusion criteria in the sample

- The general assistants who did not give their consents to participate in the study.
- The general assistants that were on leave or ill during the period of data collection.

#### **4.5.3 Sampling methods**

It was assumed that the general assistants were normally distributed across the psychiatric hospitals in Cape Town. For the purpose of this study all four psychiatric hospitals were selected and the total population as mentioned above constituted of 181 general assistants. The next step after establishing the population size was to determine the research sample size. A statistical based technique, Cochran's formula was used to determine the sample size. The stratified sampling method was employed to select the sample.

#### 4.5.4 Determination of sample size

In order to compute and determine the sample size, the researcher assumed the following:

That the general assistants in all four hospitals were normally distributed and, therefore, computed the sample size based on Cochran formula as described by Cochran (1977:76-83).

The confidence level was 95% which implies that the level of significance was 5%;

The probability (p) that a general assistant would respond was assumed to be 50% and the probability (q) that a general assistant does not respond was also assumed to be 50%.

The margin of error (e) was assumed to be 0.05.

$$n = \frac{N * Z_{\alpha/2}^2 * p * q}{Ne^2 + Z_{\alpha/2}^2 * p * q} \quad (1)$$

$$n = \frac{181 * (1.96^2) * (0.5) * (0.5)}{181 * (0.05)^2 + (1.96^2) * (0.5) * (0.5)} = 123.03 \approx 124 \quad (2)$$



#### 4.5.5 Sampling technique

The sample size was calculated based on the Cochran's formula (1977: 76-83) as indicated above in (1). The sample computed in (2) was 124. Since the number of general assistants in the different institutions varies, stratified systematic sampling was used to determine the number of participants per hospital as reflected in Table 4.1.

Each hospital was considered a stratum and the participants were selected systematically. Therefore, in Hospital A, 39 of the 58 general assistants were interviewed, 56 of the 80 general assistants in Hospital B were interviewed, 27 of Hospital C's 40 general assistants

were interviewed and lastly 2 of Hospital D's 3 general assistants considered were interviewed. Further selection at the hospital level was achieved through the systematic sampling technique.

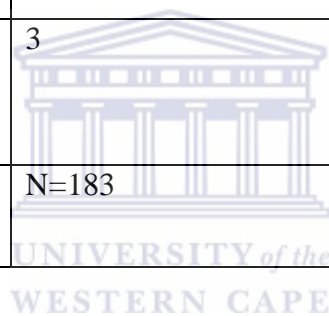
Systematic sampling is one of the sampling methods used to select a representative sample from a large research population. Burns and Grove (2011:303) state that systematic sampling refers to a sampling technique which entails the selection of participants in a systematic and orderly format. In this technique, the participants are selected at a constant interval. This means that every  $k$ th participant on an ordered/specific list of the total population for a specific research study are selected systematically after a randomly selected starting point has been identified.

An alphabetical list of all the general assistants was obtained in all the different hospitals. The first name on the list was selected as the first participant, then subsequently the rest of the participants were selected by using a constant interval,  $k = N/n$ . The selection process continued until the desired number of participants had been selected as indicated by the computed sample (Burns & Grove, 2011:303- 304).

The constant interval ( $k$ ) was  $k = N/n = 181/124 = 1.5$  and, therefore, 1.5 was rounded off and, therefore, every second (2) participant was selected to obtain a representative sample at each institution. For the purpose of this study, general assistants from all four government psychiatric hospitals in the Western Cape (WC) were included in the study to obtain a representative sample of the general assistants in the psychiatric hospitals in the Western Cape.

**Table 4 .1: Stratified systematic sampling**

Hospitals	N	Sampled(n)
Hospital A	58	$n_1 = \frac{58 * 124}{180} = 39$
Hospital B	80	$n_1 = \frac{80 * 124}{180} = 56$
Hospital C	40	$n_1 = \frac{40 * 124}{180} = 27$
Hospital D	3	$n_1 = \frac{3 * 124}{180} = 2$
Total	N=183	n=124



#### **4.6 Pilot Study**

A pilot study refers to a small scale study using a sample of the population (Burns & Grove, 2011:49). The purpose of the pilot study is to enable the researcher to conduct a miniature trial run on the methodology of the proposed study. The pilot study helped the researcher to validate and test the adapted questionnaire.

A random sample of 20 participants (general assistants) was selected to conduct the pilot study. The selection of sample was made from the lists of general assistant's names that were obtained from the psychiatric hospitals that are still working within the four hospitals and who signed the participation consent form. Further, the 20 participants who formed part of the pilot study were not included in the final sample. The pilot study was used to test the

validity and reliability of the data collection instrument. The collected data were then analysed to determine whether or not there are shortcomings, problems and weaknesses with the tool. The results of the pilot study indicated that the Cronbach's Alpha was 0.86, which reflects that the questionnaire was valid. As a result of the computed Cronbach's Alpha score, no changes were made to the initial questionnaire. Furthermore, the participants indicated that they understood the questionnaire and instructions hence the questionnaire was not amended. The scale of interpretation as well as the likert scale was tested during the pilot study and it was found valid and useful for the purpose of the study.

#### **4.7 Data and sources**

This study used only primary data collected from the field work through a survey utilising a structured questionnaire that took place from December 2013 to February 2014. Primary data refers to first-hand information that has not yet been published but it also includes data/literature of the original author. The primary data that were accessed and used during this study included the Theory of Planned Behaviour. Besides the primary data, this study also made use of secondary data. The sources of the secondary data were newspapers, text books, unpublished articles and any published work.

Various data bases including Ebscohost, Pubmed and, Medline among others were searched for articles to substantiate the literature. The researcher also consulted various text books to obtain information while focusing on the background of the perceptions of mentally ill clients which were expressed in some complaints, both verbally and in writing, on their unfair treatment in the various facilities.

## 4.8 Data collection instrument

### 4.8.1 Introduction

A structured questionnaire was used to elicit responses from participants. The questionnaire was adapted and modified from various authors (Adewuya & Oguntade, 2007:933; Crabb *et al.*, 2012:544). Consent and permission to adapt and modify the questionnaires were obtained per email from the various authors (see consent letter in Appendix D). However, the initial permission that was granted by the previous researchers could not be retrieved from both email addresses (GroupWise) of the University of the Western Cape and Hospital A, due to the migration of the email providers of the two institutions. As a result, the consent had to be requested again and unfortunately only one researcher responded prior to the data collection phase of the study. The questionnaire contained four sections. These included: demographic information (Section A), knowledge (Section B), attitudes (Section C) and perceptions (Section D) of general assistants towards mental illness and mentally ill patients.

The investigator modified and adopted the instruments from various previously used instruments measuring attitudes, knowledge and perceptions of various groups of people towards mental illness in various circumstances. These instruments include:

- Community Attitudes towards Mental Illness scale (CAMI) as describe by Barke *et al.* (2010)
- Crabb *et al.* (2012); Ukpong and Abasiubong (2010)
- Link's Discrimination-Devaluation Scale as described by Adewuya and Oguntade (2007)
- Internalised Stigma of Mental Illness Scale as described by Botha *et al.* (2006)
- And the questionnaire utilised by Sadik *et al.* (2010).

The instruments listed above were applied on different categories of people including medical staff such as doctors and nurses; the general public and patients. The researcher modified and adopted the study instruments from the above listed instruments to test the knowledge, perceptions and attitudes of the general assistants.

The modification of the instrument was applied in Section B which focused on knowledge of the general assistants towards mental illness. The researcher constructed a 28 questions section which tested general and elementary knowledge of the general assistants on mental illness. To ensure the validity of the instrument, after modifying the questionnaire, the investigator submitted the draft instrument for peer reviews from fellow Master's and doctoral students, the project supervisor and the statistician. The internal validity was confirmed through the Cronbach's Alpha obtained from the pilot study which was as follows 0.72 for knowledge, 0.82 for perception and 0.82 for attitudes. .

#### **4.8.2 Description of the variables**

As mentioned in the previous paragraph, the questionnaire consisted of four sections which focussed on demographic data, basic knowledge on mental illness, attitudes and perceptions of general assistants pertaining to mental illness and mentally ill clients. In this section the researcher describes each of the aforementioned variables in detail.

##### **4.8.2.1 Demographic Data**

Section A, on participant demographics focused on personal attributes of the participants which can take on three types of data, including ordinal, nominal and continuous data/variables. According to Brink (2001:94), these variables cannot be manipulated.

Burns and Grove (2011:176) define a variable as the qualities, properties or characteristics of a thing or person that can vary and which can take on various forms or measurements.



Ordinal data refers to two or more categories of data which is ranked in a specific order. In this section of the questionnaire, the ordinal data that were measured included age of the participants.

The demographic variables were defined using categorical variables (nominal and ordinal data) which refer to data that can be divided into two or more categories. Examples of categorical data include aspects such as gender, religion, marital status and ethnicity of the participants.

Age of the participants refers to number of years a participant has lived from his or her date of birth. The marital status provides an indication on whether the participant is married, single, divorced or widowed based on cultural laws. The ethnicity on the other hand, is a description of the person's race and the religion refers to the participants' beliefs/ reference to a higher spiritual authority which he or she worships.

#### **4.8.2.2 Knowledge on mental illness**

Section B of the questionnaire focused on the basic knowledge on mental health, which is considered as the indispensable and elementary knowledge of the general assistants towards mental illness. This section contained 28 questions based on factual information about basic mental illness as well as some myths regarding mental illness. Close-ended questions were used which produces ordinal data which is easy for coding during the data analysis process. It can also be easily understood by the participants of the study.

The questionnaire was developed and adapted in English only. Furthermore, the questionnaire was formulated in a manner that it could be easily understood. Clear guidelines or instructions were provided for the participants in terms of how they were to answer the questions. Responses to this type of questions vary with responses like yes/no,

agree/disagree, true/false or (a)/ (b) being required at different instances. Due to the fact that knowledge is difficult to measure, especially in situations where people/participants did not attend a structured programme, the researcher developed a ratio scale which classified the participants' obtained score as either no knowledge, little knowledge, moderate knowledge or good knowledge (See section 4.12 A).

#### **4.8.2.3 Attitudes of general assistants pertaining to mentally ill patients**

The questions related to the attitudes were adapted from the Community attitudes scale towards mental illness (CAMI) and social distance scales which were used in previous studies (Adewuya & Oguntade, 2007:930; Sadik *et al.*, 2010:31). A combination of positive and negative constructs was incorporated and this section was also based on questions that focussed on scales exploring stigmatisation and other attitudes. The questions in this section were Likert scale type questions, to investigate and determine the attitudes of the general assistants on mental illness and mentally ill clients. The responses were divided into 5 sub-types of agreement and it varied from strongly disagree-disagree- neither agree nor disagree-agree and to strongly agree.

#### **4.8.2.4 Perceptions of general assistants pertaining to mentally ill patients**

The last section, section D, which focused on the perceptions of general assistants, contained 11 questions which were likert scale type questions like the ones on attitudes. These questions were also modified from instruments used in previous studies (Hamdan-Mansour & Wardam, 2009:702; Barke *et al.*, 2011:1194; Adewuya & Oguntade, 2007:931). The participants also had to complete the questions based on the 5 levels of agreement and had to indicate with a cross whether they strongly agree/ agree/ neither agree nor disagree/disagree or whether they strongly disagree with the statement that was made by the researcher in the question.

### 4.8.3 Data collection method

The administration of the questionnaire only took place after ethical approval was obtained from the Higher Degree Ethical Committee in the Faculty of Community Health Sciences, at the University of the Western Cape, the Research Ethics Committee of the Western Cape's Provincial Health Department and the Ethical and Executive committee of the four psychiatric institutions.

After permission was obtained from the chief executive officers of the four hospitals, the researcher liaised with the Directors of the respective nursing department to arrange a date, time and place for data collection. Initially the idea was to set up a date and place where all the general assistants could assemble at one central point, but due to the structural layout of the hospitals and the weather it was not possible in all the institutions.

At Hospital D and Hospital C, it was possible to set up a date and time with all the participants that were sampled and to have a detailed information session prior to the distribution of the consent forms and questionnaires. The purpose of the study was explained in detail and the investigator ensured that all the participants who were willing to participate sign the consent form. Subsequently, all the forms were distributed and the researcher explained all the questions and how the consent forms have to be completed and certain aspects that needed to be clarified were cleared and explained to ensure that all the participants understood what they had to do.

At Hospital A and Hospital B, the researcher moved from one ward to another and held brief introductory information sessions with all the general assistants present. After the introductory meetings the participants that were sampled were recruited and the purpose of the study as well as the rationale behind the study was explained to the participants.

Participants were given an explanation on the ethical considerations that the study submits to and were informed that their participation was completely voluntary and that they had the right to decline at any given time. They were also made to understand that their non-participation or withdrawal from the study would have no negative repercussions on them in whatever way. After the ethical considerations and the consent forms were discussed, the researcher discussed the actual questionnaire and gave participants the opportunity to ask questions on any aspects that they did not understand.

At Hospital B and Hospital C two participants in each hospital needed some of the questions to be translated to isiXhosa for a better understanding, and the researcher requested help from isiXhosa speaking registered nurses working within the different hospitals to explain both the consent form and the questionnaire in isiXhosa. However, during the interview the participants indicated that they were uncomfortable and not willing to complete the questionnaire and asked to be excused from the study. The estimated time for the completion of the questionnaire was between 30-45 minutes.

#### **4.8.4 Procedure for data collection**

The researcher had set up appointments with the four hospital managers and the participants in advance, in order to inform them about the study and to arrange dates for completion of the surveys. Due to the fact that the general assistants are shift workers, different dates were set aside for the surveys. After confirming the various dates, the researcher together with the nursing managers arranged for the venues for data collection. Where it was not possible to use a venue because it was occupied, permission was obtained to go to the respective work posts of the participants to conduct the surveys.

A list of all the general assistants working in a facility was obtained and based on the computed selection interval; the investigator selected the research participants. Therefore, not

all general assistants took part in the survey. Only those that were selected through the systematic sampling method to form the sample population were included in the study.

## **4.9 Validity and reliability of the instrument**

### **4.9.1 Validity**

Validity is concerned with how well the instrument represents all the components of the variables being measured (Brink, 2001:167-169). Scholars also define validity as the accuracy of an instrument and it often involves collecting and analysing data to determine the accuracy of an instrument (Brink, 2001:167-169; Creswell, 2012:170-176). Validity is divided into several sub types, internal and external validity. Further, sub validity aspects are classified under the two main headings. However, only those related to this study will be discussed in details. They include content validity, criterion validity and face validity.

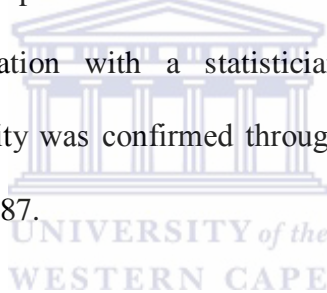
Content validity is defined by Burns and Grove (2011: 335) as the extent to which an instrument or measurement includes all the major elements which are relevant to the construct being measured. Content validity also refers to the degree that the instrument covers the content that it is supposed to measure (Yaghmale, 2003: 25). Content validity was enhanced by ensuring that all the core items on the instrument attempted to measure knowledge, attitudes and perceptions of the general assistants. The knowledge that was measured is the basic knowledge of general assistants pertaining to mental illness. Furthermore, the validity and reliability pertaining to the attitudes and perceptions of general assistants were enhanced by means of Factor analysis.

Criterion validity refers to the extent to which one measure estimates or predicts the values of another measure or quality. Criterion validity was ensured and enhanced because the items/variables on the questionnaire predict the outcome in this instance; the instrument

forecasts the knowledge, attitudes and perceptions of the sample. The criteria validity was also constructed during the factor analysis.

Face Validity is defined as the degree to which a measure is clear and unambiguously tapping the construct it purports to assess and it also refers to the “obviousness” of the test- the degree to which the purpose of the test is apparent to those taking it. To evaluate the face validity of the instrument, the instrument was circulated among peer mentors, which were conducted by fellow Master’s and Doctoral students as well as registered nurses who specialise in psychiatry. Furthermore, the project supervisor also went through the questionnaire to ensure face validity.

To ascertain that the various aspects of the instrument validity were guaranteed, the researcher worked in collaboration with a statistician who reviewed the proposed questionnaire. The internal validity was confirmed through the Cronbach’s Alpha obtained from the main study which was 0.87.



#### **4.9.2 Reliability**

Reliability is described as the consistency of the instrument and it is often seen as an indication as to whether or not the instrument consistently measures what it is intended to measure.

In order to test the reliability of the questionnaire, the researcher conducted a pilot study with 20 participants, who were randomly selected from the population under study. Using the Cronbach’s Alpha formula, the researcher calculated the internal consistency and the correlation coefficient of the instrument. The results of the pilot study indicated that Cronbach Alpha was 0.87, which means that the internal consistency and reliability of the

instrument was good. No changes were, therefore, made to the adapted and modified questionnaire.

#### **4.10 Difficulties encountered during data collection**

Some of the difficulties that were encountered during the data collection phase are first of all the long waiting period that lapsed between the time the proposal was submitted for review by the provincial Health Research Department and difficulties liaising with the relevant people at different institutions. These two challenges delayed the progress of the work.

At Hospital D, permission was only granted to conduct the study only with the general assistants who work in the psychiatric unit and there were only three of them. This affected both the sampling process and ultimately the generalisability of the results because the small representation of the facility may not capture all the views of the general assistants at the specific institution. At some institutions, the researcher had to follow up on a regular basis, how far the process was in terms of the research committee. At provincial level, a wrong research number was allocated which also delayed the consent process.

Another obstacle that could have affected the data collection process was the structural layout of the institutions. Attempts to get all the general assistants to one area for the information/briefing sessions failed due to the fact that the buildings are far apart. This meant that the researcher had to go from department to another at Hospital A and Hospital B to ensure that detailed information sessions were held with all the participating members.

Two general assistants also refused to participate in the study and unfortunately two other participants asked to be excused from the study due to language barriers.

#### **4.11 Cleaning of Data**

To ensure that the data obtained were of good quality, the researcher conducted a data cleaning process where all the invalid data were removed. After the data collection period, all the data were entered on an excel spread sheet which were checked thrice to ensure that data is not replicated or incorrectly entered. Misspellings and incorrect data were also checked and rectified. The statistical analysis programme, SPSS version 22, was used to detect any invalid data. The opinion of a statistician was sought for the validation of the data cleaning process. Frequency tables and logic tests were also checked to detect errors in the captured data. The researcher also recoded Reverse coding items with the help of a statistician, for some of the items in Section C and Section D which were negatively stated in the questionnaire.

#### **4.12 Statistical analyses**

The statistical analysis was mainly descriptive in nature. As the aim of the study was to explore the level of basic mental health knowledge and to determine the attitudes and the perceptions of general assistants towards mentally ill patients, descriptive analysis was thought to be the most appropriate approach. Hence, the descriptive analytical approaches that were employed to describe the investigated phenomena were descriptive statistics, bivariate analysis and inferential statistics.

The results of the descriptive analysis are displayed using frequency tables, percentages and proportions. To compare the level of knowledge, attitudes and perceptions of general assistants and determine which of the category has the highest value, item analysis was applied. Item analysis gives an indication of the most common behaviour of the participant towards mental illness and mentally ill patient. Each item was presented with frequency tables, percentages and proportions. The total score of knowledge, attitudes and perceptions were also computed and cross tabulated to determine the total score of knowledge per

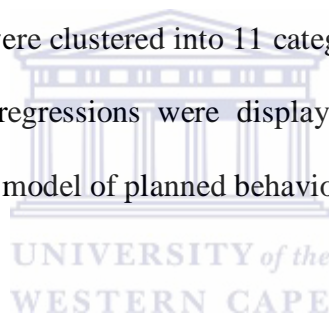


demographic variable and a new codification was created for the interpretation of the results as described in section 4.12. Further, to determine the nature of variation and examine the data on each variable, computation of the mean and standard deviation were applied.

In bivariate analysis: The Chi square tests and Spearman's Rho Correlation were applied to determine either the association or the relationship between two variables.

To test the reliability, Cronbach Alpha was applied for a value of 0.7 and above. To analyse the data, the Software Excel and Statistical Package for Social Sciences, SPSS version 22 were used. The assistance of a statistician was also utilized during the data analysis process.

With regards to the inferential analysis, multiple linear regression was applied, after the variables from section C and D were clustered into 11 categories, by using the factor analysis technique. The multiple linear regressions were displayed to see the best predictors of behavioural intention and test the model of planned behaviour.



#### **4.13 Scale of interpretation**

##### **4.13.1 Introduction**

The researcher based the interpretation of the results on the response bias scale (RBS) supplement as described in the manual for administration, scoring and interpretation by Ben-Porath and Tellegen (2011)

In order to describe and determine the results, a scale of interpretation was developed.

##### **4.13.2 Interpretation of the total scores for knowledge**

The scale of Interpretation that was developed to describe and analyse the total score of participant's knowledge was as follows:

If a score was obtained that ranked between: 0 - 0.25 was considered as 'no knowledge'

A score between 0.26 - 0.5 was considered as 'poor knowledge'

A score ranged 0.51 - 0.75 was considered as 'moderate knowledge.'

A score between 0.76 - 1 was considered as 'good knowledge.'

#### **4.13.3 Interpretation of the total scores for attitudes**

The univariate scores that were associated to the various attitudes of the general assistants towards mental illness were developed as follows:

1: 1.00- 1.49

2: 1.50-2.49

3: 2.50-3.49

4: 3.50-4.49

5: 4.50- 5.00



In order to interpret the results, the researcher summarised the scale of the attitudes into two categories namely positive and negative. Even though the Likert scale consisted of 5 items, the initial scale was amended and the different ranges were combined to produce meaningful results. The researcher considered that all total scores that ranged between 1.00 and 3.49 as negative whilst, those that ranged between 3.50 and 5.0 were regarded as positive attitudes. The newly amended ranges were negative (1) and positive (2).

Thus 1=1.0-3.49 and 2=3.5-5.0.

#### **4.13.4 Interpretation of the total scores of perception**

The description of the tool developed to analyse and describe the total score of the perceptions of general assistants is below.

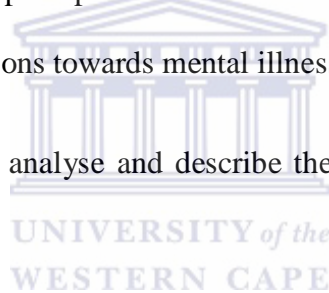
A likert scale used to collect the data had items with responses ranging from strongly disagree (1=1.0-1.49), disagree (2=1.5-2.49); neither agree nor disagree (3=2.5-3.49), agree (3.5-4.49) and strongly agree (4.5-5.0). The ranges in brackets refer to the scale of interpretation as indicated above. In order to interpret the results, the researcher summarised the scale of the perceptions into two categories namely positive and negative. Even though the Likert scale consisted of 5 items, the initial scale was amended and the different items were combined to produce meaningful results. The newly amended ranges were negative (1) and positive (2).

Thus 1=1.0-3.49 and 2=3.5-5.0.

Level 1= Having negative perceptions towards mental illness and was ranged 1.0-3.49

Level 2= Positive perceptions towards mental illness and was ranged 3.50- 5.0

The scale that was developed to analyse and describe the total score of the perceptions of general assistants is as follows:



A likert scale was used to collect the data with items having responses ranging from strongly disagree (1=1.0-1.49), disagree (2=1.5-2.49); neither agree nor disagree (3=2.5-3.49), agree (4=3.5-4.49) and strongly agree (5=4.5-5). The ranges in brackets refer to the scale of interpretation (see section below) However the initial scale was amended and the different ranges were combined as follows: negative scale ranged between 1=1.0-3.49 and the positive scale ranged from 2=3.50-5.0.

Level 1= Having negative perceptions towards mental illness and was ranged 1.0-3.49

Level 2= Positive perceptions towards mental illness and was ranged 3.50- 5.0.

#### 4.14 Statistical analysis pertaining to the Theory of Planned Behaviour

To test the accuracy and applicability of the theoretical framework, factor analysis was applied. Burns and Grove (2011:397-398) assert that factor analysis investigates the interrelationships between large numbers of variables and disentangles those relationships to identify clusters of variables that are most closely linked. Furthermore, factor analysis assists researchers to identify theoretical constructs and to confirm the accuracy of the developed constructs. The application of this statistical method was enhanced by grouping together the most closely linked numerical variables in section C and D of the questionnaire.

For the purpose of the study, the concepts of the theoretical framework are defined by means of operational definitions that will clarify and simplify the variables that pertain to the theoretical framework.

