

**Mental Health Literacy of Young People in South Africa: A Study
of University of KwaZulu-Natal Students**

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Dissertation submitted in partial fulfilment of the requirements for the degree

MASTER OF SOCIAL SCIENCES (Clinical Psychology)

in the

SCHOOL OF APPLIED HUMAN SCIENCES

COLLEGE OF HUMANITIES

at the

UNIVERSITY OF KWAZULU-NATAL

PIETERMARITZBURG, SOUTH AFRICA

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2018

DECLARATION

I, Constance Thulsile Zita, declare that

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I, Prof Augustine Nwoye, confirm that the work reported in this dissertation was carried out by Constance Thulsile Zita, under my supervision



Signed: _____ Date: 18/05/2018 _____

Professor Augustine Nwoye

ACKNOWLEDGEMENTS

I would like to thank God for the strength that He provided me with throughout my studies. The University of KwaZulu-Natal students played a vital role into the success of this research project and I appreciate a lot for their participation and contribution. Furthermore, I am thankful to my supervisor, Professor A. Nwoye, for the guidance that he provided throughout this project. Without him, this project would not have been a success. I would also like to extend my gratitude to my family for the support they provided throughout my studies, especially my mother; Lizzy Shabangu, and my brother, Phillemon Zitha.

DEDICATION

I would like to dedicate this work to the students of the University of KwaZulu-Natal, Pietermaritzburg Campus, Professor A. Nwoye (my supervisor), and myself. This study would not have been a success without this team. It is also dedicated to those affected by mental illness.

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ABSTRACT

The central objective of the present study was to investigate the mental health literacy of the University of KwaZulu-Natal undergraduate Black students. The specific objective was to explore the level of the students' mental health literacy as a prelude to determining the extent to which there is need to promote the students' constant awareness of their mental health status. A quantitative research method was employed in implementing the study. A total sample of 128 participants was included in the data collection process. A structured survey questionnaire consisting of 15 questions about mental health disorders and people's perceptions of mental illness served as the study's instrument for data collection.

The results of the study show that 39.1% of participants were able to identify the major symptoms of common mental health disorders about the excessive use of substances. This comprises less than the simple majority of the participants studied. Furthermore, the results of the study revealed that 42.2% of the participants could accurately identify the symptoms of mental health illness regarding impairment in areas such as social, academic, relationships, and emotional stability. Similarly, the study discovered that 46.1% of the participants could accurately identify a difficulty in concentration, poor memory, and poor decision making as symptoms of mental illness. In addition, only 27.3% of the participants could accurately identify a disturbance in sleeping patterns and a change in appetite as symptoms of mental illness. The results of the study also show that about 28.1% of the participants could accurately identify the non-stop experiences of headache without any medical explanation as a symptom of mental illness. Overall, however, the results of the study suggest that majority of the participants do not have sufficient mental health literacy.

The implications of these findings were drawn. The researcher adopted the recommendation by the overwhelming majority of the participants (90.6) that a Mental Health Wellness Centre be established at the University of KwaZulu-Natal to improve the mental health literacy of the students. Implications for further research were also briefly drawn.

CHAPTER ONE

INTRODUCTION

1.1. Background of the study

People's perceptions regarding mental illness are influenced by their knowledge and beliefs about mental health disorders. Jorm, Angermeyer, Kartshnig, Korten, Jacomb, Christensen, Rodgers and Pollitt (as cited in Jorm, 2011, p. 231) referred to people's knowledge and beliefs about mental disorders as "mental health literacy". Furthermore, mental health literacy consists of several components (Jorm, 2000). These components of mental health literacy involves one's the ability to identify specific mental disorders or different types of psychological distress; knowledge and beliefs about risk factors and causes, self-help interventions, professional help available for them; attitudes which aid their ability to recognise and seek help appropriately; and knowledge of how to seek mental health information (Jorm, 2000, p. 396).

Indeed, according to Jorm, Angermeyer, Kartshnig, Korten, Jacomb, Christensen, Rodgers and Pollitt (as cited in Jorm, 2011, p. 182), mental health literacy can be defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention". In addition, Jorm (2011) believes that it should be noted that mental health literacy does not only entail having knowledge of mental disorders derived from the abnormal psychology course. It should rather be knowledge that can possibly be beneficial to one, in order to take action regarding their mental health or those of significant others (Jorm, 2011). Collaborating the above observation by Jorm (2011), Weist, Kutcher and Wei (2015), remarked that mental health literacy presents a variety of benefits. These benefits include preventative measures, one's ability to recognise mental illness at an early stage and intervention, as well as the reduction of stigma associated with mental illness (Weist et al., 2015).