The following operational definitions are used to provide insights into the theoretical concepts which form part of the theoretical framework. Ajzen and Fishbein (1991:179) suggested that certain concepts contribute to behaviour. Furthermore, the Theory of Planned Behaviour asserts that person's behavioural beliefs, attitude, normative beliefs, subjective norms, control beliefs as well as a person's perceived behavioural control leads to a person's intention to perform or execute certain behaviour (ref). Thus, the operational definition for each concept is defined below.

**Behavioural beliefs:** refers to the beliefs/ perceptions a person holds towards certain behaviour. In relation to mental illness, these include the beliefs people have pertaining to the mentally ill behaviour as well as their own behaviour towards mentally ill people.

**Attitude:** refers to how a person feels about and perceive mentally ill clients.

**Normative beliefs:** refers to the beliefs and views that the society has with regards to mental illness and mentally ill clients.

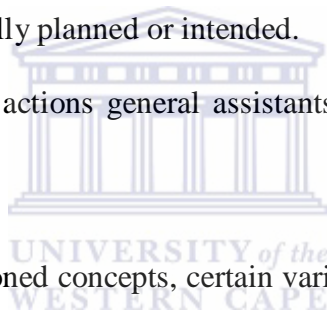
**Subjective norms:** refers to a person's inherent norms, perceptions and beliefs, regarding mental illness.

**Control beliefs:** refers to the probable beliefs people have regarding their ability to control or manage their behaviour and it contributes to a persons' perceived behavioural control.

**Perceived behavioural control:** refers to the general assistants perceptions that they have to perform certain behaviour.

**Intention:** refers to the measure/ extent to which a person feels or wants to enforce the behaviour that is initially planned or intended.

**Behaviour:** refers to the actions general assistants portray towards the mentally ill people.



With reference to the aforementioned concepts, certain variables or questions have been used to measure the efficacy and applicability of the theoretical framework pertaining to the study.

**In order to compute intentions:** the mean score of items/questions (C31, C36, C41, C44, C50 and C51) were computed.

**For behavioural beliefs:** the mean score of items/questions (C43, C45, C51, D54, D57, D59, D60, C29, C30, C37 and C40) were computed.

**For subjective norms:** the mean score of items/questions (D56, D58, D64 and C39) were computed.

**For normative beliefs:** the mean score of items/questions (D55; C33, C38 and D53) were computed.

**To compute attitude:** the mean score of items/questions (C32, C36, C35, C46 and C47) were computed.

**To compute behaviours:** the mean score of (C34, C36, C48, C49 and C50) were computed.

Linear and multiple regression analysis were applied to test the reliability as well as the relationships that exist within the variables. Regression according to Burns and Grove (2011:398-399) refers to the statistical analysis which is applied to predict the value of one variable when the value of one or more variables is known. The variable to be predicted in the statistical method is known as the dependant variable (intentions) and the independent variables are the variables which are used to predict the values of the dependant variable. In order to apply the regression analysis, intentions were identified as the dependant variable and behavioural beliefs, attitude, normative beliefs and subjective norms were identified as the independent variables.



#### **4.15 Ethical considerations**

This study was done in accordance with the ethical and professional guidelines stipulated by Burns and Grove and Brink to enhance good ethical practices (Brink, 2001:32- 35; Burns & Grove, 2011:111-125). Ethical considerations and principles as specified in the Declaration of Helsinki were also applied and considered because the research conducted involves human beings (Burns & Grove, 2011: 105).

Informed consent was sought from all participants and they were informed about what the study entails. The investigator obtained written consent after the participants were informed about the purpose, aim of the study and all the relevant information pertaining to the rights of the participants were explained. Participants were also informed of their rights to withdraw from the study at any point or completely refuse to participate in the study.

Other information that was shared with the participants prior to seeking their consents to participate include the title of the research project, the principal investigator, the contact details of the investigator, the purpose of the study, the study procedure, the duration of the study and how the results will be used and published. The participants were also informed about the principal investigators institutional affiliation, and were thus informed that the investigator is a student at the University of the Western Cape who is currently studying towards obtaining a Masters degree in Advanced Psychiatric Nursing. The information was conveyed during the introductory sessions that were held before the data collection period commenced. The rights and welfare of the participants were protected at all times (Brink, 2001:35).

Confidentiality was enhanced by ensuring that the questionnaires were anonymous. The consent forms were separated from the questionnaires and filed separately to ensure that confidentiality, privacy and anonymity are enhanced. Participants were also informed that all the information will be handled confidentially and that no information will be disclosed without obtaining consent. Furthermore, the investigator coded all the questionnaires in a random and non specific manner as the questionnaires were received so that the questionnaires could not be linked to any person specifically. Each hospital's sheets were kept separately and coded with a different code.

The privacy of the research participants was also protected. Participants were also informed that the questionnaires will be placed in a lockable cupboard and password protected computers will be used to capture and analyse the data.

Participants were also informed that anonymity will be maintained throughout the research (Brink, 2001: 32). The researcher coded the questionnaires to protect the identity and names of the participants.

Participation in the study was voluntary and participants were not forced neither manipulated to participate in the research study.

No known risks were identified as associated with this study. Consequently, to reassure the participants, the researcher informed the participants that there were no foreseeable risks and should any risk be identified during the study then participants will be afforded an opportunity to vent their feelings, and they will also be counselled by the researcher. Participants were also informed that should they require further assistance then they will be referred to the employee assistance programme.

In addition, participants were also informed that there were no potential benefits or compensation for participation in the study, but the study might contribute towards the development and implementation of training guidelines. The proposed study was conducted after approval was sought and obtained from the Ethical Research Committee of the University of the Western Cape, the Ethical Research Committee of the Western Cape's Health Department and the Ethical and Executive Committee of the four psychiatric institutions.

#### **4.16 Conclusion**

This chapter has explored the research design and methodology that was employed in the study. The chapter has also described the data collection process that was used to investigate and determine knowledge, attitudes and perceptions of the general assistants in the four psychiatric hospitals in the Western Cape. Chapter four has also highlighted the targeted population, sampling method, data collection instruments, data collection process, concerns of validity and reliability, and ethical considerations related to the study. The following chapter, Chapter 5, consists of the results of the study.



## Chapter 5: Results

### 5.1 Introduction

This chapter presents the results from the data analysis process. It also provides a description of the methods that were used to obtain the data. Data analysis is defined as the processes implemented by the researcher to reduce, organise and explain the data which were collected into a meaningful display (Brink, 2001:200; Burns & Grove, 2011:44). This process is regarded as a very important aspect in research because it transforms raw data into meaningful results that enhance understanding and insight for the prospective reader.

Therefore, in this chapter the results and responses of the general assistants pertaining to the objectives are organised and analysed. Descriptive analysis was used to describe the results and the results are presented by means of frequency tables and graphs. Chi square tests were also performed to test whether there are relationships between the different variables which are discussed in detail in the following chapter. Factor analysis was also applied to group and cluster the variables. Thereafter, linear and multiple regression tests were applied to test the Theory of Planned Behaviour with reference to the knowledge, attitude and perceptions of the general assistants.

The chapter is organised under the following headings: objectives of the study, general characteristics of the sample, analysis of the demographic variables; descriptive statistical analyses of the demographic questions; results pertaining to the knowledge of general assistants, results on the attitudes of the general assistants with respect to mental illness, and lastly the results on the perceptions of general assistants towards mentally ill patients. The association between the knowledge and the demographic variables are also reported. Factor

analysis, multiple regression and the findings on the testing of the theoretical framework are also included in this chapter.

## **5.2 Objectives and general characteristics of the sample**

### **5.2.1 Objectives**

Despite the fact that the general assistants do not need formal or high level of knowledge pertaining to mental illness, it is important that they should possess some notion about mental illness. As human beings they do have attitudes and perceptions towards mental illness. In view of this, the study aimed to:

Investigate the level of basic mental health knowledge of general assistants pertaining to mental illness,

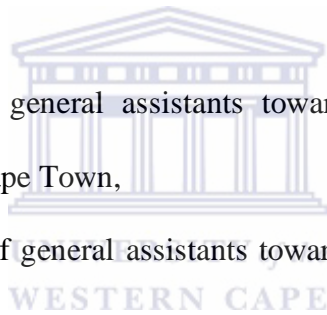
Explore the attitudes of general assistants towards mentally ill patients in four psychiatric hospitals in Cape Town,

Explore the perceptions of general assistants towards mental illness and mentally ill patients, and

Apply and test the theory of planned behaviour to the study.

### **5.2.2 General characteristics of the sample**

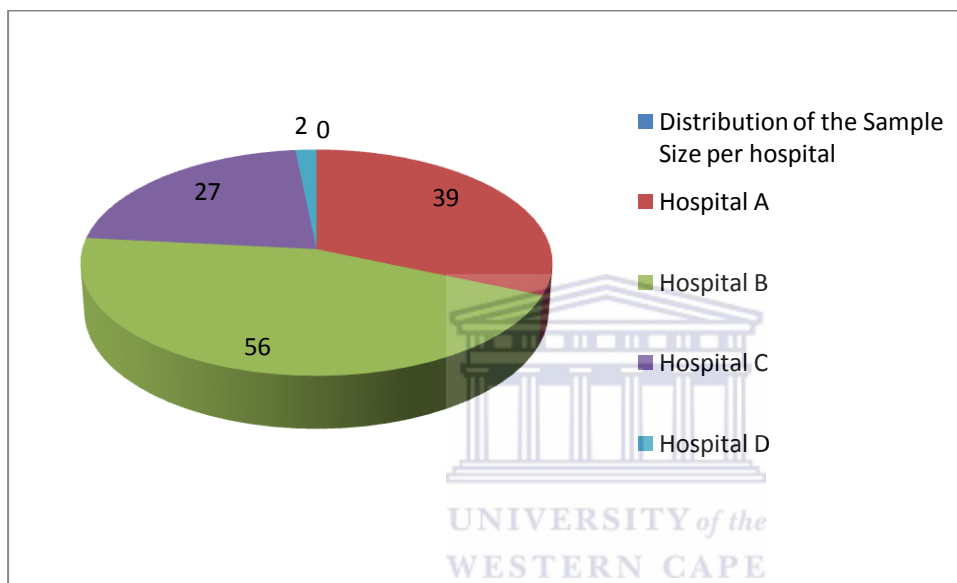
A total of 124 participants were recruited to participate in the study. Furthermore, meetings were also arranged at the different hospitals to explain the purpose of the study and to inform participants about the study. A total of 124 questionnaires were also distributed and even though all the questionnaires were returned, not all the questions were answered completely.



### 5.3 Analysis of the demographic variables of the sample

#### 5.3.1 The Distribution of the sample per institution

Figure 5.1 provides a layout of the sample distribution per institution or psychiatric hospital. A random sample of 128 participants was selected in the institutions as follows: 56 participants at Hospital B; 27 participants at Hospital D; 39 participants at Hospital A and 2 participants at Hospital C.



**Figure 5.1: Distribution of the sample size per hospital**

#### 5.3.2 Socio-demographic variables

##### 5.3.2.1 Introduction

This section deals with the socio-demographic variables of participants. The socio-demographic variables according to Brink (2001:94) are also considered as the attribute variables of the population or the sample that are studied and that cannot be manipulated by the researcher. The demographic variables that are discussed in this chapter include gender, age, marital status, educational level, religion, ethnicity of the participants, and participant's psychiatric work experience of the general assistants in the four psychiatric hospitals.

### 5.3.2.2 Distribution of participants by gender

Table 5.1 indicates that the majority of the participants 94 (75.8%) were female while male were in the minority, with only 30 (24.2%). This might be due to the fact that traditionally, females were the only ones who performed this level of domestic work.

**Table 5.1: Distribution of participants by gender**

Gender	Frequency	Percentage
Male	30	24.2
Female	94	75.8
Total	124	100

### 5.3.2.3 Distribution of participants by age

The results in Table 5.2 reveal that out of 124 participants, 1(0.8%) respondent did not indicate his or her age group while 123(99.2%) indicated their respective age groups. The results indicate that the majority of participants were within the age group 41-50, n=47(37.9%), while the second largest group that participated in the study were in the age group 51-60, n=34(27.4%). It is evident from these results that most of the participants on average were in the mid- to older age range and they might probably have acquired some knowledge about mental illness as a result of the exposure to mental health care clients. The median age of the participants was 45.30 years old.

**Table 5.2: Distribution of participants by age**

Age group	Number of participants	Percentage
21-30	10	8.1
31-40	29	23.4
41-50	47	37.9
51-60	34	27.4
61+	3	2.4
Total	123	99.2
Missing	1	0.8
Total	124	100.0

### 5.3.2.4 Distribution of participants by marital status

Table 5.3 indicates the distribution of the sample based on their marital status. It also shows that the majority of the participants are married  $n=61(49.6\%)$ , while the second largest group were single  $n= 43(35\%)$ . The participants that were divorced were  $n=16(13\%)$  while the remaining  $n=3(2.4\%)$  were widows. Also  $n=1(0.8\%)$  participant did not indicate his or her marital status.

**Table 5.3 Distribution of the sample based on marital status**

Marital status	Number	Percent	Valid Percent
Single	43	34.7	35
Married	61	49.2	49.6
Divorced	16	12.9	13
Widow	3	2.4	2.4
Total	123	99.2	100
Missing	1	0.8	
Total	124	100	

### 5.3.2.5 Distribution of participants by ethnicity

According to Table 5.4, the majority of the participants were coloured  $n=74(60.2\%)$  and the second largest group were African  $n= 47(38.2\%)$ . The White and Indian population group were the minority and both ethnic groups had only 1 participant each, consisting of 0.8% each. One participant did not indicate his or her ethnicity. The fact that there were more coloured participants could be due to the fact that the population in the Western Cape consisted of more coloured people than any other ethnic groups in the past. Historically, the coloured people mostly occupied positions as general assistants/ cleaners in the four psychiatric hospitals.

**Table 5.4 Distribution of participants by ethnicity**

<b>Ethnicity</b>	<b>Number</b>	<b>Percent</b>	<b>Valid Percent</b>
<b>Coloured</b>	74	59.7	60.2
<b>White</b>	1	0.8	0.8
<b>African</b>	47	37.9	38.2
<b>Indian</b>	1	0.8	0.8
<b>Total</b>	123	99.2	100
<b>Missing</b>	1	0.8	
<b>Total</b>	124	100	

### 5.3.2.6 Distribution of participants by religion

The results in Table 5.5 reveal that from the total sample of 124, n= 2 (1.6%) participants did not indicate which religion they practice while the remaining 122(98.4%) participants responded. The Christian participants constituted n=114 (93.4%) of the total sample while Muslims were n= 6(4.9%). There were also n=1(0.8%) who were Hindu and n=1(0.8%) of the participants who indicated other.

**Table 5.5: Distribution of participants by religion**

<b>Religion</b>	<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>
<b>Christian</b>	114	91.9	93.4
<b>Muslim</b>	6	4.8	4.9
<b>Hindu</b>	1	0.8	0.8
<b>Other</b>	1	0.8	0.8
<b>Total</b>	122	98.4	100
<b>Missing</b>	2	1.6	
<b>Total</b>	124	100	

### 5.3.2.7 Distribution of participants by experience

Table 5.6 displays the years of experience of participants in a psychiatric facility. Of the total 124 participants, 1 (0.8%) did not respond to the amount of experience in a psychiatric facility. Of the 123(99.2%) participants, n= 55(44.7%) had less than 5 years of experience, n= 24(19.5%) had 5 to 10 years of experience, n= 3(2.4%) participants had between 11 and 15 years of experience, and n= 41(33.3%) had 16 and above years of experience.

**Table 5.6: Distribution of participants by years of experience**

Years of experience	Number	Percent	Valid Percent
0-5 years	55	44.4	44.7
5-10 years	24	19.4	19.5
11-15 years	3	2.4	2.4
16+ years	41	33.1	33.3
<b>Total</b>	123	99.2	100.0
<b>Missing</b>	1	0.8	
<b>Total</b>	124	100	

### 5.3.2.8 Distribution of participants by level of education

As shown in Table 5.7, n=123(99.2%) of the participants responded to the question on level of education, while n=1(0.8%) of the participant did not provide any response to the question on education. Interestingly, n=64 (52%) of the total participants completed between Grade 10-12, while n=4 (3.3%) had tertiary education. Of the remaining n=55 participants, 10(8.1%) of the participant's educational level ranged between grade R-4 while n=45(36.6%), on the other hand, had completed grade 5-9.

**Table 5.7: Distribution of participants by level of education**

Level of education	Frequency	Percent	Valid Percent
<b>Grade R-4</b>	10	8.1	8.1
<b>Grade 5-9</b>	45	36.3	36.6
<b>Grade 10-12</b>	64	51.6	52.0
<b>Tertiary education</b>	4	3.2	3.3
<b>Total</b>	123	99.2	100.0
<b>Missing</b>	1	.8	
<b>Total</b>	124	100.0	

## **5.4 Results on the knowledge of general assistants pertaining to mental illness**

### **5.4.1 Introduction**

Section B of the questionnaire focussed on the knowledge of the participants. The results on this section are presented below. The results are first reported in terms of univariate analysis (item analysis). Thereafter, the total score of the knowledge of the general assistants are reported. Bivariate analysis and inferential statistics are also reported in the appropriate section with other related concepts.

### **5.4.2 Item analysis**

#### **5.4.2.1 Knowledge on mental illness and prior training about mental illness**

Table 5.8 provides the results of the questions that tested whether general assistants have knowledge about mental illness and whether they had any prior basic in-service training or informal training on mental illness. Informal training refers to the type of training on ward or departmental level where registered nurses/ students have information sessions about specific diseases and mental illness.

The results indicated that of the 124 participants, n=2(1.6%) did not indicate how much knowledge they had pertaining to mental illness, n=45 (36.9%) of the general assistants



reported that they had knowledge regarding mental illness, whilst n=70 (57.4%) of the participants indicated that they had little knowledge and n=7(5.7%) of the participants indicated that they had no knowledge regarding mental illness.

With reference to Question B<sub>5</sub>, which test whether general assistants had in-service training, the results indicate that only n=29 (24%) of the participants had in-service/ informal training on mental illness while the majority of the participants n=92(76%) indicated that they never had informal training or in-service training regarding mental illness. Of the 124 participants, only 121 (97.6%) responded to the question and n=3(2.4%) did not indicate whether they had any previous in-service training.

**Table 5.8: Knowledge regarding mental illness and prior training about mental illness**

	Question/Statement	Frequency	Percent	Valid percent
B1	How Much Knowledge Do You Have Regarding Mental Illness?			
	Very Much	45	36.3	36.9
	A Little	70	56.5	57.4
	None	7	5.6	5.7
	Total	122	98.4	100.0
	Missing	2	1.6	
B2	Did you ever have in-service training/informal training about mental illness?			
	Yes	29	23.4	24
	No	92	74.2	76
	Total	121	97.6	100
	Missing	3	2.4	

#### 5.4.2.2 Factual information and myths regarding mental illness

Table 5.9 and Figure 5.2 provide the results of the questions addressing factual information and myths regarding mental illness as indicated in questions B<sub>3</sub> to B<sub>6</sub>.

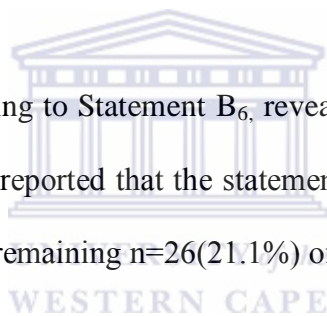
The results pertaining to question B<sub>3</sub> indicate that n=100(82%) of the participants responded that mental illness results from chemical imbalance of the brain, while n=22(18%) of the participants thought that mental illness does not emanate from chemical imbalances of the

brain. The aforementioned results represents the responses of 122 participants because n=2(1.6%) of the participants did not offer an opinion to the statement.

With reference to statement B<sub>4</sub> which states that, “People who have family members with mental illness will definitely get mental illness”, n=23(18.5%) of the participants stated that the statement is true while n=99(81.1%) of the patients stated that the statement is false, n= 2 (1.6%) of the 124 participants did not respond to the statement.

The results for item B<sub>5</sub> which stated that “people with mental illness are always rude and violent” are indicated as follows: A bigger portion n=86(69.9%) of the 124 participants reported that the statement is false, while almost 1/3 of the participants, n=37(30.1%) reported that the question is true. Of the total of 124 participants, a total of 123 (99.2%) responded.

The results in Figure 5.2, pertaining to Statement B<sub>6</sub>, reveals that out of the 124 participants, n=97 (78.9%) of the participants reported that the statement: “All people with mental illness are dangerous” is false while the remaining n=26(21.1%) of the participants indicated that the statement is true.



**Figure 5. 2: Results of Questions B3 to B6**

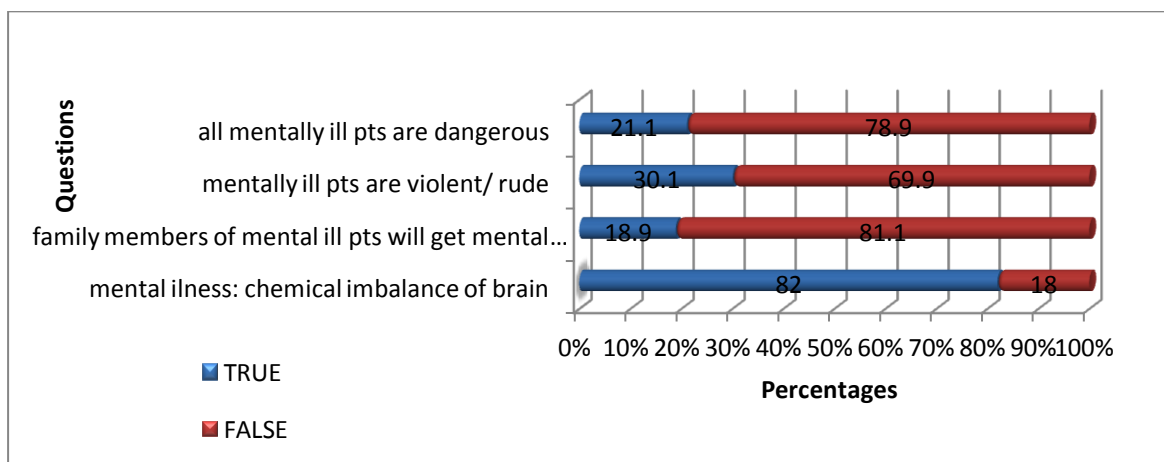


Table 5.9 display the results for statements B<sub>7</sub> to B<sub>10</sub>. The results obtained from statement B<sub>7</sub> revealed that the majority, n=114(92.7%) of the participants agreed to the statement that ‘stress can lead to other medical conditions such as high blood pressure and heart problems’. The remaining n=8(6.5%) reported that the statement made is false, while n=1(participant) was neutral with regards to the statement because the participant indicated true and false on their questionnaire. One other did not respond to the question.

Furthermore the results reveal that, n=98 (80.3 %) participants indicated that statement B<sub>8</sub>: ‘person who has recovered from mental illness will not be able to return to work, is false, while n=24 (19.7%) of the participants responded that the statement is true and n= 2(1.6%) did not respond to the statement.

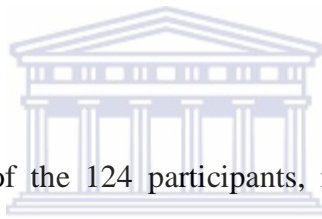


Table 5.9 also shows that out of the 124 participants, n=90 (73.8%) of the participants reflected that the statement “mental health is the absence of a mental illness,” is true while n=32 (26.2%) reported that it is false.

The results of statement B<sub>10</sub> reveal that n=75 (61%) of the participants confirmed the statement that ‘violence is associated with mental illness’ while n= 48(39%) rejected the statement by responding that the statement is false.

**Table 5.9: Factual information and myths regarding mental illness**

Questions	Factual information and myths regarding mental illness	Answers	Percentage (%)	Valid Percent (%)
B3	Mental illness is normally a result of a chemical imbalance of the brain? True False Total Missing	100 22 122 2	80.6 17.7 98.4 1.6	82 18 100
B4	People who have family members with mental illness will definitely get mental illness. True False Total Missing	23 99 122 2	18.5 79.8 98.4 1.6	18.9 81.1 100
B5	People with mental illness are always violent and rude True False Total Missing	37 86 123 1	29.8 69.4 99.2 0.8	30.1 69.9 100
B6	All people with mental illness are dangerous. True False Total Missing	26 97 123 1	21 78.8 99.2 0.8	21.1 78.9 100
B7	Stress can lead to other medical conditions such as high blood pressure and heart problems. True False Neutral Total Missing	114 8 1 123 1	91.9 6.5 0.8 99.2 0.8	92.7 6.5 0.8 100
B8	A person who recovers from the mental illness will not be able to return to work. True False Total Missing	24 98 122 2	19.4 79.0 98.4 1.6	19.7 80.3 100
B9	Mental health is the absence of a mental illness. True False Total Missing	90 32 122 2	72.6 25.8 98.4 1.6	73.8 26.2
B10	Violence Is Associated With Mental Illness. True False Total Missing	75 48 123 1	60.5 38.7 99.2 0.8	61.0 39.0 100

### 5.4.2.3 Basic knowledge on the aetiology, causes, risk factors and facts about Mental illnesses

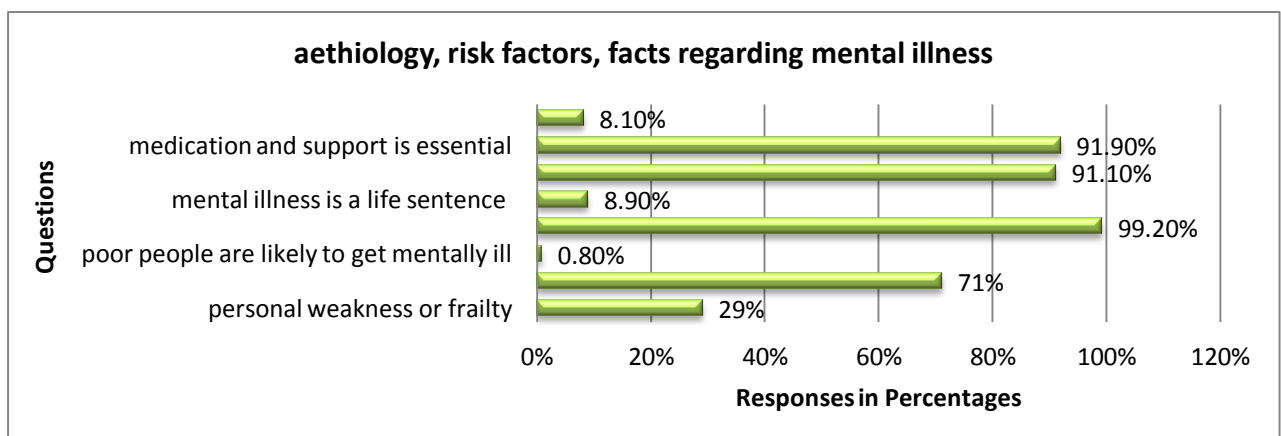
The results on the basic knowledge about the aetiology, causes, risk factors and facts on mental illnesses are displayed in Table 5.10 and Figure 5.3.

With reference to statement B<sub>11</sub>, the results in Figure 5.3 indicate that n=88(71%) of the 124 participants stated that mental illness is hereditary and can be passed on from one generation to another, while the remaining n=36 (29%) indicated that mental illness is a result of personal weakness.

Figure 5.3 also reveals that with regards to question B<sub>12</sub>, n=123(99.2%) of the 124 participants responded that anyone regardless of their intelligence, social class or income level is more likely to get a mental disease, while one respondent indicated that poor and uneducated people are more likely to get mental disease.

Out of the total of 124 participants, n=11 (8.9%) of the participants regard mental illness as a life sentence, while the other 113( 91.1%) participants stated that mental illness can be regarded as a disease where a person’s quality of life can improve with treatment.

**Figure 5.3: Aethiology, risk factors, facts regarding mental illness**



The results, with reference to statement B<sub>14</sub>, in Figure 5.3 reveal that n=114 (91.9%) of the total sample responded that medication and continuous support is essential for mentally ill patients, while the remaining 10(8.1%) indicated that good friends are essential for mentally ill clients to be stable.

The responses to statement B<sub>15</sub>, represented in Figure 5.4, show that out of the total participants, n=90(72.6%) stated that substance and drug abuse increase the risk of mental illness, while n=15(12,1%) of the total sample reported that a family history of mental illness increases one's risk of mental illness. The remaining n=19(15.3%) participants indicated that if you are friends with mentally ill patients then it increase the risk of mental illness



**Figure 5.4. Risk factors that increase risk of mental illness**

#### 5.4.2.4 Myths regarding mental illness

In general, there are various myths, misperceptions and beliefs around mental illnesses. Some of these myths and beliefs were included in the questionnaire to test the opinions of the research participants on the appropriateness of these myths and beliefs.

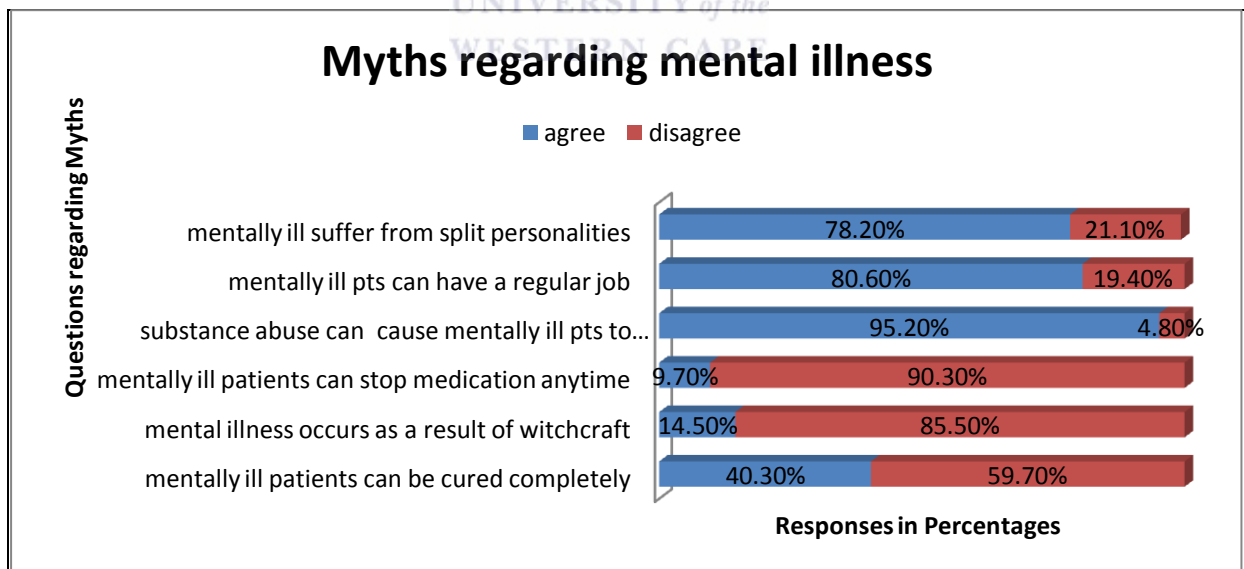
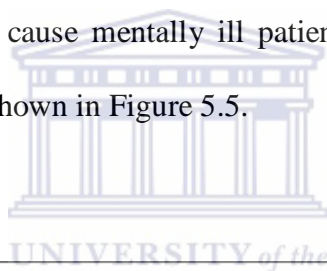
With reference to statement B<sub>16</sub>, Figure 5.5 reveals that more than half of the participants n=74 (59.7%) disagreed with the statement that mentally ill patients can be cured completely,

while n=50(40.3%) of the participants indicated that mentally ill patients can be cured completely.

Interestingly, the results on statement B<sub>17</sub> indicated that n=106(85.5%) of the participants disagreed with the statement “mental illness occurs as a result of witchcraft”, while the remaining 18 participants (14.5%) agreed with the statement.

The results on statement B<sub>18</sub> showed that the majority of the participants, n=112(90.3%) rejected the statement that “mentally ill patients can stop their medication at any given time and can start their medication again without experiencing problems”. The remaining n=12 (9.7%) of the participants, however agreed to the statement.

In addition, the results of question B<sub>19</sub> reveal that n=118(95.2%) of the 124 participants agreed that substance abuse can cause mentally ill patients become worse, while 6(4.8%) disagreed with the statement- as shown in Figure 5.5.



**Figure 5.5 Myths regarding mental illness**

The results for statement B<sub>20</sub> in Figure 5.5 and Table 4.10 show that n=100(80.6%) of the participants responded that mentally ill patients can have a regular job and still function well while the remaining 24(19.4%) disagreed with the statement.

The results for statement B<sub>21</sub> indicate that the majority of the participants, n=97(78.9%) are of the opinion that mentally ill patients suffer from split personalities while the minority, 26(21.1%) disagreed with the statement.

#### **5.4.2.5 Basic knowledge on treatment plans, modalities, treatment facilities**

The results displayed in Table 5.10 reveal that n = 118(95.9 %) of the 124 participants agreed that mentally ill patients always need medication to control their sickness while n=5 (4.1%) participants disagreed with the statement.

The results also reveal that n= 102 (82.9%) of the 124 participants agreed to the statement: “Mentally ill patients can be treated successfully at community health centres”, while n=21 (17.1%) disagreed. The majority of the participants, n= 111(90.2%) of the total participants, responded that they disagree with the statement that mental illness can be cured by a sangoma, One participant was neutral in the matter and another participant did not respond. Only n=11 (8.9%) agreed that a sangoma can cure mental illness.

#### **5.4.2.6 Basic knowledge regarding the management of mentally ill clients**

The results for statement B<sub>25</sub> displayed in Table 5.10 showed that the majority of the participants, n=123 (99.2 %) responded that mentally ill patients should be admitted in hospitals when they are a danger to themselves and others while one participant did not respond to the statement.

With reference to statement B<sub>26</sub> that explored whether “Mentally ill patients should receive treatment from a doctor, clinic or mental health nurse,” Table 5.10 also reveal that the majority of the participants, n=118(95.9%) responded yes to the statement. On the other hand, n=5(4.1%) participants responded by stating ‘no’, implying that mentally ill patients should not receive treatment from a clinic, doctor or mental health nurse. Finally, n=1 (0.8%) participant did not respond to the statement.



Furthermore, the results presented in Table 5.10 with regard to statement B<sub>27</sub>, which states that: ‘Mentally ill patients who are aggressive and swearing without triggers are just rude’, indicate that n=64 (52.5%) of the participants responded ‘yes’, meaning that they think that the patients are just being rude; n=58(47.5%) of the participants replied ‘no’, which means they don’t view the patients as rude. However, n = 2 (1.6%) of the 124 participants did not respond to the statement.

The results of B<sub>28</sub>, showed that out of the 124 participants, n=117(95.1%) replied ‘yes’ to the Statement “the patients who are difficult to manage, talking to themselves and who are violent in the hospital as psychotic”, however n=6 (4.9%) of the participants disagreed with the statement, one participant did not respond.



**Table 5.10: Basic Knowledge about the aetiology, causes, risk factors & facts regarding mental illness**

Questions B <sub>11</sub> to B <sub>28</sub>	Questions regards to aetiology, causes, risk factors & facts regarding mental illness	Frequency(n)	Valid Percent (%)
11	Mental illness is caused by: Personal weakness/frailty It is hereditary and can be passed on from one generation to the next Total	36 88 124	29.0 71.0 100
12	Who is more likely to get mental illness: poor and uneducated people or anyone regardless of their intelligence, social class or income level Total	1 123 124	0.8 99.2 100
13	Mental illness can be regarded as a : Life sentence A persons quality of life can improved with treatment Total	11 113 124	8.9 91.1 100
14	The following is essential for mentally ill patients: Medication and support Good friends Total	114 10 124	91.9 8.1 100
15	The following aspects increase the risk of mental illness: Substances & drug abuse Family history of mental illness Being friends with mentally ill patients Total	90 15 19 124	72.6 12.1 15.3 100
16	Mentally ill patients can be cured completely I agree I disagree Total	50 74 124	40.3 59.7 100
17	Mental illness occurs as a result of witchcraft I agree I disagree Total	18 106 124	14.5 85.5 100
18	Mentally ill patients can stop their medication at any time without experiencing any problems. I agree Disagree Total	12 112 124	9.78 90.22 100
19	Substance abuse can cause mentally ill patients to become worse. I agree Disagree Total	118 6 124	95.2 4.8 100
20	Mentally ill patients can have a regular job and function well I agree Disagree Total	100 24 124	80.6 19.4 100

Questions B <sub>11</sub> to B <sub>28</sub>	Questions regards to aetiology, causes, risk factors & facts regarding mental illness	Frequency(n)	Valid Percent (%)
21	Mentally ill patients suffer from split personalities I agree Disagree Total Missing	97 26 123 1	78.9 21.1 100
21	Mentally ill patients suffer from split personalities I agree Disagree Total Missing	97 26 123 1	78.9 21.1 100
22	Mentally ill patients always need prescribed medication to control their sickness I agree Disagree Total Missing	118 5 123 1	95.2 4.0 100
23	Mentally ill patients can be treated successfully at community health centres I agree Disagree Total Missing	102 21 123 1	82.9 17.1 100
24	Mental illness can be treated by a sangoma or traditional healer I agree Disagree Neutral Total Missing	11 111 1 123 1	8.9 90.2 0.8 100
25	Mentally ill patients should be admitted in hospitals when they are a danger to themselves and others yes no Total Missing	123 0 123 1	100 0 100
26	Mentally ill patients must receive treatment from a clinic or doctor or mental health nurse yes no Total Missing	118 5 123 1	95.9 4.1 100
27	Mentally ill patients who are aggressive and swearing without any triggers are just rude yes no Total Missing	117 6 123 1	95.1 4.9 100
28	When patients are difficult to manage, talking to themselves and they are violent in the hospital, are they psychotic? Yes No Total Missing	117 6 123 1	95.1 4.9 100

#### **5.4.2.7 Verification of the objective (1): “To identify the level of basic knowledge of General Assistants pertaining to mental illness”**

In order to verify the level of basic knowledge of the general assistants pertaining to mental illness three steps were applied which include:

- Item analysis ,
- Association of items and socio-demographic variables developed in bivariate analysis section and
- Analysis of total score of knowledge.

##### **5.4.2.7.1 Items analysis**

The analysis of the various items related to the knowledge of the general assistants shows that most of the participants responded correctly to the statements, therefore, they were classified as having good knowledge.

##### **5.4.2.7.2 Total scores**

To identify the level of basic knowledge of the general assistants on mental illness, the total score of the items addressing knowledge of the general assistants was computed. A scale was established to interpret the level of knowledge as indicated below:

Level 1= Having no knowledge of mental illness ranged between 0.00- 0.25

Level 2= indicates poor knowledge of mental illness ranged between 0.26-0.5,

Level 3= indicates moderate knowledge and ranged between 0.51-0.75

Level 4=indicates that the participants have good knowledge and the Scale ranged between 0.76-1.00.

Table 5.11 presents the results obtained after computing the total score of the knowledge as scaled above. Of the 124 research participants, only n=119 (96%) completed all the questions in the knowledge section. The missing participants n=5 (4%) refer to the participants who did

not respond to all the questions. Although a category was created for “No knowledge”, none of the participants were in this category. The majority of the participants  $n=90(75.6\%)$  demonstrated that they have ‘good knowledge’ about mental illnesses and  $n=27(22, 7\%)$  showed ‘moderate knowledge’, while only  $n=2 (1.7\%)$  revealed ‘poor knowledge’ regarding mental illness. In addition, the mean and standard deviation (SD) of the total score of the knowledge were ( $\bar{x}=0.83$  and  $SD=0.11$ ). As the mean falls in the range (0.76-1), it is reasonable to conclude that the participants have good knowledge pertaining to mental illness.

**Table 5.11: Frequency table of the total knowledge**

Total knowledge	Frequency	Percent	Valid percent
Poor knowledge	2	1.6	1.7
Moderate knowledge	27	21.8	22.7
Good knowledge	90	72.6	75.6
Total	119	96.0	100
Missing	5	4	

## 5.5 Results on the attitudes of General Assistants towards mental illness

### 5.5.1 Introduction

The results presented in this section are based on statements C29-C52 in the questionnaire. This section is aimed at determining what the attitudes of the general assistants are towards mentally ill patients in the psychiatric institutions. The results are primarily presented in univariate analysis and the total score of the attitudes. The bivariate analysis is presented with inferential statistics in the appropriate section (Section 5.7). The results are based on a likert scale and are presented in the same fashion.

### 5.5.2 Item analysis

Since permission had been obtained to adapt and modify the questionnaire, the researcher analyzed the results based on the response bias scale (RBS) supplement as described in the manual for administration, scoring and interpretation designed by Ben-Porath & Tellegen (2011). A scale of interpretation was constructed between 1 and 5 to enhance the interpretation of the results in a meaningful manner.

Table 5.12 provides the responses of the participants in relation to the statements in Q29-52. The scores that were applied to the univariate results, on the attitudes of general assistants towards mental illness, were developed as follows:

1.00-1.49

1.50-2.49

2.50-3.49

3.50-4.49

4.50- 5.00



Further, the ranges including number 1 to 3 were combined and were considered as negative attitudes for the total score of attitudes whilst the ranges number 4 to 5 were combined and regarded as positive attitudes.

#### 5.5.2.1 I feel ashamed of mentally ill patients

The results in Table 5.12 below show that the majority of the participants  $n=53$  (42.7%) indicated that they strongly disagree with the statement above, another  $n=30$ (24.2%) indicated that they disagree with the statement that was made. In contrast  $n=39$ (31.5%) of the participants indicated that they are ashamed of mentally ill clients,  $n=25$ (20.2%) agreed with the statement, I feel ashamed of mentally ill patients, while the remaining  $n= 14$ (11.3%) of participants strongly agreed with the statement. Out of 124 participants, one person was neutral - which means he/she neither agreed nor disagreed and  $n=1$  (0.8%) did not respond to

the statement. The average mean and standard deviation were ( $\bar{x} = 3.67$  and  $SD = 1.47$ ). With reference to the scale of interpretation, as indicated above, it could be seen that the participants were ranked between 3.50 and 4.49, an indication that the majority of the participants disagreed with the statement that “I feel ashamed of mentally ill patients”, implying that the participants displayed positive attitudes.

#### **5.5.2.2 I do not like working with mentally ill patients**

Table 5.12 below, indicates that the majority of the participants  $n=56(45.2\%)$  reported that they strongly disagreed with the statement. Furthermore,  $n=46(37.1\%)$  of the participants disagreed with the statement, meaning that they like working with mentally ill patients. However, out of the remaining  $n=16(12.9\%)$ ,  $n=14$  (11.3%) indicated that they agreed with the statement, while the remaining  $n=2(1.6\%)$  strongly agreed with the statement; meaning that they do not like working in this environment, with mentally ill patients. Furthermore, the average mean and standard deviation were ( $\bar{x} = 4.14$  and  $SD = 1.04$ ). With reference to the scale of interpretation, as indicated above, it could be observed that the participants were ranked between 3.50 and 4.49, an indication that the majority of the participants disagreed with the statement that; “I don’t like working with mentally ill patients”. These results also imply a positive attitude towards mentally ill patients.

#### **5.5.2.3 I feel working with mentally ill patients is stressful**

Table 5.12 below shows that a total of  $n=4(3.3\%)$  of the participants strongly agreed with the statement,  $n=34(27.6\%)$  agreed with the statement. The remaining  $n=34$  (27.6%) disagreed with the statement. Another  $n=39$  (31.7%) indicated that they strongly disagreed with the statement. Of the 124 participants,  $n=12$  (9.8%) neither agreed nor disagreed with the statement,  $n=1$  (0.8%) participant did not respond. The mean and standard deviation were ( $\bar{x} = 2.43$  and  $SD = 1.28$ ). With reference to the scale of interpretation, as indicated above,

it could be observed that the majority of the participants were ranked between 1.5 and 2.49, an indication that the majority of the participants disagreed with the statement: “ I feel working with mentally ill patients is stressful”. However, the mean score reveals the opposite. With the value of 2.43, it is reasonable to imply that they had negative attitudes towards mentally ill patients.

#### **5.5.2.4. I’m afraid of mentally ill patients**

The results in Table 5.12 indicate that out of the 124 participants n=107 (86.3%) disagreed with the statement that they are afraid of mentally ill patients. Of the n=107(87%) who disagreed, n=50(40.7 %) strongly disagreed while the remaining n=57(46.3%) simply disagreed. Table 5.12 also indicates that n=7(5.7%) are afraid of mentally ill patients (agreed with the statement). Furthermore, n=9(7.3%) neither agreed nor disagreed with the statement while one participant (0.8%) did not respond to the question. The average mean and standard deviation were ( $\bar{x} = 4.22$  and  $SD = 0.82$ ). With reference to the scale of interpretation, as indicated above, it could be seen that the participants were ranked between 3.50 and 4.49, an indication that the majority of the participants disagreed with the statement: “**I’m afraid of mentally ill patients**”. Since the mean score was 4.22, it implies that the attitude of general assistants were positive with regards to this item.

#### **5.5.2.5 I don’t want to stay with mentally ill patients in the same house**

The results in Table 5.12 indicate that n=41(33.3%) strongly disagree with the above statement. Approximately, a third of the participants, n=40 (32.5%) also disagreed with the statement: I don’t want to stay with mentally ill patients in the same house. A portion of the participants, n= 26(21.1%) agreed to the statement and further n=3(2.4%) strongly agreed with the statement. This could be due to the fact that they observed mentally ill patients’ behaviour on a daily basis. Furthermore, n= 13(10.6%) were neutral; they neither agreed nor



disagreed. Lastly, one participant did not offer an opinion to the statement. The average mean and standard deviation were ( $\bar{x} = 3.73$  and  $SD = 1.20$ ). With reference to the scale of interpretation, the mean score indicates that the participants were ranked between 3.5 and 4.4, an indication that the majority of the participants were in agreement with the statement “**I don’t want to stay with mentally ill patients in the same house**”. It could be concluded that they had a positive attitude towards staying with mentally ill patients in the same house.



**Table 5.12 Attitudes of general assistants towards mental illness**

Questions	Total Responses	SA	A	N	D	SD	Missed Responses	Mean	STD
Q29. I feel ashamed of mentally ill patients	n=124	14	25	1	30	53	1	3.7	1.48
	%	11.4	20.3	0.8	24.4	43.1	0.8		
Q30. I don't like working with mentally ill patients	n=124	2	14	5	46	56	1	4.14	1.04
	%	1.6	11.4	4.1	37.4	45.5	0.8		
Q31. I feel working with mentally ill patients is stressful	n=124	4	34	12	34	39	1	2.43	1.28
	%	3.3	27.6	9.8	27.6	31.7	0.8		
Q32. I'm afraid of mentally ill patients	n=124	0	7	9	57	50	01	4.22	0.82
	%	0	5.7	7.3	46.3	40.7	0.8		
Q33. I don't want to stay with mentally ill patients in the same house	n=124	3	26	13	40	41	1	3.74	1.20
	%	2.4	21.1	10.6	32.5	33.3	0.8		

%; percentage, n=frequency, SA= Strongly Agree, A=Agree, N=Neutral, D=Disagree, SD= Strongly Disagree and STD=Standard Deviation

### 5.5.2.6 I often feel like laughing at the mentally ill patients

The results presented in Table 5.13 indicated that out of the total of 124 participants, n=43(35%) strongly disagreed to the statement: 'I often feeling like laughing at the mentally ill patients'. It can also be seen that n=38(30.9%) disagreed with the statement. A small portion of the participants, n=26(21.1%) agreed that they often feel like laughing at the mentally ill patients and an even smaller portion n= 6(4.9%) strongly agreed with the statement. Finally, out of the 124 participants, one participant did not respond. The average mean and standard deviation were ( $\bar{x} = 3.70$  and  $SD = 1.28$ ). Casting the total mean against the above scoring scale reveals that the participants were ranked between 3.5 and 4.4,

which is an indication that the majority of the participants disagreed that “**they often feel like laughing at mentally ill patients**”. This implies a positive attitude towards the patients.

#### **5.5.2.7 Mentally ill patients often provoke anger in me**

With reference to the statement “Mentally ill patients often provoke anger in me”. The results in Table 5.13 show that the majority of the participants responded that mentally ill patients don’t provoke anger in them. Out of 124 participants, n=51 (41.5%) indicated that they strongly disagree with the statement while n= 36 (29.3%) of the participants disagreed with the statement. A small portion of the participants n=7(5.7%) were neutral and indicated that they neither agreed nor disagreed with the statement indicating that mentally ill patients often provoke anger in them. In contrast to the above results, n=27(22%) indicated that they agreed with the statement while another n=2(1.6%) participants strongly agreed that mentally ill patients provoke anger in them. The average mean and standard deviation were ( $\bar{x} = 3.87$  and  $SD = 1.22$ ). Referring to the scale indicated above, the mean falls between 3.50 and 4.49. This is an indication that the majority of the participants disagreed that “**Mentally ill patients often provoke anger in them**”. This implies a positive attitude.