Studies in South Africa such as those conducted by Mohamed-Kaloo and Laher (2014), Kakuma, Kleintjies, Lun, Drew, Green and Flisher (2010), and Hugo, Boshoff, Traut, Zungu-Dirwayi and Stein (2003), as well as the Mental Health and Poverty Project (2010) which included South Africa have directed their major interest on monitoring mental health literacy of members of the health professions and community members. None of the local studies showed an interest in studying the mental health literacy of young people in South

Africa, particularly the students. Hugo et al. (2003), who also focused on community members, found that the majority of participants could not identify mental disorders which were presented in vignettes and considered them to be stress related or lack of will power. Furthermore, findings from Hugo et al. (2003) suggest that misinformation about mental health contributes to the stigmatisation of mental illness and its under-treatment.

Similarly, Kakuma et al. (2010) found that stigma plays a role on factors associated with mental illness. These factors include persistent suffering, disability, and economic loss (Kakuma et al., 2010). Mohamed-Kaloo and Laher (2014) focused on members of the health professionals, the general practitioners, in studying the perceptions of mental illness of Lenasia community members. The results of their study showed that mental health literacy is very limited among the members of the Lenasia community and this leads to stigmatisation of mental illness in the community. The participants' knowledge of mental health disorders was drawn from their academic knowledge.

Moreover, findings from Mohamed-Kaloo and Laher (2014) also revealed that the community members from Lenasia hide their mental illness and this result in misdiagnoses as well as underdiagnoses. Furthermore, Mohamed-Kaloo and Laher (2014) identified a need to team up with traditional healers because the community members prefer to consult their general practitioners and traditional healers as they believe that they are acceptable in the community. Similarly, the Policy on Mental Health and Poverty (2010) found that traditional explanatory models of illness and use of traditional healers to treat mental disorders is common, yet there is evidence that there is little collaboration between western based and traditional healing systems. One can therefore conclude thus far that there is poor mental health literacy within the communities in South Africa which may hinder people from accessing psychological help.

From the researcher's knowledge, the mental health literacy of the students remains unknown in South Africa. Yet they seem to be at a higher risk of developing mental illnesses. According to Manos (as cited in Tartani, 2011), most mental illnesses such as depression and psychotic disorders often have an onset during young adulthood. Therefore, students' mental health literacy was viewed as an important area that should be investigated and would assist in coming up with prevention and promotion programmes of mental health of the university students.

Interestingly, scholars from outside South Africa have emphasised the need to study mental health literacy of college students. According to Hunt and Eisenberg (2010), mental health is a growing concern amongst college students as the period of college education belongs to a period of stressful transition in their lives. College students usually go through different transitions during their college years of study. Consequently, if untreated, mental illness faced by students may negatively affect their academic performance, productivity, social relationships and increase the likelihood of substance abuse (Hunt & Eisenberg, 2010). This conclusion has been supported by findings from the American Psychiatric Association (2000) which showed that young adults, such as university or college students are more vulnerable to the development of major mental disorders such as schizophrenia, bipolar and major depressive disorder, anxiety disorders as well as substance abuse. This may be due to the fact that research has shown that young people are at high risk for the onset of mental disorders during their youth ages, in particular the students (American Psychiatric Association, 2000). Together, these findings demonstrate that university students are the most vulnerable group that needs to be closely and carefully monitored with regard to the level of their mental health literacy. University students constitute a majority group compared to the health professionals which the South African researchers appeared to have focused on in their research efforts on this theme. As part of the effort to correct this imbalance, the present researcher has been motivated to carry out a study addressing the mental health literacy of University of KwaZulu-Natal students.