#### **5.5.2.8 I often get upset with mentally ill patients**

The results pertaining to this statement are represented in Table 5.13 and it indicates that 48(38.7%) of the participants strongly disagreed with the statement that they often get upset with mentally ill patients. A further, n=33 (26.6%) of the participants responded that they disagreed with the statement too. On the other hand, n=24(19.5%) of the participants indicated that they do get upset with mentally ill patients and 2(1.6%) strongly agreed with the statement; also, n=16(13%) of the participants neither agreed nor disagreed with the statement. Lastly, one participant did not reveal his or her attitude related to this statement.

The mean and standard deviation of the total score were ( $\bar{x}=3.83$  and  $SD=1.20$ ). Placing the mean value on the scale of interpretation above, it shows that the participants were ranked between 3.50 and 4.49. This is an indication that the majority of the participants disagreed with the statement “**I often get upset with mentally ill patients**”. This also implies a positive attitude.

#### **5.5.2.9 I will easily marry someone with mental illness**

Table 5.13 shows that the majority of the participants,  $n=92$  (74%), are not willing to marry someone with mental illness. In terms of degree of unwillingness,  $n=53$ (43.1%) strongly disagreed with the statement while another  $n=38$ (30.9%) simply disagreed with the statement. Another  $n=12$ (9.8%) neither agreed nor disagreed with the statement. Also  $n=1$  (0.8%) of the participants did not respond to the statement. Those who strongly agreed were  $n=4$ (3.3%) and  $n=16$ (13%) agreed to easily marrying someone with mental illness. The average mean and standard deviation computed for this statement were  $\bar{x}=2.02$  and  $SD=1.16$ . Referring the mean to the scale of interpretation indicated above, it could be seen that the participants were ranked 1.50-2.49. This is an indication that the majority of the participants disagreed that they **will easily marry someone with mental illness**. This implies that the general assistants displayed reluctance to easily marrying someone with mental illness and it also implies that the general assistants display negative attitudes towards mentally ill patients in this regard.

#### **5.5.2.10 I don't trust mentally ill patients**

What is interesting in Table 5.13 is that the majority of the participants indicated that they don't trust the mentally ill patients, with  $n=55$ (44.7%) of the participants agreeing to the statement. Nine (7.3%) participants revealed that they strongly agreed and, therefore, don't trust the patients. In contrast,  $n=26$ (21.1%) disagreed and the remaining  $n=15$ (12.2%)

reported that they strongly disagreed with the statement. Of the 124 participants, only one participant did not respond, while  $n=18(14.6\%)$  neither agreed nor disagreed with the statement 'I don't trust mentally ill patients.' The average mean and standard deviation represented in this item were ( $\bar{x} = 2.86$  and  $SD = 1.2$ ). Weighing the mean value on the scale of interpretation defined above, it shows that the participants were ranked within 2.50 - 3.49, thus indicating that the majority of the participants agreed that **“they don't trust mentally ill patients”**. This implies a negative attitude towards mentally ill patients.

#### **5.5.2.11 I treat all mentally ill patients the way I treat my children**

With reference to Table 5.13, it is evident that the majority of the participants agreed that they treat the mentally ill patients as their children. The results indicated that  $n=123$ , out of the total 124 participants, responded to the question while one participant did not offer an opinion. The results that are discussed in this paragraph only represent the results of the  $n=123$  participants, of which  $n=62(50.4\%)$  agreed to treating all mentally ill patients the way they treat their children. Another  $n=30(24.4\%)$  of the participants confirmed that they strongly agree with the statement. Ten (8.1%) of the 124 participants remained neutral which means they neither agreed nor disagreed with the statement. The minority of the participants,  $n= 21(17.1\%)$ , disagreed with the statement. The average mean and standard deviation were ( $\bar{x} = 3.78$  and  $SD = 1.08$ ). Placed on the scale for interpretation indicated above, it reveals that the participants were ranked between 3.50 and 4.49, an indication that the majority of the participants agreed to **treating all mentally ill patients the way they treat their children**. The assumption is that the general assistants treat their children positively, thus, based on the scale of interpretation the results reveal a positive attitude.

#### **5.5.2.12 I would feel ashamed if I have mentally ill family members**

The responses pertaining to statement 40 as displayed in Table 5.13 reveal that the majority of the participants would not feel ashamed if they had mentally ill family members. Just like in the previous items, one of the total population did not respond to the question. Fifty-four (43.9%) participants indicated that they strongly disagreed with the statement, while another  $n=37$  (30.1%) simply disagreed with the statement. In contrast, some participants indicated that they would feel ashamed if they had a family member who is mentally ill  $n= 29$ (23%). These fell in the category of agreed and strongly agreed. The average mean and standard deviation of the unit were ( $\bar{x} = 3.89$  and  $SD = 1.29$ ). Situating this mean on the scale of interpretation placed it between 3.50 and 4.49, which indicates that the majority of the participants **would not feel ashamed if they had mentally ill family members**. Based on this unit, it could be assumed that the majority of the general assistants had positive attitudes towards mentally ill patients.

#### **5.5.2.13 I often become frustrated if the patients don't do what is required of them**

One participant (0.8%) did not offer a response to the statement 'I often become frustrated if the patients don't do what is required of them' while the remaining  $n=123$  (99.2%) participants gave an opinion. In total  $n= 34$ (27.6%) participants reported that they disagreed with the statement mentioned above. Following this, another  $n= 34$  (27.6%) of the participants strongly disagreed that they often become frustrated if the patients don't do what is expected of them. Furthermore,  $n=18$ (14.6%) of the participants neither agreed nor disagreed with the statement, while  $n=32$  (26%) agreed that they often become frustrated if the patients don't do what is expected of them and  $n=5$ (4.1%) strongly agreed. The computed mean and standard deviation were ( $\bar{x} = 3.49$  and  $SD = 1.26$ ). Locating the obtained mean to the designed scale of interpretation shows that the participants were ranked between 2.50 -

3.49. This is an indication that the majority of the participants disagreed with the statement: **I often become frustrated if the patients don't do what is required of them.** Despite the fact that the majority disagreed with the statement, the mean indicated that the participants were likely to have a negative attitude towards mentally ill patients.

#### **5.5.2.14 I usually get upset if patients continue to mess and wet the floors especially after I cleaned**

In Table 5.13 the majority of the participants  $n=38$  (30.9%) showed that they disagreed with the statement that they get upset if patients continued to mess and wet the floor after they have cleaned it. Another  $n=34$  (27.6%) of the participants also confirmed it by indicating that they strongly disagreed with the same statement. Contrary to this,  $n=31$ (25.2%) of the participants indicated that they do get upset if the patients continue to mess and wet the floors especially after they have cleaned, while  $n=10$  (8.1%) neither agreed nor disagreed with the statement. Lastly,  $n=10$ (8.1%) strongly agreed that they usually got upset if patients continued to mess after they cleaned. The calculated mean and standard deviation were ( $\bar{x} = 3.45$  and  $SD = 1.34$ ). Weighed against the developed scale of interpretation reveals that the participants were ranked between 2.5-3.49, indicating that the majority of the participants were likely to have a negative attitude despite the fact that the frequency table indicated that the majority disagreed with the statement **“I usually get upset if patients continue to mess and wet the floors especially after I cleaned”**.

**Table 5.13: Attitudes of General Assistants towards mentally ill patients**

Questions	n	SA	A	N	D	SD	Missed responses	Mean	SD
Q34. I often feel like laughing at the mentally ill patients	n=124	6	26	10	38	43	1	3.70	1.28
	%	4.9	21.1	8.1	30.9	35	0.8		
Q35. Mentally ill patients often provoke anger in me	n=124	2	27	7	36	51	1	3.87	1.22
	%	1.6	22	5.7	29.3	41.5	0.8		
Q36. I often get upset with mentally ill patients	n=124	2	24	16	33	48	1	3.82	1.19
	%	1.6	19.5	13	26.8	39	0.8		
Q37. I will easily marry someone with mental illness	n=124	4	16	12	38	53	1	2.02	1.16
	%	3.2	13	9.8	30.9	43.1	0.8		
Q38. I don't trust mentally ill patients	n=124	9	55	18	26	15	1	2.86	1.20
	%	7.3	44.7	14.6	21.1	12.2	0.8		
Q39. I treat all mentally ill patients the way I treat my family	n=124	30	62	10	16	5	1	3.78	1.08
	%	24.4	50.4	8.1	13	4.1	0.8		
Q40. I would feel ashamed if I have mentally ill family members	n=124	6	23	3	37	54	1	3.89	1.29
	%	4.9	18.7	2.4	30.1	43.9	0.8		
Q41. I often become frustrated if the patients don't do what is required of them	n=124	5	32	18	34	34	1	3.49	1.26
	%	4.1	26	14.6	27.6	27.6	0.8		
Q42. I usually get upset if patients continue to mess after I cleaned	n=124	10	31	10	38	34	1	3.45	1.34
	%	8.1	25.2	8.1	30.9	27.6	0.8		

**%: percentage; SA: strongly agree, A: agree; NAD: neither agree nor disagree; D: disagree; SD: strongly disagree; SD: standard deviation; n: frequency**

**5.5.2.15 I don't want to work with someone who has mental illness.**

In Table 5.14, it could be noted that out of the 124 participants, n=123(99.2%) responded to the statement while n=1(0.8%) did not respond to the question. With regards to the results in Table 5.14, the majority of the participants, n=52(42.3%), indicated that they disagreed with



the statement; meaning that the majority of the people want to work with mentally ill patients. Another  $n=46$  (37.4%) strongly disagreed with the statement. Out of 124 participants,  $n=10$  (8.1%) neither agreed nor disagreed with the statement. Lastly,  $n=15$  (12.2%) agreed with the statement. In addition, the average mean and standard deviation were ( $\bar{x} = 4.05$  and  $SD = 0.97$ ). With reference to the scale of interpretation above, the mean fell within 3.50 - 4.49 which means the majority of the participants disagreed that they don't want to work with someone who has mental illness. These results imply that the majority of the general assistants have positive attitudes towards mentally ill patients.

#### **5.5.2.16 I'm often afraid and scared of being in the same place with mentally ill patients.**

This item is also represented in Table 5.14. The majority of the participants disagreed with the statement that indicated that they are not afraid and scared of being in the same place with mentally ill patients. This could be due to the fact that they are exposed to mentally ill patients and that they might have gained an understanding into the patient's behaviour.

Of the 124 participants,  $n=123$  participants (99.2%) responded to the question while the remaining  $n=1$  (0.8%) of the participants did not respond to the questions. Therefore, the results obtained are based on the responses of the  $n=123$  (99.2%) participants. Of the 123 participants,  $n=50$  (40.7%) responded that they strongly disagreed with the statement while another  $n=45$  (36.6%) responded that they disagreed. Further,  $n=12$  (9.8%) participants neither agreed nor disagreed with the statement. Lastly,  $n=13$  (10.6%) participants agreed with the statement while another  $n=3$  (2.4%) strongly agreed with the statement above. The mean and standard deviation computed were ( $\bar{x} = 4.02$  and  $SD = 1.08$ ). With reference to the scale of interpretation indicated above, the participants were ranked 3.50 - 4.49, an indication that the majority of the participants disagreed that they are **often afraid and scared of being in the same place with mentally ill patients**. These results show positive attitudes of the general assistants towards mentally ill patients.

### **5.5.2.17 I feel comfortable working with mentally ill patients**

The results in Table 5.14 show that the majority of the patients feel comfortable working with mentally ill patients because out of the total participants, n=52(42.3%) agreed with the statement made in unit 52. Furthermore, n=36(29.3%) participants indicated that they strongly agreed with the statement. However, n=17 (13.8%) participants disagreed which means that they are not comfortable working with the mentally ill clients and n=6(4.9%) participants strongly disagreed with the statement. One participant (0.8%) did not answer the question while n=12(9.8%) neither agreed nor disagreed with the statement. The average mean and standard deviation were ( $\bar{x} = 3.77$  and  $SD = 1.16$ ). Weighed on the scale of interpretation, it can be seen that they were ranked 3.5-4.49, an indication that the majority of the participants agreed to feeling comfortable working with mentally ill patients. These display positive attitudes towards mentally ill patients.

### **5.5.2.18 Mentally ill patients should be discriminated against when applying for services or work**

The results pertaining to this item as displayed in Table 5.14 indicate that the majority of the participants were not in agreement with the statement. Of the n=124, one participant did not respond to the question. For those who responded, n=64 (52%) strongly disagreed with the statement that mentally ill patients should be discriminated against when applying for services or work. Another n=46(37.4%) indicated that they disagreed with the statement which means that they are not in favour of the fact that mentally ill patients should be discriminated against. Three participants (2.4%) were neutral with regards to the statement, meaning that they did not agree nor disagree with the statement. Lastly, a small percentage of the participants, n=10(8.1%) agreed that mentally ill clients should be discriminated against. The mean and standard deviation calculated for this unit were ( $\bar{x} = 4.33$  and  $SD = 0.88$ ).

Gauging the mean value on the scale of interpretation reveals that the participants were ranked 3.5 - 4.49, indicating that the majority of the participants disagreed that 'mentally ill patients being discriminated against when applying for services or work'. This implies that the general assistants displayed positive attitudes towards mentally ill patients in this regard.

#### **5.5.2.19 Mentally ill patients should get an equal opportunity like those who are not mentally ill when they are applying for work.**

The results pertaining to item 46 as indicated in Table 5.14 revealed similar results as the previous item. The majority of the participants were in favour of the fact that mentally ill patients should get equal opportunities as those who are not mentally ill when they are applying for services or work. Out of the total number of the participants, n=49(39.8%) agreed with the statement and n=43 (35%) strongly agreed that mentally ill patients should get equal opportunities as those who are not mentally ill. Furthermore, n=8(6.5%) of the participants neither agreed nor disagreed with the statement. Table 5.14 indicates that n=17 (13.8%) participants were of the opinion that mentally ill patients should not get equal opportunity as those who are not mentally ill because they disagreed with the statement made in item 47. Lastly, n=6(4.9%) strongly disagreed with the statement as well. The average mean and standard deviation of this item were ( $\bar{x} = 3.86$  and  $SD = 1.18$ ). Locating the mean on the scale of interpretation reveals that the participants were ranked at 3.5-4.49. This is an indication that the majority of the participants disagreed that mentally ill patients should get an equal opportunities as those who are not mentally ill when they are applying for work. This reveals an aspect of positive attitudes of the general assistants towards mentally ill patients.

#### **5.5.2.20 I feel that mentally ill patients are a nuisance.**

The results of item 48 displayed in Table 5.14 revealed that the majority of the participants displayed a positive outlook on the question because the majority of the respondents,  $n=57(46.3\%)$  strongly disagreed, with the statement that “I feel mentally ill patients are a nuisance”. Further,  $n=48(39\%)$  participants simply disagreed that the mentally ill patients are a nuisance. Hanging on the fence,  $n=11(8.9\%)$  neither agreed nor disagreed that they feel mentally ill patients are a nuisance. The remaining  $n=1(0.8\%)$  strongly agreed and  $n=6(4.8\%)$  agreed that they feel that mentally ill patients are a nuisance. The mean and standard deviation computations gave the following values ( $\bar{x} = 4.25$  and  $SD = 0.87$ ). Representing the mean value on the scale, shows that the participants were ranked at 3.5-4.49. This is an indication that the majority of the participants disagreed that they feel that mentally ill patients are a nuisance; implying that the general assistants showed a component of positive attitudes towards mentally ill patients.

#### **5.5.2.21 I sometimes behave or treat patients negatively**

Table 5.14 reveals the results of the statement ‘I sometimes behave or treat patients negatively’. The findings reveal that the majority of the participants do not sometimes behave or treat the patients negatively. The reported results only reflect the responses of the  $n=123$  participants that responded to the question as  $n=1(0.8\%)$  participant did not respond to the question. Of the total  $n=123$  participants, approximately half  $n=65(52.8\%)$  strongly disagreed with the statement and  $n=41(33.3\%)$  disagreed that they sometimes treat mentally ill patients negatively. In contrast to the aforementioned results,  $n=7(5.7\%)$  participants agreed that they sometimes behave or treat patients negatively and  $n=3(2.4\%)$  participants strongly agreed with the statement. Lastly,  $n=7(5.7\%)$  of the participants indicated that they neither agreed nor disagreed that they sometimes behave or treat patients negatively. With a mean and

standard deviation of ( $\bar{x} = 4.28$  and  $SD = 0.98$ ), the mean of the participants' responses were ranked between 3.5-4.49, an indication that the majority of the participants did not agree that sometimes they behave or treat patients negatively. This adds another component of positive attitudes of the general assistants.

#### **5.5.2.22 I'm sometimes harsh with mentally ill patients**

In Table 5.14 the results pertaining to item 50 reveals that the majority of the participants rejected the statement above. Out of the total of 124 participants,  $n=47(38.2\%)$  revealed that they strongly disagreed that sometimes they are harsh with mentally ill patients. Furthermore, Table 5.14 also indicates that about a third of the participants  $n=43(35\%)$  disagreed with the statement stated in item 50 while  $n=21(17.1\%)$  agreed that they are sometimes harsh with mentally ill clients and  $n=4(3.3\%)$  strongly agreed with the statement. The remaining  $n=8(6.5\%)$  of the participants neither agreed nor disagreed with the statement. The results reported above only represent the responses of the 123 participants as one participant did not respond to the statement. The item mean and standard deviation were ( $\bar{x} = 3.88$  and  $SD = 1.19$ ). Placing the mean on the scale of interpretation places it at 3.5-4.49, revealing that the majority of the participants are not sometimes harsh with mentally ill patients. This is another display of positive attitudes towards mentally ill patients by the general assistants.

#### **5.5.2.23 I get so frustrated at times that I feel like swearing**

According to the results in Table 5.14, the majority of the participants disagreed with the statement above. Of the total 124 participants,  $n= 52(41.9\%)$  strongly disagreed that they get so frustrated at times that they feel like swearing. Furthermore,  $n= 37(29.8\%)$  participants disagreed with the statement. In contrast,  $n=22(17.7\%)$  participants agreed with the statement, admitting that they get so frustrated at times that they feel like swearing. The other

n=4(3.2%) participants strongly agreed that they get so frustrated at times that they want to swear. Eight (6.5%) participants indicated that they neither agreed nor disagreed with the statement and one participant did not offer a response. The mean and standard deviation of the responses to the item were ( $\bar{x} = 3.90$  and  $SD = 1.22$ ). On the scale of interpretation, it could be placed at 3.5 - 4.49, an indication that the majority of the participants disagreed that they get so frustrated at times that they feel like swearing. This also implies that the general assistants displayed an aspect of positive attitudes towards mentally ill patients.

#### **5.5.2.24 I feel that mentally ill patients are useless.**

The results pertaining to item 52, as indicated in Table 5.14, revealed that out of the 123 valid participants, n=71(57.7%) indicated that they strongly disagree and reject the statement that stated that “they feel mentally ill patients are useless”. Furthermore, n=46 (37.4%) participants also disagreed with the statement in item 52. The results also indicate that n=4(3.3%) of the participants did not agree nor disagree with the statement and in contrast with the above results, n=1(0.8%) participant strongly agreed while another n=1(0.8%) participant agreed that s/he feels that mentally ill patients are useless. The mean and standard deviation were ( $\bar{x} = 4.50$  and  $SD = 0.68$ ). With reference to the designed scale of interpretation, the mean fall at 4.50-5.0, indicating that the majority of the participants disagreed that they **feel that mentally ill patients are useless**. This also portrays a positive attitude displayed by the general assistants towards mentally ill patients.

**Table 5.14: Attitudes of General Assistants towards mentally ill patients**

Questions	Frequency & Percent	SA	A	N	D	SD	Missed responses	Mean	SD
Q43. I don't want to work with someone who has mental illness	n=124	0	15	10	52	46	1	4.05	0.97
	%	0	12.2	8.1	42.3	37.4	0.8		
Q44. I'm often afraid and scared of being in the same place with mentally ill patients	n=124	3	13	12	45	50	1	4.02	1.08
	%	2.4	10.6	9.8	36.6	40.7	0.8		
Q45. I feel comfortable working with mentally ill patients	n=124	36	52	12	17	6	1	3.77	1.16
	%	29.3	42.3	9.8	13.8	4.9	0.8		
Q46. Mentally ill patients should be discriminated against when applying for work	n=124	0	10	3	46	64	1	4.33	0.88
	%	0	8.1	2.4	37.4	52	0.8		
Q47. Mentally ill patients should get the same opportunities then those who are not mentally ill	n=124	43	49	8	17	6	1	3.86	1.18
	%	35	39.8	6.5	13.8	4.9	0.8		
Q48. I feel that mentally ill patients are a nuisance	n=124	1	6	11	48	57	1	4.25	0.87
	%	0.8	4.9	8.9	39	46.3	0.8		
Q49. I sometimes behave or treat patients negatively	n=124	3	7	7	41	65	1	4.28	0.98
	n=124	2.4	5.7	5.7	33.3	52.8	0.8		
Q50. I'm sometimes harsh with mentally ill patients	%	4	21	8	43	47	1	3.88	1.19
	Percentage	3.3	17.1	6.5	35	38.2	0.8		
Q51. I get so frustrated at times that I feel likes wearing	Frequency N=124	4	22	8	37	52	1	3.90	1.22
	Percentage	3.3	17.9	6.5	30.1	42.3	0.8		
Q52. I feel mentally ill patients are useless	n=124	1	1	4	46	71	1	4.50	0.68
	%	0.8	0.8	3.3	37.4	57.7	0.8		

**%: percentage; SA: strongly agree, A: agree; NAD: neither agree nor disagree; D: disagree; SD: strongly disagree; SD: standard deviation; n: frequency**

### **5.5.3 Verification of the sub-objective: “determine the attitude of General Assistants pertaining to mental illness”**

The verification of the objective (1) was accomplished in three steps: (1) analysis of items, (2) association of items and socio-demographic variables which is developed in the section of bivariate analysis and (3) analysis of total score of attitudes.

#### **5.5.3.1 Item analysis**

The Likert scale was used to collect the data which ranged from strongly disagree (1=1.0-1.49), disagree (2=1.5-2.49), neither agree nor disagree (3=2.5-3.49), agree (3.5-4.49) and strongly agree (4.5-5.0). However, for the purpose of analysis and in order to present meaningful results, the initial scale of interpretation was amended and the scale was divided into two categories: positive attitudes and negative attitudes. The negative attitude was ranged from 1-3 and the positive from 4-5. Hence, the items/statements that indicated negative attitudes were C36, C37, C40 and C48.

#### **5.5.3.2 Total score of attitudes**

To determine the attitudes of general assistants pertaining to mental illnesses, the total score of attitudes of the general assistants was computed. A Likert scale was used to collect the data which ranged from strongly disagree (1=1.0-1.49), disagree (2=1.5-2.49), neither agree nor disagree (3=2.5-3.49), agree (3.5-4.49) and strongly agree (4.5-5.0). The ranges in brackets refer to the scale of interpretation. However, the initial scale was amended and the different ranges were combined as follows: negative scale ranged between 1=1.0-3.49 and the positive scale ranged from 2=3.5-5.0.

Level 1= Having negative attitudes towards mental illness: 1.0-3.49

Level 2= Positive attitudes towards mental illness: 3.50- 5.0



Based on Table 5.15, the majority of the participants  $n=123(99.2\%)$  responded to all the questions and one participant did not respond. The table shows that  $n=41(33.1\%)$  of the 124 participants had negative attitudes while the majority of the participants  $n= 82(66.1\%)$  revealed positive attitudes towards mental illness. Furthermore, the means and standard deviations of the total score were computed. The results indicate that the means of the total score is 3.75 and the standard deviation = 0.51. Since the mean of the total score of the attitudes of general assistants fell within the range 3.5-5.0, it can be concluded that the majority of the participants have positive attitudes towards mental illness.

**Table 5.15: Distribution of participants per attitudes**

Attitudes	Frequency	Percent	Valid Percent
Negative	41	33.1	33.3
Positive	82	66.1	66.7
Total	123	99.2	100
Missing System	1	0.8	
Total	124	100	

## **5.6 Perceptions of general assistants pertaining to mentally ill patients**

### **5.6.1 Introduction**

The results in this section reveal the responses of the general assistants with regards to the questions pertaining to their perceptions regarding mentally ill patients. These are addressed in items 53 to 64 in the questionnaire.

### **5.6.2 Items Analysis**

#### **5.6.2.1 People with mental illness have unpredictable behaviour**

The results displayed in Table 5.16 revealed that the majority of the participants,  $n=71(58.7\%)$  agreed with the statement that mentally ill patients have unpredictable behaviours. The other  $n=29(24\%)$  participants also attested that they strongly agreed with the statement while  $n=11(9.1\%)$  participants stated that they disagreed that mentally ill patients have unpredictable behaviour and  $n=4(3.3\%)$  of the participants strongly disagreed with the statement. Further, Table 5.16 also indicates that  $n=6(5\%)$  participants neither agreed nor disagreed with the statement. The associated mean and standard deviation were ( $\bar{x} = 3.91$  and  $SD = 0.98$ ) and based on the scale of interpretation, the mean falls within the range 3.5-4.49. This should be an indication that the majority of the participants disagreed that “People with mental illness have unpredictable behaviour”; the general assistants displayed positive attitudes towards mentally ill patients.

#### **5.6.2.2 People with mental illnesses should be feared**

Table 5.16 displays the results for  $n=122$  participants who gave an opinion out of the total of 124 participants. The results reveal that the majority of the participants  $n=49(40.2\%)$  disagreed with the statement while  $n=47(38.5\%)$  participants strongly disagreed with the statement that states that mentally ill patients must be feared. Further,  $n=11(9\%)$  of the

participants neither agreed nor disagreed with the statement while n=14(11.5%) of the participants agreed that mentally ill patients must be feared and n=1(0.8%) respondent strongly agreed that mentally ill patients should be feared. The mean and standard deviation computations gave the values of  $\bar{x} = 4.04$  and  $SD = 1.01$  respectively. Weighing the mean value on the scale places it between 3.50 and 4.49. This indicates that the majority of participants disagreed with the statement, leading to the conclusion that the majority of participants had a positive perception towards the mentally ill clients in this regard.

### **5.6.2.3 People with mental illness should not be allowed to get married**

The results in Table 5.16 reflect the responses of n=122 participants who offered an opinion. Of 122 participants, n=40 (32.8%) strongly disagreed that mentally ill patients should not be allowed to get married, and n=35(28.7%) simply disagreed with the statement. Contrary to the above, n=34(27.9%) of the respondents agreed that mentally ill patients should not be allowed to get married and n=3(2.4%) simply agreed with the same statement. Ten (8.1%) respondents neither agreed nor disagreed. The computed mean and standard deviation for the item were ( $\bar{x} = 3.57$  and  $SD = 1.24$ ) respectively. When weighed on the scale of interpretation, the value falls on the 3.50- 4.49 category. This indicates that the majority of the participants disagreed to the statement: “People with mental illness should not be allowed to get married”. This could imply that the general assistants displayed positive perception towards mentally ill patients.

### **5.6.2.4 Female patients must be sterilised**

Table 5.16 shows that the majority of the participants in responded that female mentally ill patients must be sterilised. Of the total of 122 respondents, n= 56(45.9%) agreed that female patients must be sterilised and n=14(11.5%) strongly agreed that female mentally ill clients must be sterilised. In contrast, n=18(14.5%) respondents strongly disagreed with the

statement and  $n=21(17.2\%)$  simply disagreed.. The mean and standard deviation ( $\bar{x} = 2.78$  and  $SD = 1.28$ ) were calculated and the mean was compared across the measurement scale. The mean fell between 2.50 and 3.49, an indication that the majority of the participants agreed that “Female patients must be sterilised”. This display negative perception of General Assistant towards mentally ill with regards to reproduction.

#### **5.6.2.5 Mentally ill patients should be kept in hospitals or places outside of the communities**

The results relating to this item, as represented in Table 5.16, indicate that  $n=57(46.7\%)$  of the participants strongly disagreed with the fact that mentally ill patients should be kept in hospitals and outside of the communities. More respondents,  $n=39(32\%)$ , simply disagreed with the statement. Conversely,  $n=17(13.9\%)$  participants agreed that mentally ill patients should be kept in hospitals with further  $n=3(2.5\%)$  strongly agreeing that mentally ill patients should be kept in hospitals and mental institutes. Six (4.8%) respondents neither agreed nor disagreed with the statement and the remaining  $n=2(1.6\%)$  participants did not respond to the item. The mean and standard deviation computations gave the values of ( $\bar{x} = 4.07$  and  $SD = 1.14$ ), with the mean value pitched between 3.5 and 5 on the measurement scale. This is an indication that the majority of the participants disagreed to the statement that “Mentally ill patients should be kept in hospitals or places outside of communities”, which shows positive perception in this aspect.

#### **5.6.2.6 I think mentally ill patients should not be allowed to have children**

The results displayed in Table 5.16 indicate that  $n=51(41.8\%)$  of the total of 122 participants agreed that mentally ill patients should not have children while  $n=7(5.7\%)$  strongly agreed with the statement. In contrast,  $n=24(19.7\%)$  participants disagreed with the statement while  $n=23(18.9\%)$  strongly disagreed with the statement. A total of  $n=17$  (13.9%) participants said

they neither agreed nor disagreed with the statement. The mean and standard deviation computed for this item gave the respective values ( $\bar{x} = 3.04$  and  $SD = 1.27$ ). When the mean value is placed on the designed scale, it is seen to fall between 2.50 and 3.49, indicating that the majority of the participants agreed that mentally ill patients should not be allowed to have children. This is considered to portray a negative view towards the mentally ill patients.



**Table 5.16: Perceptions of General Assistants Pertaining to Mentally Ill Patients**

Questions	Frequency & Percent	SA	A	N	D	SD	Missed responses	Mean	STD
Q53. People with mental illness have unpredictable behaviour	Frequency	29	71	6	11	4	3	3.91	0.98
	Percentage	24	58.7	5.0	9.1	3.3	2.4		
Q54. People with mental illness should be feared	Frequency	1	14	11	49	47	2	4.04	1.01
	Percentage	0.8	11.5	9.0	40.2	38.5	1.6		
Q55. People with mental illness should not be allowed to get married	Frequency	3	34	10	40	35	2	3.57	1.24
	Percentage	2.5	27.9	8.2	32.8	28.7	1.6		
Q56. Female patients must be sterilized	Frequency	14	56	13	21	18	2	2.78	1.28
	Percentage	11.5	45.9	10.7	17.2	14.8	1.6		
Q57. Mentally ill patients should be kept in hospitals or places outside of communities	Frequency	3	17	6	39	57	2	4.07	1.14
	Percentage	2.5	13.9	4.9	32.0	46.7	1.6		
Q58. I think mentally ill patients should not be allowed to have children	Frequency	7	51	17	24	23	2	3.04	1.27
	Percentage	5.7	41.8	13.9	19.7	18.9	1.6		

%: percentage; SA: strongly agree, A: agree; NAD: neither agree nor disagree; D: disagree; SD: strongly disagree; SD: standard deviation; n: frequency

### 5.6.2.7 I think all mentally ill patients have funny and strange behaviour

Table 5.17 shows that out of the 124 research participants, only n=122 offered a response to the statement. The results show that n=36(29.8%) respondents strongly disagreed that all mentally ill patients have funny and strange behaviour while n=36(29.8%) simply disagreed with the same statement. In contrast, n=34 (27.4%) of the participants agreed that all

mentally ill patients have funny and strange behaviour and n=6(4.8%) participants strongly agreed with the statement. Finally, n=9(7.4%) of the participants neither agreed nor disagreed with the statement. The mean and standard deviation were found to be ( $\bar{x} = 3.51$  and  $SD = 1.31$ ) respectively. With reference to the scale of interpretation, the value of the mean lies between 3.50 and 4.49. As the value lies between 3.50-4.49, it reveals that the majority of the participants did not think that all mentally ill patients have funny and strange behaviour. It could be concluded, therefore, that the majority of the participants had a positive attitude towards the mentally ill patients in relation to this aspect.

#### **5.6.2.8 All people with mental illness drop out of school some time**

The results presented in Table 5.17 are from n=122(98.4%) respondents out of 124 study participants. It could be observed, as revealed in Table 5.17, that most of the participants disagreed with the statement: ‘All people with mental illness drop out of school some time’. The other n=49(40.2%) respondents strongly disagreed while n=13 (10.7%) neither agreed nor disagreed with the statement. However, n=57(46.7) respondents agreed with the statement while n=3(2.4%) strongly agreed that “all people with mental illness drop out of school some time.” The calculated mean value and standard deviation for the item were ( $\bar{x} = 3.29$  and  $SD = 1.45$ ) respectively. On the representation scale, the value falls between 2.5 and 3.49; meaning that the majority of the participants agreed that “**All people with mental illness drops out of school some time**”. This is an indication of a negative perception about mentally ill clients.

#### **5.6.2.9 Mentally ill patients don’t have a future**

Table 5.17 shows that, with regards to the statement “Mentally ill patients don’t have a future”, approximately half of the participants n=64 (52.5%) strongly disagreed with the statement. The Table also indicates that n=38(31.1%) of the participants simply disagreed

with the statement. Contrary to the above opinions, n=14(11.5%) of the participants agreed that mentally ill patients don't have a future. The results also reflect that n=6(4.9%) of the participants neither agreed nor disagreed with the statement while n=2(1.6%) of the participants did not respond to the statement. The value of the mean and standard deviation were ( $\bar{x} = 4.25$  and  $SD = 0.99$ ) respectively. The mean value falls between 3.5 and 5, an indication that the majority of the participants disagreed that "Mentally ill patients don't have a future". The results imply that the participants portray positive perceptions and views about mentally ill clients.

#### **5.6.2.10 Mentally ill people can't work**

The results with respect to this statement, as reflected in Table 5.17, reveal that exactly half of the respondents n=61(50%) strongly disagreed that mentally ill patients can't work while one third n=39(32%) simply disagreed. Five (4.1%) of the participants neither agreed nor disagreed with the statement. Fourteen (11.5%) agreed that mentally ill patients can't work while three (2.5%) others strongly agreed with the statement. The missing participants pertaining to this question were n=2(1.6%). Two participants did not offer an opinion to this statement. This gave the total mean and standard deviation calculations at ( $\bar{x} = 4.16$  and  $SD = 1.10$ , respectively. When the value of the mean is placed on the scale, it is found to occur between the 3.5- 4.49 marks. This is an indication that the majority of the participants disagreed that "**Mentally ill people can't work**". This implies that the general assistants view/ perceive mentally ill patients in a positive manner with regards to their ability to work.

#### **5.6.2.11 Families and friends must support people with mental illness**

Table 5.17 reflects that the majority of the participants n=76(62.3%) strongly agreed that mentally ill patients should be supported by family and friends. The other n=39(32%)



respondents agreed with the statement while n=6 (4.9%) disagreed with the fact that mentally ill patients should be supported by family and friends. Of the 124 participants, n=2(1.6%) did not respond to the statement. The mean and standard deviation were ( $\bar{x} = 4.52$  and  $SD = 0.75$ ). When classified according to the scale, the mean was gauged at the level: 4.49-5.00, an indication that the majority of the participants agreed that family and friends should support people with mental illness. This implies that the general assistants had positive perceptions regarding mentally ill patients and support structures.

#### **5.6.2.12 Mentally ill patients should be allowed to stay in communities and should be involved in community activities**

With reference to this item, Table 5.17 reveals that a total of 121 participants responded. Slightly above half of the respondents, n=68(56.2%) strongly agreed that mentally ill patients should be allowed to stay in the communities and should be involved in community activities. Further, n=39(32.2%) of the total of 124 participants agreed to the statement. However, in contrast with the above, n=7(5.8%) of the participants disagreed that mentally ill patients should be allowed to stay in communities and n=1(0.8%) participant strongly disagreed. Six (5.0%) participants neither agreed nor disagreed with the statement. The calculated mean and standard deviation for this item were ( $\bar{x} = 4.37$  and  $SD = 0.89$ ) respectively. With reference to the scale of interpretation, the participants' mean responses were ranked at 3.5-4.49. This is an indication that the majority of the participants agreed that "Mentally ill patients should be allowed to stay in communities and should be involved in community activities". This could also be seen as a positive attitude that the general assistants had shown towards the mentally ill clients with regards to their community involvement and participation.

**Table 5.17: Perceptions of general assistants pertaining to mentally ill patients**

Question	Results	SA	A	N	D	SD	Misused Responses	Mean	SD
Q59. I think all mentally ill patients have funny and strange behaviour	n	6	34	9	36	36	3	3.51	1.31
	%	5	28.1	7.4	29.8	29.8	2.4		
Q60.All people with mental illness drops out of school some time or the other	n	3	57	13	0	49	2	3.29	1.45
	%	2.5	46.7	10.7	0	40.2	1.6		
Q61. Mentally ill patients don't have a future	n	0	14	6	38	64	2	4.25	0.99
	%	0	11.5	4.9	31.1	52.5	1.6		
Q62. Mentally ill people can't work	n	3	14	5	39	61	2	4.16	1.10
	%	2.5	11.5	4.1	32.0	50	1.6		
Q63.Families and friends must support people with mental illness	n	76	39	1	6	0	2	4.52	0.75
	%	62.3	32	0.8	4.9	0	1.6		
Q64.Mentally ill patients should be allowed to stay in communities and should be involved in community activities	n	68	39	6	7	1	3	4.37	0.89
	%	56.2	32.2	5.0	5.8	0.8	2.4		

**%: percentage; SA: strongly agree, A: agree; NAD: neither agree nor disagree; D: disagree; SD: strongly disagree; SD: standard deviation; n: frequency**

### **5.6.3 Verification of the sub-objective: “determine the perceptions of general assistants pertaining to mental illness”**

**The verification of the objective was conducted in three steps:**

- (1) Item Analysis
- (2) Association of items and socio-demographic variables which was developed in section of bivariate analysis and
- (3) Analysis of total score of perceptions.

#### **5.6.3.1 Item analysis`**

The likert scale was used to analyse the data which ranged from strongly disagree (1=1.0-1.49), disagree (2=1.5-2.49), neither agree nor disagree (3=2.5-3.49), agree (3.5-4.49) and strongly agree (4.5-5.0). However, to facilitate the analysis process and in order to present meaningful results, two categories were established and the scale of interpretation for results was also adjusted. The categories into which the perceptions were compressed into were negative perceptions and positive perceptions. The negative scale ranged from 1-3 and the positive from 4-5.

#### **5.6.3.2 Total score of perceptions**

To determine the perceptions of general assistants towards mental illnesses, the total score of perceptions of the general assistants was computed. A likert scale was used to collect and analyse the data which ranged from strongly disagree (1=1.0-1.49), disagree (2=1.5-2.49), neither agree nor disagree (3=2.5-3.49), agree (3.5-4.49) and strongly agree (4.5-5). The ranges in brackets refer to the scale of interpretation (see the section below). However, the initial scale was amended and the different ranges were combined as follows: negative scale ranged between 1=1.0-3.49 and the positive scale ranged from 2=3.50-5.0.

Level 1= Having negative perceptions towards mental illness and was ranged 1.0-3.49

Level 2= Positive perceptions towards mental illness and was ranged 3.50- 5.0

Out of the total of 124 participants, the majority of the participants n=121(97.6%) responded to all the questions and n=3(2.4%) participants did not respond and are regarded as missing responses. Table 5.18 below shows that n=52(43%) of the total respondents, n=121, had negative perceptions while the majority of the participants n= 69(57%) indicated positive perceptions towards mental illness. Furthermore, the means and standard deviation of the total score were computed and the values of 3.50 and 1.10 were obtained for the mean and standard deviations respectively. Since the mean of the total score of the perceptions of general assistants fell within the range 3.5-5.0, it could be interpreted that the majority of the participants had positive perceptions on mental illness and mentally ill patients.

**Table 5.18: Frequency table of the total score of the perceptions of the general assistants**

Perceptions	Frequency	Percent	Valid Percent
Negative	52	41.9	43.0
Positive	69	55.6	57.0
Total	121	97.5	100
Missing	3	2.4	
Total	124	100	

## **5.7 The association between the knowledge, attitudes and perceptions of general assistants based on gender**

### **5.7.1 Introduction**

In this section, the researcher presents the results on the association between the Knowledge, Attitudes and Perceptions (KAP) and socio- demographic variables of the general assistants. The association was determined through the application of the Chi- square test for the

categorical variables. Hence, the variables were cross tabulated two by two. In addition, to determine the relationship between two other variables that were either ordinal or numerical, the Spearman's Rho Correlation was applied. The statistical significance were highlighted for a  $p\text{-value} < 0.005$ ,  $p\text{-value} < 0.001$  and lastly for a  $p\text{-value} < 0.01$

## **5.7.2 Association between knowledge and socio-demographic variables**

### **5.7.2.1 The association between knowledge and gender**

The results of the study reveal that 44.8 % of males reported that they have knowledge pertaining to mental illness; the remaining 55.2% reported that they have little knowledge pertaining to mental illness. The majority of the females (58.1%) reported that they have little knowledge,  $n = 32$  indicated that they have a lot of knowledge, and the remaining  $n=7$  said they have no knowledge pertaining to mental illness.

The majority of the males  $n=21(72.4\%)$  and females  $n=71(77.2\%)$  reported that they never had informal training regarding mental illness.

More than 80% of males ( $n=24$ ) and  $n= 76$  females (82.6%) reported that mental illness is normally a result of a chemical imbalance of the brain. The remaining participants regarded the statement as false.

Furthermore,  $n=23 (76.7\%)$  males indicated that the statement: 'People who have family members who are mentally ill will definitely get mental illness' is false. The remaining  $n=7 (23.3\%)$  agreed that the statement is true. More females  $n= 76(82.6\%)$  indicated that the statement is false.

Table 5.19 also shows that  $n= 20(66.7\%)$  males disagreed with the statement that people with mental illness are always violent and rude. This results is similar to the previous questions, more females  $n=66(76.7\%)$  reported that the statement is false as well. The results also indicate that a third of both the males and females stated that the statement is true.

**Table 5.19: Association between knowledge and distribution per gender**

Questions	Answer	Males		Females		Total		Chi square test
		n	%	n	%	n	%	
Violence is associated with mental illness	TRUE	17	56.7	58	62.4	75	61	0.307
	FALSE	13	43.3	35	37.6	48	39	
Mental illness is caused by	Personal weakness	14	46.7	22	23.4	36	29	5.97**
	Hereditary can pass on from generation	16	53.3	72	76.6	88	71	
Who is more likely to get mental illness	Poor and uneducated people	1	3.3	0	0	1	0.8	3.16*
	Anyone regardless of class background	29	96.7	94	100	123	99.2	
Mental illness can be regarded as	A Life sentence	4	13.3	7	7.4	11	8.9	0.95
	A persons quality of life can improve with treatment	26	86.7	87	92.6	113	91.1	
The following is essential for mentally ill pts to be stable	Medication and continuous support	26	86.7	88	93.6	114	91.9	1.482
	Good Friends	4	13.3	6	6.4	10	8.1	
The following aspects increase risk of mental illness	Substance & drug abuse	2	2	68	72.3	90	72.6	0.22
	Family history of mental illness	4		11	11.7	15	12.1	
	Being friends with mentally ill	4		15	16	19	15.3	
Mentally ill pts can be cured completely	I A	1	7	33	35.1	50	40.3	4.393*
	I D	1	3	61	64.9	74	59.7	
Mental illness occurs as a result of witchcraft	I A	8	26.7	10	10.6	18	14.5	4.708**
	I D	22	73.3	84	89.4	106	85.5	
Mentally ill pts can stop their medication at any time	I A	3	10	9	9.5	10	9.7	0.005
	I D	27	90	85	90.4	112	90.3	
Substance abuse can cause mentally ill pts to become worse	I A	28	93.3	90	95.7	118	95.2	0.287
	I D	2	6.7	4	4.3	6	4.8	

**n = frequency    % = percentage of the total sample    \*: statistically significant at 0.10;  
 \*\*: statistically significant at 0.05; \*\*\*: statistically significant at 0.01; %:**

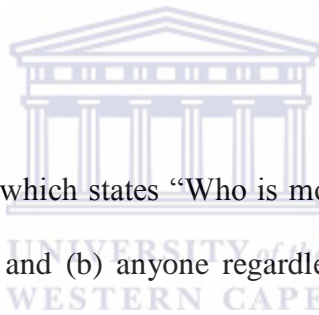
**Table 5.19: Association between knowledge and distribution per gender**

Questions	Answer	Males		Females		Total		Chi square test
		N	%	n	%	n	%	
Mentally ill pts can have a regular job and function well	I agree	24	80	76	80.9	100	80.6	0.011
	I disagree	6	20	18	19.7	24	19.4	
Mentally ill pts suffer from split personalities	I agree	22	73.3	75	80.6	97	78.9	0.727
	I disagree	8	26.7	18	19.4	26	21.1	
Mentally ill pts always need prescribed medication	I agree	29	96.7	89	95.7	118	95.9	0.54
	I disagree	1	3.3	4	4.3	5	4.1	
Mentally ill patients can be treated successfully at CHC's	I agree	23	76.7	79	84.9	102	82.9	1.09
	I disagree	7	23.3	14	15.1	21	17.1	
Mental illness can be cured by a sangoma	I agree	5	16.7	6	6.5	11	8.9	3.220
	I disagree	25	83.3	86	92.5	111	90.2	
	neutral	0	0	1	1.1	1	0.8	
Mentally ill pts should be admitted when they are a danger to themselves and others	yes	30	100	93	100	123	100	No statistics computed because mentally ill pts must be admitted when they become a danger for themselves. It is a constant
	no	0	0	0	0	0	0	
Mentally ill pts must receive treatment from a clinic or doctor	yes	29	96.7	89	95.7	118	95.9	0.054
	no	1	3.3	4	4.3	5	4.1	
Mentally ill pts who are very aggressive & swearing they are just rude	yes	18	60	46	50	64	52.5	0.97
	no	12	40	46	50	58	47.5	
When pts are difficult to manage talking to themselves & they are violent in the hospital are they psychotic	yes	28	93.3	89	95.7	117	95.1	0.27
	no	2	6.7	4	4.3	6	4.9	

n = frequency      % = percentage of the total sample    \*: statistically significant at 0.10;  
 \*\*: statistically significant at 0.05; \*\*\*: statistically significant at 0.01; %:

Table 5.19 reveals that for certain variables of knowledge, there exists an association between knowledge and gender although the researcher assumed that there was no association between knowledge and gender. The results indicate that there was statistical significance for the variable that indicates that “mental illness is caused by either personal weakness or it is hereditary and it can be passed on from one generation to another”. Another significant variable was the statement “Mental illness can be cured completely”

Furthermore, Table 5.19 indicates that, with reference to question B11 that states that “mental illness is caused by either (a) personal weakness or (b) it is hereditary and can be passed on from one generation to the next, the association was statistically significant ( $\chi^2 = 5.97$  and  $p = 0.05$ ).



With reference to statement B12 which states “Who is more likely to get mental illness: (a) the poor and uneducated people and (b) anyone regardless of intelligence, social class or income level”, there was an association which was statistically significant between gender and the knowledge of the participants ( $\chi^2 = 3.16$  and  $p = 0.06$ ).

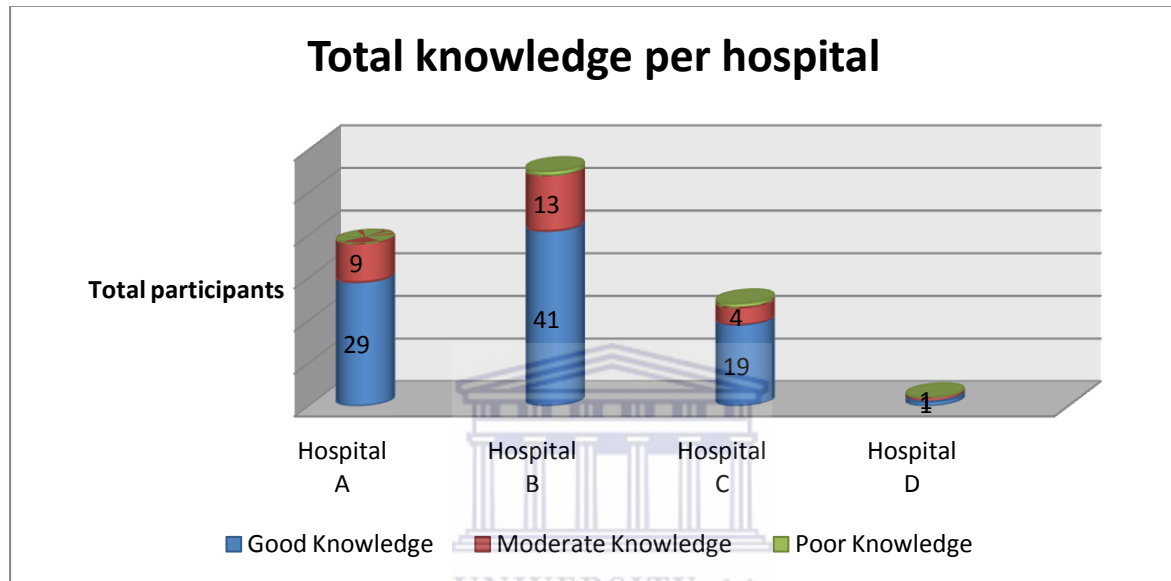
Also the results for statement B16 “mentally ill patients can be cured completely” also yielded statistically significant results ( $\chi^2 = 4.39$  and  $p = 0.08$ ).