1.2. Statement of the problem

The predominance of mental illness amongst young people, particularly students, is of great concern all over the world. Different studies have shown that young people are at a higher risk for the development of mental illness and the onset is usually during their college years. The American Psychiatric Association (2000) and Hunt and Eisenberg (2010) also believe that college or university students are at a higher risk for the development of mental illness due to the challenges they are faced with during their transition into adulthood. Coles, Heimberg and Weiss (as cited in McNeal, 2015), stated that the onset of mental illness is usually around age 24 and during this period, young people go through various developmental transitions which makes them even more vulnerable to the development of mental disorders. What is argued is that young people need to be in a position in which they

can identify the signs and symptoms of mental illness and seek appropriate help when necessary. Not only do they have to be able to identify the need for mental health services for themselves, but they should be able to assist others such as the adult population (Kelly, Jorm & Wright, 2007; Jorm, 2011). Studying the mental health literacy of the University of KwaZulu-Natal students may assist in determining their level of mental health literacy since, from the researcher's knowledge, it appears that such studies have not yet been conducted within the South African universities.

1.3. Purpose of the study

The main purpose of the current study was to investigate the mental health literacy of the University of KwaZulu-Natal students and to bring about awareness into the area of mental health.

1.4. Objectives of the study

The specific objectives of the study are to:

1. Explore the students' knowledge of symptoms of common mental health disorders.
2. Assess the extent to which students' knowledge of mental health disorders is accurate or inaccurate.
3. Determine the percentage of the sampled students that can accurately identify the symptoms of major mental illnesses.

1.5. Research questions

1. What is the extent of students' knowledge of symptoms of common mental health disorders?
2. To what extent are the students' perceptions of mental illness accurate or inaccurate?
3. What is the proportion of the sampled students who can accurately identify major symptoms of major mental illnesses?

1.6. Significance of the study

Given the higher prevalence rate of mental illness amongst youth and the absence of studies within the area of mental health amongst South African university students, there is a need to study the mental health literacy of this population. Kelly et al. (2007) believe that positive outcomes regarding mental health can be achieved when young people and their key helpers have good mental health literacy, either through facilitation of early help-seeking behaviour in young people themselves or assisting the adult population to be able to identify early signs and symptoms of mental health disorders and seek help appropriately on their behalf. Studying the “mental health literacy” of students will assist in monitoring their mental health literacy status. It will, by extension, enable us to raise awareness about the importance of mental health literacy amongst university students, where need be.

1.7. Assumptions of the study

It is one of the major assumptions of the present study that it is possible to measure students’ level of mental health literacy. Another assumption of the study is that students have perceptions of what constitutes mental health disorders which they would be willing to share with the researcher.

1.8. Scope and delimitations of the study

Although the study had an interest in identifying the “mental health literacy” of young people in South Africa, the scope of the study was limited to exploring the mental health literacy of young people studying at the University of KwaZulu-Natal (Pietermaritzburg campus). The actual sample population for the study was further delimited to the Black undergraduate students of the university. For this reason it was anticipated that the findings may not be used to generalise the results to other undergraduate university students from other universities in South Africa. In addition, post-graduate Black students and other non-Black students of the University of KwaZulu-Natal were excluded from this study, which again implies that the results of the study were not intended to be generalized to the mental health experience of post-graduate and non-Black students of the university.

Data was collected through the use of an instrument adapted from a non-South African study and adjusted for the current sample.

1.9. Operational definition of terms

Mental health literacy: “Knowledge and Beliefs about mental disorders which aid their recognition, management or prevention” Jorm, Angermeyer, Kartshnig, Korten, Jacomb, Christensen, Rodgers and Pollitt (as cited in Jorm, 2011, p. 182).

Mental illness: This is a mental health condition or disorders that affect one’s mood, their thoughts and behaviour (Mayo Clinic).

Mental health disorders: This consists of a number of challenges with a variety of symptoms which are generally characterised by a combination of abnormalities in one’s thoughts, emotions, behaviour and relationships with others (WHO, 2017).

Undergraduate students: For purposes of this study this refers to young people who have graduated from high school and have been accepted into, and currently undergoing their first degree studies at the University of KwaZulu-Natal, South Africa (Vocabulary.com).