Lastly, the statistical significance pertaining to B17 “Mental illness occurs as a result of witchcraft” signified ( $\chi^2 = 4.71$  and  $p = 0.05$ ), which means that there was an association between the knowledge of the participants based on gender.



### 5.7.2.2 The association between total score of knowledge and socio-demographic variables

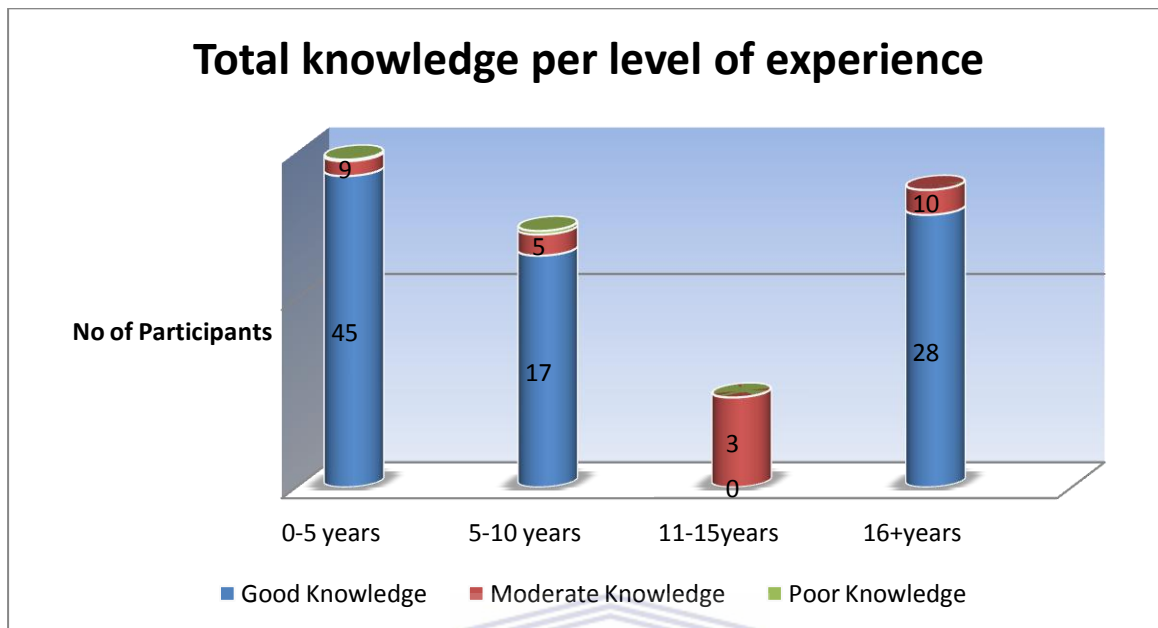
The total score pertaining to knowledge was cross tabulated with the demographic variables including the association between the knowledge and psychiatric institution, gender, level of education, ethnicity, age, marital status and years of experience.



**Figure 5.6: Presentation of the total knowledge per hospital**

Figure 5.6 is a representation of the total n level of basic knowledge of the participants in the study. Of the 124 participants, only n= 119(96%) were computed. Five (4%) of the participants were missing and they did not respond to all the questions. The above figures indicate that n=2(1.6%) of the total of 124 participants have poor knowledge, and they are stationed at Hospital B and Hospital C. Forty one (73%) of Hospital B's participants displayed good basic knowledge followed by their Hospital A counterparts, with 29(74%). Nineteen (70.3%) participants at Hospital C also demonstrated good knowledge and 50% of Hospital D's participants also displayed good knowledge. With regards to moderate knowledge, a total of 26 participants were identified. Nine (23, 1%) of these participants were

from Hospital A; 13 (23.2%) from Hospital B; 4 (15%) from Hospital C and 1(50%) from Hospital D.



**Figure 5.7: Distribution Knowledge of the participants per level of experience**

The results of the total knowledge of participants by ethnicity revealed that of the total 124 participants, n=90 (76%) participants showed that they have good basic knowledge of mental illnesses. The distribution per ethnic group was as follows: n=57(80%) of the coloureds displayed good knowledge, followed by n=32(70%) white participants. Of the total of 119 who indicated their ethnic group, n=27 (23%) of the total coloured participants demonstrated moderate knowledge on mental illness and lastly n=2(4.4%) of the African participants indicated that their knowledge is poor.

The association between the level of experience of the general assistants and the total knowledge are displayed in Figure 5.7. This figure reveals that n= 45 of the 55 participants who had between zero to five years of experience demonstrated good and moderate knowledge pertaining to mental illness. The majority of the general assistants who had worked for between 5-10 years also yielded results which indicate that the majority of the participants in this category had moderate knowledge pertaining to mental illness. Similar

results were found for the participants who had worked for 16 years or more. Only n=2 (1,6%) displayed poor results and they were from categories 0-5 years(n=1) and 5-10 years (n=1).

The total score on knowledge was also computed per level of education of the general assistants. The results indicate that the majority of the participants in the different categories have good basic knowledge regarding mental illnesses. Of the total participants that were in the category Grade R- grade 4, n=5 (50%) showed that they had good knowledge while n = 4 (44%) revealed moderate knowledge and the remaining participant revealed poor knowledge. Interestingly, n=12(19%) of the participants in the category Grade 10-12 had moderate knowledge, while n=2(3.1%) participants in the same category demonstrated poor knowledge regarding mental illness.

In the following paragraph the attitudes of the general assistance are discussed in detail.

### **5.7.3 Association between attitudes and socio-demographic variables**

The results in this section reflect the association between the items/questions pertaining to the attitudes and the socio- demographic variables gender, psychiatric hospitals, age, marital status, ethnicity, religion, level of education and years of experience of the general assistants.

#### **5.7.3.1 I feel ashamed of mentally ill clients**

The results show that there is a statistically significant association between feeling ashamed of mentally ill clients and marital status as shown by the values;  $\chi^2 = 19.95$  and  $p = 0.04$ . The feeling of being ashamed of mentally ill clients was associated with ethnicity as well,  $\chi^2 = 30.16$  and  $p = 0.001$ . The association with the same item and psychiatric institution was also found, with the values at  $\chi^2 = 17.91$  and  $p = 0.09$ .

Further, there was a statistically significant association between willing to work with mentally ill patients and psychiatric institution as indicated by the values  $\chi^2 = 32.97$  and  $p = 0.000$ .

#### **5.7.3.2 I feel working with mentally ill patients is stressful**

The association was found between the feeling of working with mentally ill patients being stressful and the psychiatric hospital as indicated by the numerical values  $\chi^2 = 29.5$  and  $p = 0.003$ . An association was also found between the feeling of working with mentally ill patients being stressful and gender. This association is confirmed by the following values  $\chi^2 = 16.4$  and  $p = 0.001$ . In addition, the feeling of working with mentally ill patients being stressful was also in association with religion as indicated by the values  $\chi^2 = 19.29$  and  $p = 0.03$ .

#### **5.7.3.3 I often feel like laughing at mentally ill clients**

There was a statistically significant association between the feeling of laughing at mentally ill clients and ethnicity as portrayed by the Chi square and the p values  $\chi^2 = 18.04$  and  $p = 0.09$ .

#### **5.7.3.4 Mentally ill patients often provoke anger in me**

Also, there was a statistically significant association between mentally ill patients often provoke anger in the general assistants and their religion as indicated by the Chi square and p values  $\chi^2 = 21.72$  and  $p = 0.03$ .

#### **5.7.3.5 I often get upset with mentally ill patients**

The statement “I often get upset with mentally ill patients” also indicated a relationship with significance. The chi-square results and p value were: ( $\chi^2 = 23.08$  and  $p = 0.014$ ).

#### **5.7.3.6 I will easily marry someone even if he or she has a mental illness**

With reference to easily marrying someone even if he or she has a mental illness and ethnicity, there was statistical significance: Chi square and p values  $\chi^2 = 1.64$  and  $p = 0.09$ .

#### **5.7.3.7 I don't trust mentally ill patients**

There was an association between trusting mentally ill patients and the psychiatric hospital. This was shown by the chi-square results  $\chi^2 = 17.55$  and  $p = 0.08$ .

#### **5.7.3.8 I treat all mentally ill patients the way I treat my children**

The statement "I treat all mentally ill patients the way I treat my children" showed an association with ethnicity as well. This is shown by the chi-square results  $\chi^2 = 25.26$  and  $p = 0.005$ .

#### **5.7.3.9 I would feel ashamed if I have mentally ill patients**

The statement "I would feel ashamed if I have mentally ill patients" was in an association with psychiatric hospital and the results suggested that there was also a statistical significance between the above statement and the gender of the general assistant. The chi square and p values were  $\chi^2 = 9.46$  and  $p = 0.04$ . The same item showed an association with ethnicity with chi square and p values  $\chi^2 = 21.12$  and  $p = 0.047$  confirming this association. The statement also showed an association with education as demonstrated by the Chi square and p value  $\chi^2 = 19.29$  and  $p = 0.04$ .

#### **5.7.3.10 I often become frustrated if the patients don't do what is required of them**

Becoming frustrated if the patients don't do what is required of them was found to be associated with ethnicity. The values  $\chi^2 = 19.41$  and  $p = 0.04$  show this association. An association was also found between becoming frustrated if the patients don't do what is

required of them and the level of education of the participants. This association is demonstrated by the Chi-square values  $\chi^2 = 16.89$  and  $p = 0.08$ .

#### **5.7.3.11 I usually get upset if the patients continue to mess and wet the floor especially after I cleaned**

There was an association between getting upset if the patients continued to mess and wet the floor especially after the general assistant has cleaned and the psychiatric hospitals. The results were  $\chi^2 = 24.95$  and  $p = 0.004$ .

#### **5.7.3.12 I usually don't want to work with someone who has mental illness**

Another association was also found between the item "I don't want to work with someone who has mental illness" and psychiatric hospitals. The results indicated the following ( $\chi^2 = 21.25$  and  $p = 0.004$ ). There was also an association between the same item and the religion of the general assistant ( $\chi^2 = 17.09$  and  $p = 0.008$ ).

#### **5.7.3.13 I'm often afraid and scared of mentally ill patients**

An association was found between being afraid and scared of mentally ill patients and psychiatric hospital. The results revealed the following: ( $\chi^2 = 25.07$  and  $p = 0.004$ ). The same item was also in association with gender ( $\chi^2 = 12.86$  and  $p = 0.007$ ). An association was also found with the religious practice of the general assistants, the association is confirmed by the following results ( $\chi^2 = 20.29$  and  $p = 0.07$ ). In addition, an association was also found with being afraid and scared of mentally ill patients and experience from the following results ( $\chi^2 = 118.19$  and  $p = 0.07$ ).

#### **5.7.3.14 I feel comfortable working with mentally ill patients**

An association was also found between feeling comfortable working with mentally ill patients and gender as indicated by the following chi square results ( $\chi^2 = 9.43$  and  $p = 0.04$ ).

#### **5.7.3.15 Mentally ill patients should be discriminated against when applying for work or services**

The item “Mentally ill patients should be discriminated against when applying for work or services” was associated with marital status as seen in the results ( $\chi^2 = 13.82$  and  $p = 0.08$ ).

#### **5.7.3.16 Mentally ill patients should get an equal opportunity like those who are not mentally ill when they are applying for work**

The statement “Mentally ill patients should get an equal opportunity as those who are not mentally ill when they are applying for work” showed an association with the gender of the general assistants. This is confirmed by the values of the chi square test and the p values  $\chi^2 = 8.22$  and  $p = 0.07$ .

#### **5.7.3.17 I feel that mentally ill patients are a nuisance**

The statement “I feel that mentally ill patients are a nuisance” was found to be associated with the religious practice of the general assistants. The association is indicated by the values of the Chi square test and the p value respectively;  $\chi^2 = 22.48$  and  $p = 0.09$ . Based on the Chi square test results, ( $\chi^2 = 20.06$  and  $p = 0.045$ ), the feeling that mentally ill patients are a nuisance was also found to be in an association with the psychiatric institution.

### **5.7.3.18. I sometimes behave or treat patients negative.**

With a Chi Square score and p value of  $\chi^2 = 8.57$  and  $p = 0.05$ . respectfully, behaving or treating patients negatively was seen to be associated with the gender of the general assistants.

### **5.7.3.19 I'm sometimes harsh with mentally ill patients**

The responses of the statement “I’m sometimes harsh with mentally ill patients” when computed using the Chi square formula revealed that there is an association with the participants’ experience at psychiatric institution. The values were ( $\chi^2 = 19.14$  and  $p = 0.06$ ).

### **5.7.3.20 I get so frustrated at times that I feel like swearing**

The statement “I get so frustrated at times that I feel like swearing” was in association with the mental health facility based on the results of the Chi square test and the p value  $\chi^2 = 21.26$  and  $p = 0.020$ . The same item was in association with ethnicity as demonstrated by the computations  $\chi^2 = 18.88$  and  $p = 0.09$ .

### **5.7.3.21 I feel mentally ill patients are useless**

The feeling that mentally ill patients are useless was associated with the ethnicity of the general assistants as shown by the results of the Chi square test and p value  $\chi^2 = 26.07$  and  $p = 0.087$ . “I feel mentally ill patients are useless” was associated with the religion of the general assistants. This association is defined based on the scores of the Chi square test and p value ( $\chi^2 = 30.11$  and  $p = 0.038$ ). Furthermore, an association was seen between “I feeling that mentally ill patients are useless” and the institution with reference to the Chi square value ( $\chi^2 = 19.36$  and  $p = 0.081$ ).



## **5.7.4 Association between perceptions and socio-demographic variables**

### **5.7.4.1 People with mental illness have unpredictable behaviour**

There is an association which is statistically significant at a level 10% between the item “People with mental illness have unpredictable behaviour” and the psychiatric hospital ( $\chi^2 = 17.31$  and  $p = 0.09$ ). This item is also associated with ethnicity with ( $\chi^2 = 22.62$  and  $p = 0.03$ ). With religion the association was statistically significant ( $\chi^2 = 26.63$  and  $p = 0.004$ ). With the level of education the association was statistically significant ( $\chi^2 = 18.45$  and  $p = 0.049$ ).

### **5.7.4.2 People with mental illness should be feared**

The statement: ‘people with mental illness should be feared’ was statistically significant with the psychiatric hospital as shown by these values ( $\chi^2 = 34.11$  and  $p = 0.000$ ). This item was also in association with religion as indicated by the following values ( $\chi^2 = 27.01$  and  $p = 0.005$ .) and with the level of education; ( $\chi^2 = 25.19$  and  $p = 0.004$ ..)

### **5.7.4.3 People with mental illness should not be allowed to get married**

The item “People with mental illness should not be allowed to get married” was in association with psychiatric hospital ( $\chi^2 = 27.76$  and  $p = 0.001$ ). There was a statistically significant association with religion ( $\chi^2 = 18.11$  and  $p = 0.08$ ). However, the results pertaining to the different types of religion did not indicate specific statistical significant association individually.

#### **5.7.4.4 Female mentally ill patients must be sterilised**

The item “Female mentally ill patients must be sterilised” is statistically associated with psychiatric hospital based on these values;  $\chi^2 = 27.08$  and  $p = 0.002$ ).

#### **5.7.4.5 Mentally ill patients must be kept in hospital**

There is statistical significance, thus an association between the item “Mentally ill patients must be kept in hospital” and psychiatric hospital based on the values ( $\chi^2 = 19.12$  and  $p = 0.047$ ). There was also association between this phrase and religion as indicated by the values: ( $\chi^2 = 22.933$  and  $p = 0.019$ )

#### **5.7.4.6 I think mental ill patients should not be allowed to have children**

There was a statistically significant association between “I think mental ill patients should not be allowed to have children” and gender ( $\chi^2 = 13.29$  and  $p = 0.007$ ).

#### **5.7.4.7 I think all mentally ill patients have funny and strange behaviour**

There is an association between the item “I think all mentally ill patients have funny and strange behaviour” and religion as revealed by these values ( $\chi^2 = 20.11$  and  $p = 0.015$ ).

With education, the association is shown by these results  $\chi^2 = 16.42$  and  $p = 0.097$ .

#### **5.7.4.8 All patients with mental illness drop out of school some time or the other**

There was an association between “All patients with mental illness drop out of school some time or the other” and the psychiatric hospital ( $\chi^2 = 21.63$  and  $p = 0.003$ ). The religious practice also is associated with the item as informed by the values;  $\chi^2 = 18.11$  and  $p = 0.03$ .

#### **5.7.4.9 Mentally ill patients don't have future**

The opinion that “Mentally ill patients don't have future” is statistically associated with the marital status of the general assistants as indicated by the following values:

$$\chi^2 = 13.62 \text{ and } p = 0.086.$$

#### **5.7.4.10 Mentally ill patients cannot work**

The impression that “Mentally ill patients cannot work” is associated with the psychiatric hospital based on their Chi square calculations and p value;  $\chi^2 = 20.99$  and  $p = 0.023$ .

The impression was also associated with the marital status of the general assistants as revealed by these values  $\chi^2 = 18.36$  and  $p = 0.056$ . “Mentally ill patients cannot work”

is also significantly associated with the level of education as defined by these values:

$$\chi^2 = 17.71 \text{ and } p = 0.068.$$

#### **5.7.4.11 Mentally ill patients should be allowed to stay in communities and should be involved with community activities.**

The item “Mentally ill patients should be allowed to stay in communities and should be involved in community activities” is statistically associated with gender based on the results of the Chi square test and the p value;  $\chi^2 = 7.89$  and  $p = 0.062$ . It was also found to be associated with ethnicity with the values  $\chi^2 = 23.84$  and  $p = 0.055$ .

### **5.8 Correlation**

#### **5.8.1 Correlation matrix of knowledge, attitude and perception**

Table 5.20 reveals that the paring of variables representing knowledge, attitudes and perceptions resulted in positive correlation which is statistically significant at level of 0.01.

Hence, between knowledge and attitude, there is a positive correlation ( $r = 0.54$ ,  $p \leq 0.001$ );

knowledge and perceptions, there is a positive correlation ( $r=0.51$ ,  $p\leq 0.001$ ); and attitude and perceptions, there is a positive correlation ( $r=0.65$ ,  $p\leq 0.001$ ).

**Table 5.20: Spearman's Rho Correlations**

	Knowledge	Attitude	Perceptions
Knowledge	1	0.54**	0.51**
Attitude	0.54**	1	0.65**
Perceptions	0.51**	0.65**	1
**Correlation is significant at the 0.01 level (2-tailed)			

### 5.8.2 Correlation between the components of the Theory of planned behaviour

Table 5.21 reveals that there is a strong positive correlation between behaviour and intentions ( $r=0.75$ ;  $p\leq 0.001$ ). With the paired variables, it was found that there was a positive association, and moderate relationship identified between intention and behaviour belief ( $r=0.56$ ;  $p\leq 0.001$ ); intention and attitudes ( $r=0.6$ ;  $p\leq 0.001$ ); behaviour beliefs and attitudes ( $r=0.56$ ;  $p\leq 0.001$ ); behaviour beliefs and behaviour ( $r=0.55$ ;  $p\leq 0.001$ ); attitudes and behaviour ( $r=0.62$ ;  $p\leq 0.001$ ). A weak positive relationship was found between subjective norms and intentions ( $r=0.2$ ;  $p\leq 0.05$ ); subjective norms and behaviour beliefs ( $r=0.39$ ;  $p\leq 0.001$ ); intentions and normative beliefs ( $r=0.27$ ;  $p\leq 0.001$ ); normative beliefs and behaviour beliefs ( $r=0.44$ ;  $p\leq 0.001$ ); normative beliefs and subjective norms ( $r=0.35$ ;  $p\leq 0.001$ ); attitudes and subjective norms ( $r=0.33$ ;  $p\leq 0.05$ ); attitudes and normative beliefs ( $r=0.39$ ;  $p\leq 0.05$ ); behaviour and subjective norms ( $r=0.22$ ;  $p\leq 0.05$ ) and normative beliefs and behaviour ( $r=0.34$ ;  $p\leq 0.001$ ).

**Table 5.21: Spearman's Rho Correlations**

	<b>Intentions</b>	<b>Behav- Beliefs</b>	<b>Subjective Norms</b>	<b>Normative Beliefs</b>	<b>Attitudes</b>	<b>Behaviour</b>
Intentions	1					
Behav-Beliefs	0.56**	1				
Subjective norms	0.2*	0.39**	1			
Normative beliefs	0.27**	0.44**	0.35**	1		
Attitudes	0.6**	0.56**	0.33*	0.39*	1	
Behaviour	0.75**	0.55**	0.22*	0.34**	0.62**	1

\*: correlation is significant at the 0.05 level (2-tailed) and \*\*:Correlation is significant at the 0.01 level(2-tailed)



## 5.9 Factor analysis

### 5.9.1 Introduction

The study consists of many variables, which made it difficult to analyse the data accurately. In order to enhance effective data analysis, the number of variables was reduced through the statistical method known as Factor Analysis with principal components”. Burns and Grove (2011:397-398) assert that factor analysis investigates interrelationships between large numbers of variables and disentangles those relationships to identify clusters of variables that are most closely linked. Furthermore, factor analysis is used to enlarge the construct validity of an instrument. The application of this statistical method was enhanced by grouping together the most closely linked numerical variables in section C and D. This statistical method is only suitable for numerical variables and not for categorical variables hence the reason why the method was not applied for section B.

### 5.9.2 Factor Analysis

Pallant (2013: 183) argues that the validity of factor analysis is possible if the following two criteria are met simultaneously. These criteria are Kaiser Meyer- Olkin measure of sampling adequacy and Bartlett's test of sphericity. The Kaiser Meyer- Olkin measure (KMO) of sampling adequacy and the Bartlett's test of sphericity (chi- square results) must yield the following results in order to produce good factor analysis. Bartlett's test of sphericity (chi square results) must be significant at a level of ( $p < 0.5$ ) and KMO should be between 0 to 1 and the KMO should have a minimum value of 0.6. The results in Table 4.22 show that KMO is 0.82 which is above the limit of the acceptable value and a chi square test is 1941.66 with  $p\text{-value}=0.000 < 0.05$ . This is an indication that the data is suitable and fit the factor analysis.

**Table 5.22: Kaiser –Meyer –Olkin Measure of sampling adequacy**

Kaiser –Meyer –Olkin Measure of sampling adequacy		0.82
Bartlett's test of sphericity	approx Chi Square	1941.66
	df	630
	Sig.	0.000

In addition, the factor with the eigenvalue less than 1, were rejected. Hence, 11 clusters were obtained which were classified into intentions; behavioural beliefs subjective norms, normative beliefs, attitudes and behaviour.

***Intentions: clusters 3; Behavioural beliefs: clusters 1, 2 and 11; Subjective norms: Clusters 6,7; Normative beliefs: Clusters 10,9; Attitudes: Clusters 8,4 and Behaviour: cluster 5.***

## 5.10 Application of the theory of planned behaviour

In order to test whether the theory of planned behaviour is suitable and fitted for the study, multiple regressions were used as a statistical method in order to test whether the relationships between the different variables are good. Regression was applied after the factor analysis was established and the variables were grouped together to ensure that the reliability was good as indicated in Table 5.24. Furthermore, descriptive statistics were applied and the results from the descriptive statistics are found in Table 5.23. Descriptive statistics for regression (ANOVA tests) were also applied and the results are displayed in the ANOVA table. This table shows that F (Fishers Exact) equal to 71, and a p-value of 0.000. As the p-value is less than 5%, it could be an indication that the regression model is suitable and fits for the data. With reference to the descriptive analysis indicated in Table 4, the mean scores fell within the range 3.5-5 which indicated positive results.

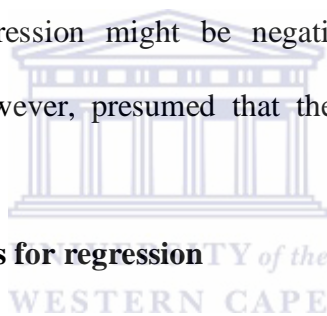
Also, it was found that there is a strong and positive correlation between intention and behaviour ( $r=0.75^{**}$ ,  $p=0.000$ ), this signifies that the proposed theoretical framework is suitable for the study.

The coefficient correlation was 0.84 and the coefficient of determination non-adjusted was 0.71. The adjusted coefficient of determination was 0.70. This means that the independent variable (predictors) explain intention at 70%. With reference to the Coefficient table, the VIF refers to the variance inflation factor. VIF also takes into account the multicollinearity factor in regression analysis. If VIF is less than 4, then the multicollinearity of factors is not affecting the results.

In Table 5.25 which pertains to Coefficient, the regression equation is:

**Intention = 0.001 + 0.54\* behavioural beliefs - Subjective norms\*0.50 + 0.56\* normative beliefs - attitude\*0.57.**

The above equation simply suggests that if everything is constant and there is no change in the numbers, when the subjective norms increase by one unit then the intention decreases by -0.50. Furthermore, it suggests that if the attitude increases to one then the intention also decreases by -0.57. In conclusion, the aforementioned equation and the results thereof signify that the intention is mostly affected by the positive variables such as the behavioural beliefs and normative beliefs. The assumption can thus be made that the subjective norms and attitudes have less significant impact on the intention in this regard. The regression model indicates that the attitude and subjective norms are negative. However, the p-value is not less than 5% which indicates that there is no statistical significance. Therefore, the presumption is that even though the descriptive statistics on both attitude and perception indicate positive results, the coefficients in regression might be negative and, therefore, need further investigation. This research, however, presumed that the general assistants in this study probably have positive attitudes.



**Table 5.23: Descriptive statistics for regression**

	Mean	Std Deviation	N
Intention	3.532	0.62	123
Behav_ belief	3.87	0.75	123
Subj_ Norms	4.22	0.63	123
Normat_ Beliefs	3.29	0.41	123
Attitudes	3.52	0.55	123



**Table 5.24: ANOVA Table**

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	32.84	4	8.21	71.71	0.00 <sup>b</sup>
Residual	13.51	118	0.11		
Total	46.35	122			

1. Dependent variable intention
2. Predictors(Constant):Attitudes; Subj\_norms, Behav\_Belief, Normat\_bel

**Table 5.25: Regression Coefficients**

Model	Beta	Sig	VIF
Constant	0.001	0.99	
Behav_bel	0.54	0	1.65
Subj_norms	-0.5	0.45	1.83
Normat-bel	0.56	0	2.43
Attitudes	-0.57	0.52	2.51

### 5.11 Conclusion

In this chapter the researcher has provided a detailed description and presentation of the results of this study.

The researcher used descriptive analyses to describe, organise and analyse the data. The descriptive analysis was processed in three phases such as descriptive statistics analysis, bivariate analysis and inferential analysis.

The results of the item analysis within the study show that 36.3% of the participants indicated that they had knowledge about mental illness; 56.5% of the participants indicated that they had little knowledge and 5.6% of the people indicated that they had no knowledge. Furthermore, from the results above 24% of participants indicated that they attended in-service training about mental illnesses, while the remaining 76 % of the participants indicated that they had no informal training about mental illness. However, despite the participants' responses on their level of knowledge, in the item analysis, the overall results in the study indicated that only (n= 2)1.6 % of the 124 participants had "poor knowledge" regarding mental illness, 21.8% percent of the participants demonstrated "moderate knowledge" and 72.6% of the participants demonstrated "good knowledge". The section on Knowledge, tested the knowledge of the participants on facts and myths about mental illness and it also tested participants on the basic treatment options that are available as well as the services available for mentally ill patients.

The overall results on attitudes show that the majority (66.7%) of the participants had positive attitudes towards mentally ill patients while (33.3 %) of the general assistants displayed negative attitudes. However, the analysis of certain items indicated that respondents were displaying negative attitudes towards mental illness. For instance, (40.7%) of the participants responded that it is stressful to work with mentally ill patients. The majority of the participants (83.1%) indicated that they will not easily marry someone with a mental illness and (66.6%) of the participants indicated that they don't trust mentally ill patients. With regard to above items it could be concluded that participants were likely to have negative attitudes with regards to certain items toward mentally ill patients.

Other items that showed negative attitudes towards mental illness were related to the statements "I often become frustrated if the patients don't do what is required of them" by (44.7%) and the statement "I usually get upset if patients continue to mess and wet the floor

especially after I cleaned,” having (41.4%) of the respondents. Even though the majority of the participants indicated that they are not afraid of being in the same place with mentally ill patients, a small percentage (22.8%) of the sample indicated that “they are afraid to be in the same place with mentally ill patients.”

The total score on the perceptions of general assistants revealed that the general assistants, overall, have positive perceptions about mental illness. The majority of the participants, (57%) had positive perceptions while the remaining (43%) showed negative perceptions. Some of the items that received negative results are the statements: “female patients must be sterilised” (57.4%) and the statement indicating that “mentally ill patients should not be allowed to have children” (61.4%). Further, the results also indicate that more than half (59.8%) of the respondents indicated that all mentally ill patients drop out of school at one point.

Furthermore, the results indicated that there is a strong and positive correlation between intention and behaviour. The results displayed in this chapter are discussed in detail in chapter 6, which consists of the discussion of the results, recommendations and the conclusion of the study.

## **Chapter 6: Discussion of the Results, Recommendations and Conclusion**

### **6.1 Introduction**

This study explored and investigated the basic knowledge, attitudes and perceptions (KAP) of the general assistants working in four psychiatric hospitals in the Western Cape Province. The KAP evaluation process involved the Theory of Planned Behaviour as described by Ajzen and Fishbein (1991: 179). The results revealed that the general assistants in all the four psychiatric hospitals had basic knowledge pertaining to mental illness. The findings also revealed that the general assistants displayed positive attitudes and perceptions towards mentally ill patients. In addition, the results show that the Theory of Planned Behaviour is well suited for the study since a relationship between intention behaviour and the behaviour of the general assistants has been established.

### **6.2 Research design procedures**

This study used a quantitative descriptive approach, specifically cross-sectional survey research design. A random sample of 124 participants was drawn from a population of 243 general assistants working in the four government owned psychiatric hospitals of Cape Town in the Western Province.

Three quarters (75.8 %) of the study participants were females and the median age of the participants was 45.5 years old. The majority of the participants were coloured, married and the average number of years of experience in a psychiatric institution was 7.5 years. Furthermore, the results indicated that the majority of the participants are Christians and most of them completed grades 10 –12 (52.0 %).

The results from the sample show that more than 50% of the total population had completed between grades 10- 12 with 4.4% of the participants having attended tertiary education.

Hence, the results were not surprising with regards to Kabir *et al.* (2004:5) and Pande *et al.* (2011:18) studies since 72.6% of participants had good knowledge towards mentally ill patients. Kabir *et al.* (2004:5) and Pande *et al.* (2011:18) findings revealed that there is a correlation between the level of education versus the knowledge, attitudes and perceptions of people regarding mental illnesses.

The reliability and internal validity of the research instrument was tested using Cronbach's Alpha. The Cronbach's Alpha value was 0.86 for the entire questionnaire. The study measured the KAP of the general assistants in relation to the various demographic variables: age, gender, marital status, ethnicity, religion, years of experience and levels of education.

The data analysis processes employed in this study involved descriptive analysis, inferential statistics; Chi Square tests, Factor analysis, multiple linear regression and the results obtained in the study were presented by means of frequency tables, graphs. In this context, the analyses were made possible with the interpretation of mean, standard deviation and percentage to describe the variables. Factor analysis was used to cluster the variables of KAP efficiently before applying the Theory of Planned Behaviour. The relationships between variables were established by using Chi-square test and Spearman's Rho correlation. In inferential statistics, regression was applied to check the relationship between behaviour intention and behaviour with the variables called: behavioural beliefs, attitudes, normative beliefs and subjective norms. Data were analysed using the following tools, Microsoft Excel and Software Package for Social Sciences (SPSS) version 22. This chapter consists of the discussions on the verification of all the objectives as outlined underneath.

### 6.3 Verification of objectives

The study had the following objectives:

- To explore the level of basic knowledge of general assistants on mental illness,
- To determine the attitudes of general assistants towards mental illness in psychiatric hospitals.
- To determine the perceptions of general assistants regarding mental illness and mentally ill patients;
- Apply and test the Theory of Planned Behaviour

#### 6.3.1 Level of knowledge of General Assistants on mental illness

The objective number one of this study was to explore the level of knowledge of general assistants on mental illness. The results on knowledge presented in chapter five show that the total scores of all the items measuring knowledge were summed up and the researcher classified knowledge in four categories. The four levels that were used to classify knowledge among participants were: (1) 'no knowledge', (2) 'poor knowledge', (3) 'moderate knowledge' and (4) 'good knowledge'. Seventy two point six percent (72.6%) of the participants demonstrated 'good knowledge' towards mental illness and mentally ill patients while 21.6 % of the participants demonstrated moderate knowledge. These results were in line with Kabir *et al.*'s (2004:5) and Pande *et al.*'s (2011:18) studies. Although the results show that the general assistants had good basic level of knowledge on mental illnesses, it should be noted that there is still a proportion of general assistants who do not have sufficient knowledge pertaining to mental illness. The results of the study are interesting because the expectation was to find that general assistants have poor knowledge pertaining to mental

illness since less than a third of the sample had in- service training regarding mental illness and the behaviour of mentally ill patients.

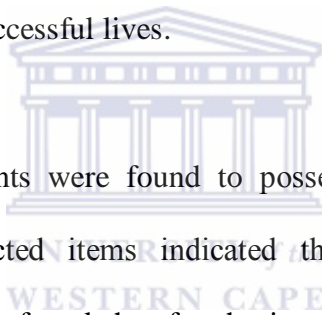
However, the comparison between the psychiatric institutions showed that 74% of the general assistants stationed at Hospital B demonstrated 'good knowledge.' Similarly, 76.3 % of Hospital A's participants also demonstrated good knowledge; while 79% of the participants at Hospital C yielded the same results.

This study, however, only focussed on basic knowledge regarding mental illness and does not reflect specific knowledge regarding specific mental illnesses. Even though the total score of knowledge revealed that participants generally had 'good knowledge' on mental illnesses, the item analysis revealed that there is still lack of knowledge among the general assistants with regards to particular aspects of mental illnesses.

Despite that the majority (76%) of the general assistants revealed that they had never had neither prior training nor formal education on mental illnesses, the results show that they have good background knowledge on mental health. This could be due to two factors, (1) general assistants might have had someone in their family or community who is mentally ill and/or, (2) they might have acquired experience and knowledge on psychiatric disorders within the institution in which they work. These assumptions are based on the findings of the CDC (2011:3) that suggest that familiarity with mental illness and mental health services as well as exposure to mentally ill patients increases the knowledge pertaining to mental illness. Subsequent to the findings of the CDC (2011:3), it is also in line with the findings of Crabb *et al.* (2011:104).

The results in this study indicated that 82% of the general assistants suggested that mental illness occurs as a result of a chemical imbalance of the brain while 72.6% of the participants view mental health as the absence of a mental illness. The majority of the participants (71%)

reported that mental illness is hereditary and can be passed on from one generation to another. Substance abuse was also identified as an attributor which can result in the fact that mentally ill patients can become worse, by 95.2% of the participants. These findings conform to the findings of Sadik *et al.* (2010:26) who found that general health workers in psychiatric hospitals in Iraqi attribute mental illness to brain disease, genetic inheritance and substance abuse. The majority of the participants also agreed that a mentally ill person's quality of life can be improved with treatment and these findings attest to the findings of the CDC (2010: 622-623) in 35 States, the District of Columbia and Puerto Rico where the majority of the educated members of the public responded that mental health treatment can help people with mental illness lead normal lives. The results also indicate that mental health treatment can help mentally ill people to live successful lives.



Despite that the general assistants were found to possess 'good knowledge' on mental illnesses, the analysis of selected items indicated that participants expressed "poor knowledge". For instance, it was found that for the item B6 "all mentally ill patients are dangerous", 21.1% of the participants expressed that all mentally ill patients are dangerous while 78.9% expressed that they disagreed with the statement.

These results are similar to the findings of Gateshill *et al.* (2010:103) who explored the attitudes towards mental illness and emotional empathy between mental health and other health professionals. Gateshill *et al.* (2010:103) found in their study that 36.2% of the non-mental health professionals and 17% of the mental health professionals regard mentally ill patients as unpredictable and dangerous. However, compared to the results of Bener & Ghuloum (2011:161), most of the participants(78.8%) in this study did not regard all people with mental illness as dangerous, as was the case with Bener & Ghuloum. Bener & Ghuloum's study focussed on the ethnic differences in the knowledge, attitudes and beliefs



towards mental illness in a traditional fast developing country, and the population consisted mostly of Arabs. These findings could be related to the exposure to mentally ill clients the general assistants have and the knowledge they have gained while working in the psychiatric settings, however the participants in the aforementioned study included the general population and it is, therefore, not clear whether these participants are exposed to mentally ill patients or not.

In this current study, 69.9% of the participants were found with positive opinion by expressing that people with mental illness are not always rude and violent however in contrast with the above results (60.5%) of general assistants suggested that violence is associated with mental illness. Adewuya and Oguntade (2007: 933) found that 70% of the doctors who participated in their study which explored the attitudes of doctors towards mental illness, conducted in West Nigeria suggest that mentally ill patients are unpredictable, dangerous and aggressive. Likewise, 60% of Jordanian nurses in Jordan view mentally ill patients as dangerous, unpredictable, harmful and dirty (Hamdan- Mansour & Wardam, 2009: 705). Furthermore, the majority of the general assistants reported that people with mental illness who are violent and swearing without any triggers are just rude. Past studies that explored knowledge, attitudes and perceptions of community and lay people and even health care workers revealed that psychiatric patients are regarded as dangerous, rude and aggressive (Chikaodiri, 2009:19-26; Gureje *et al.*, 2005:438 ). The results of this study do not confirm the results of a study conducted by Botha *et al.* (2006: 621) that explored the perceptions of the schizophrenia population in Cape Town which revealed that 60% of the participants reported that mentally ill people tend to be violent. Various misconceptions and views held by the general public often include the fact that mentally ill patients are violent. However, this has not been proven scientifically because studies that explored violence and mental illness often produced results with no statistical significant association between

mental illness and violence (Rueve and Welton, (2008:47); Fazel *et al.* (2009:2023) and Fazel *et al.* (2010:938)). According to Rueve and Welton (2008:47) the impact of mental illness in relation to violence is overemphasized in communities and it often increase the stigma pertaining to mental illness. The results in their study revealed that mentally ill people who are on treatment do not pose an increased risk for violence, however they also found that violence may be more pertinent in patients diagnosed with personality disorders and substance dependence

Fazel *et al.* also demonstrated that there is no significance between violence and mental illness, unless there is a co-morbidity such as substance abuse. There is a greater link between violence and substance abuse than between violence and mental illness (Stuart, 2003:121). Stuart's findings are also in line with Fazel *et al.*'s findings as she further asserts that mentally ill patients with a serious mental illness are more likely to be victims of violence than perpetrators there-off (Stuart, 2003:121).

With reference to the questions related to cultural beliefs e.g. "Mental illness occurs as a result of witchcraft", the results indicated that the majority of the participants disagreed (81.6%) with the statement, therefore, it can be concluded that these results contradict what Crabb *et al.* (2012:545) found. Likewise, the question that stated that *mental illness can be cured by a sangoma* was also opposed by 90.2% of the total sample.

Based on the findings of Crabb *et al.* (2012:545) which revealed that most people in Sub-Saharan Africa associate mental illnesses to cultural beliefs, it was expected that the general assistants would also make that association. Indeed, the participants of this study demonstrated that cultural beliefs affects their understanding and views pertaining to the aetiology and causes of mental illness. Further, the results on beliefs and mental illnesses from the sample were surprising to the studies of Adewuya and Oguntade (2007: 931), Kapungwe *et al.* (2011:295) and Crabb *et al.* (2012:545).

However, the aforementioned results might be due to the fact that the majority of the sample were coloured who in general do not have deep rooted cultural/ethnic beliefs as found amongst black South Africans, for instance, Zulu, Venda, Sotho and Xhosa people (Sorsdahl *et al*, 2009:441; Sorsdahl *et al*, 2013:40; Hugo *et al*, 2003: 718).

Furthermore, the findings in this study support the views of Hugo *et al*. (2003:719) that indicate that the majority of the people in the Western Cape have more western views on mental illnesses and do not attribute mental illness to supernatural spirits, witchcraft and punishment by God.

Despite the fact that only a small percentage (24%) of the participants had informal training on mental illness, the knowledge that the general assistant have might be obtained through exposure and association with mentally ill clients on a daily basis in the psychiatric units. Indeed the general assistants are in direct contact with other health care professionals who advise them or speak about mental illness on a daily basis. This could have also contributed to improving the knowledge of the general assistants. This assertion is confirmed by Jorm and Wright (2008:144) who reported that familiarity with mental illness increases the knowledge of people pertaining to mental illness and it also has the tendency to improve attitudes and perceptions towards mentally ill patients and mental illness. Gateshill *et al*. (2011:103) also revealed in their study that mental health care workers' knowledge and views regarding mental illness are different from non-mental health care workers. The same study showed that mental health care workers had more knowledge and more favourable attitudes towards mental illness than their non-mental health care peers. The above statement is supported by several other researchers that attributed familiarity with mental illness to more knowledge regarding mental illness as well as less stigmatising behaviour (Jorm & Wright, 2008:144; and Sorsdahl, Stein & Myers, 2012:101).

In addition, previous authors (enumerate authors) have also demonstrated that people who have experienced mental illness and those who have been exposed to mentally ill clients have more knowledge and favourable attitudes towards mental illness (Baumann, 2007:1; Dyduch & Grzywa, 2009: 263). The results of the study also support these views which are similar to what Jorm & Wright (2008:144) suggested.

With the statement on substance abuse, it should be noted that substance abuse is a major contributor to mental illness and co-morbidities in the Western Cape. As a result of their debilitating effects on the brain with the potential alteration in behaviour, substance abuse is one of the greatest vices in the communities around the Western Cape (Weich & Pienaar, 2009:213-219). The findings of this study unearthed that the majority (%) of the participants also identified substance abuse as one of the causes of mental illness or at least an aggravator which could cause these patients to become worse. These results are similar to the findings of Ukpong & Abasiubong (2010:57) which indicated that most Nigerians attribute mental illness to substance abuse including alcohol and cannabis abuse.

The study results unveiled that general assistants are aware of the appropriate treatment facilities that are available for mentally ill patients and the majority of the participants dismissed the fact that herbalists can heal or cure mental illness. This finding is contrary to the traditional African views because most of the time African people consult traditional healers for treatment of mental disorders (Stuart, 2003:121). Burns (2010) reported that in Kwazulu Natal, mentally ill patients spend more time seeking traditional healing as alternative to consulting hospital or mental health facilities. The results of this study can possibly be due to the fact that the majority of the participants were coloured.

Participants in this study reported that they believe that stress can lead to other medical conditions such as high blood pressure and heart problems. More females than males

regarded mental health as the absence of a mental illness and more males suggested that a person who has recovered from a mental illness will not be able to return to work.

Of the 124 participants, 61% associated violence with mental illness and 29% of the participants suggested that mental illness is a result of personal weakness while the majority (71%) of the participants indicated that mental illness is hereditary and can be passed on from one generation to another. Furthermore, the general assistants also suggested that mental illness is a result of a chemical imbalance in the brain and also view mental illness as a disease where a person's quality of life can improve with treatment. The results of this study align with the results of Sadik *et al.* (2010:26).

The results of the study also reveal that there is a statistical significance at a p level  $< 0.05\%$  for the question "*Mental illness is caused by (a) personal weakness or it's hereditary and can pass on from one generation to another*". The statistical significance is confirmed by means of the bivariate analysis which tested knowledge and the distribution of gender. Statistical significance was also found between knowledge and distribution by gender in terms of the question: "*Who is more likely to get mental illness (a) poor and uneducated people or (b) anyone regardless of their class, background*". The statistical test was significant at 0.00.

Questions such as, *Mental illness occurs as a result of witchcraft* and *mental illness can be cured completely* also showed statistical significance when gender and the knowledge on mental illness were tested to determine if there is an association between the two variables. Furthermore, the same variables revealed that there is an association between the aforementioned questions and attitude and perceptions.

The results in this study also indicate that more than 80% of the participants are of the view that mentally ill people can have work and still function optimally. This could be due to the fact that the general assistants are working in facilities where some mentally ill clients work

as interns on contracts. At some facilities, some mentally ill patients work permanently and this could have contributed to the responses on this statement.

### **6.3.2 Attitude of general assistants pertaining to mental illness**

The objective number two of this study was to determine the attitude of general assistants pertaining to mental illness.

Studies investigating and exploring the attitudes of the general public globally revealed that the attitudes towards mentally ill patients are mostly negative (Des Courtis *et al.*, 2008:503-509; Sui *et al.*, 2012:18-24; Stone & Merlo, 2011:134). These studies indicate that the general public and at times health care personnel often reveal attitudes which are discriminating, stereotyping and also causing social withdrawal (Des Courtis *et al.*, 2008:503-509; Sui *et al.*, 2012:18-24, Stone & Merlo, 2011:134). However, the results obtained from this study differ from similar studies that were conducted in other parts of Sub Saharan Africa which focussed on the general public. The results in this study show that 66.1% of General Assistants react or had positive attitude towards mentally ill patients. Attitudes displayed by some of the ethnic groups demonstrated that prejudice, stigmatisation, bias and discrimination are rife amongst the general public and some categories of healthcare personnel. Even doctors and psychiatrists, psychologists and nurses display these types of negative attitudes (Gateshill *et al.*, 2011:101; Adewuya & Oguntade, 2007:931; Ukpong & Abasiubong, 2010:56)

Despite the fact that the various health care practitioners such as doctors, psychologists and nurses are trained on mental illnesses, they are influenced by the same misconceptions and negative imagery as the public toward the mentally ill patients, which affect attitudes (Adewuya & Oguntade, 2007:931; Ukpong & Abasiubong, 2010:56).

It was expected to find a high proportion of general assistants having negative attitudes compared to the practitioner's attitudes towards mental illnesses. The results were surprising, the total score on attitudes of the general assistants was computed and the results show that n=41(33.1%) of the total participants n=124 had negative attitudes while the majority of the participants n= 82(66.1%) revealed positive attitudes towards mental illness. Further, based on the mean value of 3.75 and the standard deviation of 0.5, it was concluded that the general assistants had positive attitudes pertaining to mental illnesses. However, the attitudes of general assistants on mental illness remain positive in general; the analysis of item shows disparities and profound contrast.

In this study, the expectation was to see that general assistants respond as patients have a mental health problem; they should not be allowed to take any given job. Surprisingly, the results for question B<sub>20</sub> "Mentally ill patients can have a regular job and still function well" showed that n=100(80.6%) responded that mentally ill patients can have a regular job and still function well while the remaining 24(19.4%) disagreed with the statement. This could be related to the fact that the general assistants are working in facilities where they encounter some mentally ill patients working as interns on contracts. At some facilities, some mentally ill patients work on a permanent basis. The fact that the general assistants come into contact and know some of these individuals could have impacted on their knowledge and consequently on their opinion on this statement, seeing how well these patients can work in spite of their mental illness.

The results in this study reveal that a small proportion of the participants fear mentally ill patients (5.7%), almost 40% indicated that working with mentally ill patients is stressful and they do not like to work with mentally ill people (13%). Another small percentage of the participants are afraid of being with mentally ill patients in the same place (22.8%). The results also reveal that a third (34%) of the participants does not want to stay with mentally ill

patients in the same house and three quarters (74%) of the participants indicated that they would not easily marry someone with a mental illness. Even though a conclusion can be made that some general assistance display social restrictive attitudes with regards to certain variables, it should be noted that the percentages involved are significantly less than those obtained from similar studies in Africa. For example, Crabb *et al.* (2012:545-546) found that the majority of the participants in their cross sectional survey in Malawi revealed that 81% of the participants would not marry someone with mental illness, 40.6% would be unwilling to share a room with somebody who is mentally ill, 33.8% would be upset if they have to work with mentally ill people and 8.1% indicated that they would be ashamed if they had family members who are mentally ill. In the same fashion Barke *et al.* (2010: 1196) reported that 42.14% suggested that mentally ill patients should be excluded from the rest of the community, 38.13% do not want to stay next to someone with mental illness. Adewuya and Oguntade (2007: 934) also revealed similar findings then Crabb *et al.* (2012:545-546) and Barke *et al.* (2010: 1196). Halet *et al.* (2011: 1365) also declared that the majority of the nurses in their study, which focussed on the attitudes of nurses towards people with schizophrenia, were not in favour of marrying a person with schizophrenia.

The findings of this study displayed less stigmatising and negative attitudes towards mental illnesses and mentally ill patients. The fact that the majority of the participants displayed positive attitudes towards mentally ill patients attributed to the fact that they are familiar with mental illnesses and it concurs with the suggestions of the CDC (2011:3) that indicate that familiarity and exposure to mental illness leads to more positive attitudes towards mental illness. The exposure to mentally ill clients on a daily basis probably has impact on their attitudes towards mentally ill patients.

The results of the item analysis demonstrated that various items were in an association with some or other demographic variables. In this study an association was found between the



attitudes of general assistants towards mental illness and gender, religion, marital status as well as with psychiatric hospitals and the level of education. Items that showed statistical significance include the statement “I feel ashamed of mentally ill clients”. This was statistically significant with regards to marital status, ethnicity and the psychiatric institution. Furthermore, more males (43%) agree with the statement “I feel ashamed of mentally ill clients” compared to their female counterparts (27.9%). The statistics also revealed that 40% of the females in this study find it stressful to work with mentally ill patients, a relationship or an association was found between ‘I feel working with mentally ill patients is stressful’ and gender as well as psychiatric institution. A greater percentage of females tend to get provoked and angered by mentally ill patients especially when the patients don’t do what is expected of them. Twenty five percent of females also revealed that they would feel ashamed should they have mentally ill family members.

These results are similar to the univariate results of Adewuya and Oguntade who found that there was statistical significance between the attitudes of doctors specifically social distance of doctors and sex, age, having managed mentally ill patients, years of clinical experience and having a friend or family member who is mentally ill (Adewuya & Oguntade, 2007: 933). Christians in a study conducted by Gray (2001:72) in the UK demonstrated more favourable attitudes towards mental illness than the general public with whom they were compared to. In this study, there was also a relationship between religion and attitudes. However, it did not indicate which religion was found having more favourable attitudes towards mentally ill patients.

Hamdan- Mansour & Wardam (2009: 705) also found statistical significance between the male and female nurses pertaining to inter-sectoral collaboration. Male and female nurses also had significant differences pertaining to their perception of mentally ill patients on

whether they are rude or polite. Female nurses perceived mentally ill patients as more polite than men.

### **6.3.3 Perceptions of general assistants towards mental illness**

The objective number three of this study was to determine the perceptions of general assistants pertaining to mental illness. Although health care practitioners are trained on mental illness, they are influenced by the same misconceptions and negative imagery as the general public towards the mentally ill patients (Wahl, 1995). Consequently, the expectation in this study was to find that general assistants who have not received formal training on mental illnesses should have negative perceptions towards mentally ill patients. However, the results were surprising and showed that 43% of the general assistants have negative perceptions while 57% representing the majority, had positive perceptions towards mental illnesses and mentally ill patients. Although general assistants have displayed positive perceptions towards mentally ill patients and mental illnesses in general, it should be noted that the association between certain items of perceptions and socio-demographic variables showed that there were disparities in the results.

The results in this study revealed that 87% of the participants perceived mentally ill patients as unpredictable. Despite that 78.7% of the general assistants indicated that they disagreed with the statement that mentally ill patients should be feared. Even though the majority of the participants indicated that they will not easily marry someone with mental illness, 71.5% were in favour of the fact that mentally ill patients should get married because they disagreed with the statement, “people with mental illness should not be allowed to get married”. These findings concur with the majority of the studies that explored knowledge, attitudes and perceptions of mental illness in different settings. The majority of the participants (79%) that felt that people with mental illness should not get married are situated at Hospital A.

The results of the study also revealed that there were statistical significance between 'People with mental illness have unpredictable behaviour' and variables such as ethnicity, religion and level of education. The majority of the participants that demonstrated that people with mental illness have unpredictable behaviour were found amongst those who fell within the category Grade 7-9 (91%) followed by the participants who completed Grade 10-12 (79%). The majority (%) of the participants that agreed to the statement: 'People with mental illness have unpredictable behaviour' were found amongst those participants who had 16 years and more experience within a psychiatric facility, 83% that shared this view were Muslim and 86% were coloured and the majority of the participants were working at Hospital D.

The association between "People with mental illness should be feared" and socio-demographic variables such as psychiatric hospital, religion and level of education showed very surprising results because 86% of the participants who passed matric felt that people with mental illness should be feared, 49% had between 0 and 5 years of experience in a psychiatric institution, the majority of these participants (94%) were Christians who were working at Hospital B and lastly 85 % of the participants that agreed to this statement were African. Furthermore, the results also indicate that the majority of these participants had between 0-5 years of experience.

The Chi square results pertaining to the association with the statement: "People with mental illness should not be allowed to get married" and demographic variables revealed that there was an association between the aforementioned statement and the psychiatric hospital at a p-level of 5%. Participants at Hospital C agreed that people with mental illness should not get married followed by 80% at Hospital A. Furthermore, this view was also shared by 70% of the male participants while the majority of these general assistants were married, African and ranged between the age groups 61 years and older and participants who were in the age group 41- 50.

The results pertaining to the statement “Female mentally ill patients must be sterilised” revealed that 56% of the participants agreed to the statement. The majority of the people (39%) who agreed to the statement were within the age group 41-50 years, 47% of these participants have worked less than five years in the psychiatric hospitals, and lastly the majority of the general assistants (44%) that agreed to the statement were females.

Statistical significance was also found between the statement “mentally ill patients must be kept in hospitals or outside of the communities” and religion and psychiatric hospital variables. Of the 124 participants in the study, 77% agreed that mentally ill patients must be kept in hospitals or outside of the communities. The results of this study reveal that the majority of the Christians (80%) and 67% of the Muslims and Hindu holds this view. However, these results are indicative of negative perceptions and social distancing. Interestingly, all the participants with tertiary education, together with 80% of the participants between Grade 10-12 and 75% of the general assistants in the lower categories support this stance. The results of this study are congruent with the findings of Ukpong and Abasiubong (2010:59) which demonstrated that the majority of the public (82%) in a National survey in Nigeria agreed that mentally ill people should be kept outside of communities.

The results with regards to the statement “I think mental ill patients should not be allowed to have children” concur with the results of Sadik *et al.* (2010:32) that the majority of the participants in a public survey in Iraq agreed that mentally ill people should be prevented from having children.

In the results, an association was also found between “I think all mentally patients have funny and strange behaviour” and the following variables religion and level of education. The majority of those participants who were in the group Grade 10-12, and Grade 7-9 shared these views.

The majority of the Christian participants in this study indicated that they disagree with the statement ‘All patients with mental illness drop out of school some time or the other’ whilst their Muslim peers supports this notion. Furthermore, the majority of the participants that support this stance were working at Hospital B while the majority of the persons that disagree with this stance are located at Hospital A. A statistically significant association was found between the aforementioned variables at a p- level <5%.

The results of this study indicated that there is an association between ‘Mentally ill patients don’t have a future’ and marital status. Interestingly, an equal proportion of males and females within this study agreed that mentally ill patients don’t have a future. A greater proportion of those who are married, single, divorced and widowed support the stance that mentally ill patients do not have a future. It can, therefore, be concluded that negative perceptions with regards to this item were found amongst both sexes and amongst all forms of marital status.

The majority of the participants across all levels of education, across all institutions, and across all forms of marital status agreed that “Mentally ill patients cannot work” and furthermore, a statistical significant association was found at a p-level of 5%. Contrary to the previous findings that stated that mentally ill patients should be kept in hospitals, the findings relating to the statement “Mentally ill patients should be allowed to stay in communities and should be involved in community activities”, indicate that the majority of the participants agreed that mentally ill patients should be allowed to stay in communities and should be involved in community activities. This statement was in an association with gender at a p-level of 5 %.

Throughout this study, a vast majority of the participants agreed that family and friends must support people with mental illness.

#### **6.4 Application and testing of the Theory of Planned Behaviour.**

The objective number four of this study was to apply and test the theory of planned behaviour. The theory of planned behaviour consists of predicting and explaining the intention of people to engage in behaviour at a specific time and place. It states that behavioural achievement depends on both motivation (intention) and ability (behavioural control). In order to test whether the Theory of Planned Behaviour was suitable and fitted for the study, multiple linear regression was used as a statistical method in order to test whether the relationships between the different variables were good. A strong and positive correlation between behaviour and intentions ( $r=0.75$ ;  $p\leq 0.001$ ) was found and this signify that the proposed theoretical framework was suitable for the study.

Regression was applied after factor analysis was established and the variables grouped together to ensure good reliability as indicated in Table 5.24. Since  $F$  (Fishers Exact) = 71, 71 and a  $p$ -value of 0.000, the regression model was suitable and fitted for the data. Also, it was found that there were strong and positive correlation between intention and behaviour ( $r=0.75^{**}$ ,  $p=0.000$ )

**Intention = 0.001 + 0.54\* behavioural beliefs - Subjective norms\*0.50 + 0.56\* normative beliefs - attitude\*0.57.**

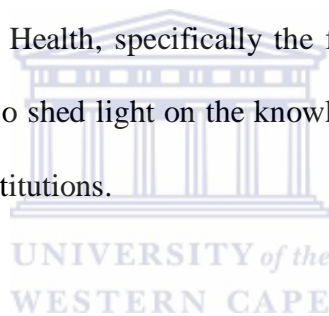
The above equation simply suggests that if everything is constant and there is no change in the numbers, when the subjective norms increase to one then the intention decrease to -0.50. Furthermore, it also suggests that if the attitude increases to one then the intention also decreases but to -0.57. In conclusion, the aforementioned equation and the results thereof signify that the intention is mostly affected by the positive variables such as the behavioural beliefs and normative beliefs. The assumption can thus be made that the subjective norms and attitudes have a less significant impact on the intention in this regard. The presumption is that

even though the descriptive statistics, both for attitude and perception, indicate positive results, the regression might be negative and, therefore, need further investigation. It will be, however, presumed that the general assistants in this study probably have positive attitudes.

### **6.5 Contribution of the study**

This study contributes to the existing knowledge pertaining to the knowledge, attitudes and perceptions of health care personnel and support staff especially general assistants.

This study also contributes to the literature specifically on the aspect that the Theory of Planned Behaviour can be applied to KAP studies since no published literature has been found on studies that applied and tested the theory in the context of this study. In South Africa and in the Department of Health, specifically the four psychiatric hospitals in Cape Town, the results of the study also shed light on the knowledge, attitudes and perceptions of general assistants within these institutions.



### **6.5 Limitations of the study**

Since the study was only conducted in four psychiatric hospitals in Cape Town, it cannot be generalised and taken as the views of general assistants in psychiatric hospitals in the rest of the country. The literature review with respect to general assistants' knowledge, attitudes and perceptions showed that literature regarding this staff category is scarce and literature on the application of the Theory of Planned Behaviour was also scarce in the context of the KAP study. The concepts as defined in the theoretical framework were also ambiguous and confusing. The other limitation is the fact that permission was only granted to involve the general assistants in the two acute psychiatric wards at Hospital D.

## **6.6 Recommendations**

It is recommended that in-service training sessions should be implemented since the majority of the participants indicated that they never had any formal or informal in-service training with regards to mental illness and mentally ill clients. This will update and/or improve the knowledge of the general assistants on pertinent mental health issues that they need to know to effectively carry out their work. In this regard, it is suggested that a basic mental health literacy training course should be included in the induction training of general assistants to reduce fears and possible ill treatment, discrimination, stigmatisation of the admitted patients by the new appointees.

The researcher also recommends that guidelines with basic information on mental illness should be established and distributed to general assistants to inform and educate them regarding basic mental health literacy. This will possibly enhance mental health literacy and to possibly reduce negative perceptions and attitudes towards mentally ill patients.

In order to determine whether all general assistants share the same views, and to test whether all the general assistants are knowledgeable pertaining to mental illness, the researcher recommends that a study should be conducted in both rural and urban areas to investigate whether these general assistants are knowledgeable about basic mental illness. Another proposed study that can be conducted should explore the relationship between the knowledge of the general assistants and stigmatising behaviour.



## 6.7 Conclusion

According to the researcher, this study is the first study conducted in the Western Cape that focuses on knowledge, attitudes and perceptions of general assistants towards mentally ill patients in the four psychiatric hospitals. This study revealed that the general assistants in the Western Cape's psychiatric hospitals are fairly knowledgeable on mental illnesses based on the fact that they can attribute mental illness to a chemical imbalance in the brain which can be worsened by substance abuse. They could also identify that mentally ill patients need to be treated with medication by either medical doctors or psychiatric nurses and they disregard treatment by witch doctors named 'sangoma's' as an appropriate way of treating mental illness.

The attitudes and perceptions displayed by the general assistants in this study were positive; less stigmatising and discriminating than similar studies that have been conducted in South Africa in particular and the African continent in general. Participants in this study believed that mentally ill patients should be integrated in the communities and should be involved in community activities, and they were also of the opinion that mentally ill patients can take up employment at various establishments and companies. The findings that are in line with those of other researchers are that mentally ill patients should not be allowed to have children and that the female patients should be sterilised. Mentally ill patients are also seen as less violent, rude and dangerous.

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## Appendices

### Appendix A: Participants information sheet



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**Title:** Knowledge, attitude and perceptions of general assistants towards mentally ill patients in a tertiary Psychiatric Hospital, in the Western Cape

#### **What is the study about?**

This is a research project conducted by Lorraine Beukes at the University of the Western Cape. I am inviting you to participate in this research project because you meet the criteria. The purpose of the project is to determine your level of knowledge regarding mental illness and your attitude and perceptions towards mentally ill patients.

#### **What will I be asked if I agree to participate?**

You will be asked to complete a questionnaire which comprises of four sections. You will then place the completed questionnaire in an envelope that you seal and place in a sealed collection box in your department.

#### **Would my participation in this study be kept confidential?**



We will do our best to keep your personal information confidential. To help protect your confidentiality, personal data will be kept in a locked cabinet and password-protected computers will be utilized to store information. Your name will not be included on the collected data, instead identification codes will be used and the investigator will use an identification key and will be able to link the collected data to your identity. If we write a report about this research project, your identity will be protected to the maximum extent possible.

**What are the risks of this research?**

There are no known risks of participating in this research project.

**What are the benefits of this research?**

The research is not designed to help you personally, but the results may help the investigator to learn more about the level of knowledge and attitudes of general assistants towards mentally ill patients.

We hope general assistants as well as other staff categories might benefit from this study.

**Do I have to be in this research and may I stop participating at any time?**

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

**Is there any assistance available if I am negatively affected by participating in this study?**

You will not be negatively affected by this study.

**What if I have questions?**

The research is being conducted by Lorraine Beukes, a student at the School of Nursing at the University of the Western Cape. If you have questions about the research study itself, please contact the investigator, her contact numbers are on the previous page.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you experienced related to the study, please contact:

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**Supervisor:**

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This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

## Appendix B: Informed consent



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E-mail: sarunachallam@uwc.ac.za

Lorraine Beukes

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### CONSENT FORM

**Title:** knowledge and attitudes of general assistants towards mentally ill patients, in a tertiary Psychiatric institution in the Western Cape

PARTICIPANT'S NAME:	
SIGNATURE:	
WITNESS NAME:	
SIGNATURE:	

I declare that:

- I, the participant, have been invited to participate in the above research project / study undertaken by Lorraine Beukes, a Masters student of the University of Western Cape.
- I have read the information sheet and consent form and that it is in a language that I am comfortable with and understand.
- It was explained that my identity will not be disclosed, my participation is strictly voluntary and I have a right to withdraw from the study at any time. Such withdrawal will not have any negative impact on me.

- All the questions that I posed have been answered.
- I have been informed that although the results of the study will be published, I will remain anonymous. Information or results obtained from the study will be confidential but will be used for a master's degree.
- There is no personal gain, financial or other, in my participation in this study.
- I might be asked to leave the study before the time if the investigator feels that it is in my best interest, or if I do not follow the study plan as agreed to.
- I hereby agree voluntarily to participate in the project / study.

Signed at \_\_\_\_\_ on \_\_\_\_\_ 20\_\_\_\_\_

Participant \_\_\_\_\_

Witness \_\_\_\_\_

Statement by / for Investigator

I, \_\_\_\_\_ the undersigned, declare that I explained the content of the document in English / Afrikaans to the Participant,

Mr. / Mrs. / Ms \_\_\_\_\_ and requested him / her to ask questions if uncertainty existed about any aspect of the document.

Signed at \_\_\_\_\_ on \_\_\_\_\_ 20\_\_\_\_\_

Investigator / Investigators representative \_\_\_\_\_

Witness \_\_\_\_\_

Should you have any questions regarding this study or wish to report any problems you have experienced related to this study, please contact the study coordinator:

Dr. S Arunachallam

University of the Western Cape

Private Bag X17

Bellville 7535

021 959 2274

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## Appendix C: Questionnaire



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Thank You for taking time out to complete the questionnaire. This questionnaire consists of four (4) sections and all the questions must be completed. Section A focus on socio-demographic/ personal data. Section B consists of questions pertaining to knowledge regarding Mental illness, section C focus on the attitudes towards mentally ill patients and the last Section, Section D consists of questions pertaining to the perceptions towards mental illness and mentally ill patients. Please feel free to contact the investigator if there are any questions and if there is any uncertainty regarding the questions.

### SECTION A

Please complete the questionnaire below. Please tick off the appropriate information with a X.

Participant's number				Sex	Male	Female
Age	21-30	31-40	41-50	51-60	61 and above	
Marital status	Single		Married	Divorce		Widow
Ethnicity	Coloured		White	African		Indian
Religion	Christian		Muslim	Hindu		Other
Years Employed At A Psychiatric Institution	0-5 years		5-10 years	11-15 years		16 & more years
Highest level of education	Grade R-4		Grade 5-9	Grade 10-12		Tertiary education

**SECTION B:**

**KNOWLEDGE PERTAINING TO MENTAL ILLNESS**

1. **How much knowledge do you have pertaining to mental illness?**
  - a. Very much
  - b. A little
  - c. None
  
2. **Did you ever have informal training or in-service training regarding mental illness and the behaviour of mentally ill patients? If yes when was the training conducted.**
  - a. Yes
  - b. No

**Please indicate if the following statements are true or false:**

3. **Mental illness is normally a result of a chemical imbalance of the brain**

True	False
------	-------

4. **People who have family members with mental illness will definitely get mental illness.**

True	False
------	-------

5. **People with mental illness are always violent and rude.**

True	False
------	-------

6. **All people with mental illness are dangerous.**

True	False
------	-------

7. **Stress can lead to other medical conditions such as high blood pressure and heart problems**

True	False
------	-------

**8. A person who has recovered from mental illness will not be able to return to work.**

True	False
------	-------

**9. Mental health is the absence of a mental illness**

True	False
------	-------

**10. Violence is associated with mental illness**

True	False
------	-------

**Please circle the correct answer.**

**11. Mental illness is caused by :**

- a. Personal weakness or frailty
- b. It is hereditary can be passed on from one generation to the next.

**12. Who is more likely to get a mental disease :**

- a. The poor uneducated people
- b. Anyone regardless of intelligence, social class or income level

**13. Mental illness can be regarded as the following:**

- a. It is a life sentence
- b. A persons quality of life can be improved with treatment such as therapy, medication, occupational therapy, social support

**14. The following is essential for mentally ill patients to be stable**

- a. Medication and continuous support
- b. Good friends

**15. The following aspects increase the risk of mental illness.**

- a. substances and drug abuse
- b. family history of mental illness
- c. Being friend with mentally ill patients

**16. Mentally ill patients can be cured completely**

- a. I agree
- b. Disagree

**17. Mental illness occurs as a result of witchcraft**

- a. I agree
- b. Disagree

**18. Mentally ill patients can stop their medication at any given time and can start their medication again without experiencing problems**

- a. I agree
- b. Disagree

**19. Substance abuse can cause mentally ill patients to become worse**

- a. I agree
- b. Disagree

**20. Mentally ill patients can have a regular job and still function well**

- a. I agree
- b. Disagree



**21. Mentally ill patients suffer from split personalities**

- a. I agree
- b. Disagree

**22. Mentally ill patients always need prescribed medication to control the sickness**

- a. I agree
- b. Disagree

**23. Mentally ill patients can be treated successfully at community health centre's**

- a. I agree
- b. Disagree

**24. Mental illness can be cured by a sangoma or traditional healer**

- a. I agree
- b. Disagree



**25. Mentally ill patients should be admitted in hospitals when they are a danger to themselves and others.**

- a. Yes
- b. No

**26. Mentally ill patients must receive treatment from a clinic or doctor or mental health nurse**

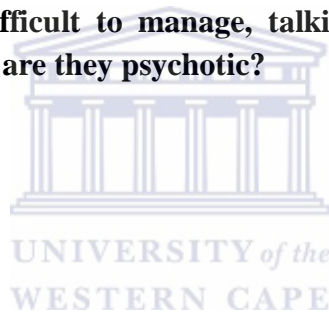
- a. Yes
- b. No

**27. Mentally ill patients who are very aggressive and swearing without triggers are just rude**

- a. Yes
- b. No

**28. When patients are difficult to manage, talking to themselves and they are violent in the hospital, are they psychotic?**

- a. Yes
- b. No



## SECTION C

Attitudes towards mentally ill patients. Please tick the correct answer with a X

NO	Statement	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
29	I feel ashamed of mentally ill patients					
30	I don't like working with mentally ill patients					
31	I feel working with mentally ill patients is stressful					
32	I'm afraid of mentally ill patients					
33	I don't want to stay with mentally ill patients in the same house					
34	I often feel like laughing at the mentally ill patients					
35	Mentally ill patients often provoke anger in me					
36	I often get upset with mentally ill patients					
37	I will easily marry someone even if he/ she has a mental illness					
38	I don't trust mentally ill patients					
39	I treat all mentally ill patients the way I treat my children					
40	I would feel ashamed if I have mentally ill family members					
41	I often become frustrated if the patients don't do what is required of them					
42	I usually get upset if the patients continue to mess and wet the floors especially after I cleaned					
43	I don't want to work with someone who has mental illness					
44	I'm often afraid and scared of being in the same place with mentally ill patients					
45	I feel comfortable working with mentally ill patients					
46	Mentally ill patients should be discriminated against when applying for services or work					
47	Mentally ill patients should get an equal opportunity then those who are not mentally ill when they are applying for work					
48	I feel that mentally ill patients are a nuisance					
49	I sometimes behave or treat patients negatively					
50	I'm sometimes harsh with mentally ill patients					
51	I get so frustrated at times that I feel like swearing					
52	I feel mentally ill patients are useless					

**SECTION D: Perceptions of general assistants towards mental illness**

**Please mark the correct answer with a X**

**1-Strongly agree –2. Agree –3.Uncertain-4. Disagree -5. Totally Disagree.**

No	Question	Answer				
		Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
53	People with mental illness have unpredictable behaviour?					
54	People with mental illness should be feared					
55	People with mental illness should not be allowed to get married.					
56	Female mentally ill patients must be sterilized					
57	Mentally ill patients must be kept in hospitals or in places outside of the communities					
58	I think mentally ill patients should not be allowed to have children					
59	I think all mentally ill patients have funny and strange behaviour					
60	All patients with mental illness drops out of school some time or the other					
61	Mentally ill patients don't have a future					
62	Mentally ill patients can't work					
63	Families and friends must support people with mental illness					
64	Mentally ill patients should be allowed to stay in communities and should be involved in community activities					

## Appendix D: Letters



### OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

29 October 2013

#### To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by Ms L. Beukes (School of Nursing)

Research Project:

The knowledge, attitudes and perception of general assistants towards mentally ill patients in psychiatric hospitals in Cape Town in the Western Cape.

Registration no:

13/8/15

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Patricia Josias'.

*Ms Patricia Josias  
Research Ethics Committee Officer  
University of the Western Cape*

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