1.10. Summary and overview of the study

This chapter served as an introduction to the present study. It provides a general background about mental health literacy. The rationale for the study, the purpose and objectives, as well as the research questions are outlined in this chapter. In addition, the relevant concepts of this study have been operationally defined. The following chapters will be presented in the remainder of this research report:

- Chapter 2 of the current study will present the literature review of the study. Local and foreign studies will be reviewed in relation to the present study.
- Chapter 3 will be concerned with highlighting the research methodology employed in implementing the study.
- Chapter 4 outlines the findings of the study and the quantitative data from the questionnaires will be presented.
- Chapter 5 focuses on discussing and integrating the results of the study with the existing literature. This is in an attempt to answer the research questions posed

regarding the mental health literacy of the youth population in South Africa, through the study of the University of KwaZulu-Natal students.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1. Introduction

In this chapter, literature about mental health literacy and related topics are critically examined. Local and foreign studies related to the present study have been reviewed. Mental health literacy will also be discussed further. Moreover, the review hopes to give a clear indication of the findings of other researchers regarding mental health literacy amongst college or university students and community members.

2.2. Theoretical and empirical review of the literature

2.2.1 Theoretical review of the literature

2.2.1.1 Conceptual framework: Social Development Theory

The conceptual framework that drove the study was the Social Development Theory. This is a theory developed by Lev Vygotsky (1978). The theory highlights the fundamental role played by people's involvement in social interactions in the development of cognitions. Lev Vygotsky (1978) was credited with the notion that the community plays a central role in the process of making meaning in people's life-world. He stated that the environment in which children/ people grow up greatly influences how they think and what they think about several issues that affect their lives. He further proposed that individuals cannot be understood without reference to the social and cultural contexts within which they are embedded (Vygotsky, 1978). Thus, Vygotsky (1978) places enormous emphasis on the societal factors contributing to cognitive development, including by extension, people's development of mental health literacy. Indeed, Vygotsky's (1978) theory suggests that mental structures and functioning of individuals raised in a specific culture will be different from those raised in other cultures (Vygotsky, 1978). Hence, he considered the nature of reasoning and problem solving as culturally determined (Kozulin, 2003).

In line with Vygotsky's (1978) social development theory, it can be concluded that South African students would be different from students from outside South Africa in their mental health literacy status as they were not raised in the same culture area and context. This suggests that a study on mental health literacy amongst South African students needed to be

carried out to study their level of mental health literacy in comparison to that of students from abroad, studied earlier by foreign researchers. Given this understanding, the student population of attention in this study was limited to those from the black population who are influenced by the local community and culture in which they were born and raised. It was expected that studying them would help in generating data towards understanding the extent of the mental health literacy of the black student population in the country.

The above indications mean that the theoretical framework that galvanized the present study is Vygotsky's (1978) theory of Social Development. The theory will be used as a framework for explaining students' mental health literacy explored in this study.

2.2.2 Empirical review of the literature

Dr. A. Jorm pioneered the Mental Health Literacy concept in the 1990s. He focused on the mental health areas he believed were neglected. According to Jorm (2000), mental health literacy is beneficial as it provides the public with the knowledge of mental health that may result in early interventions, self-help and community support. It also equips them with the skill to identify the problem. . Research conducted by Jorm, Christensen and Griffiths (2006) revealed that the public still does not recognise mental disorders. In their view the public and professionals carries different notions regarding the treatment of mental health. It is however of importance for the gap between the two belief systems to be bridged. At the same time, Jorm et al. (2006) found that mental health stigma remains a barrier to help-seeking behaviour. Mental health first-aid skills are deficient and there are several types of interventions that can improve mental health literacy (Jorm et al., 2006).

According to Marsella (as cited in Okello & Musisi, 2006), most professionals are trained using western models. Therefore those professionals and community members in the western societies assume that mental health problem resides in the individual's mind or brain. As a result their treatment plan also put more emphasis on the brain. This assumption is a contradiction to the current view of mental health and culture. Certain symptoms are understood in the socio-cultural context. Depressive symptoms may be interpreted differently in the cultural context as compared to the western model (Okello & Musisi, 2006).

Okello and Musisi (2006) further stated that it is apparent that cultural variations exist across all areas of depression. Okello and Musisi (2006) believe that the areas of depression may include; meaning, perceived causes, patterns of onset, epidemiology, symptoms

expression, course, and outcome. According to Aidoo and Harpham; Baingana; and Patel (as cited in Okello & Musisi, 2006), these cultural variations have significant implications in understanding clinical activities which includes conceptualisation, assessment, and therapy. Okello and Musisi (2006) revealed that the symptoms classified as psychotic depression with mood congruent delusions in the Diagnostic Statistical Manual-IV are recognised as an illness and the Baganda refer to it as a clan illness called *eByekika* illness. According to Okello and Musisi (2006), the Baganda conceptualises this condition as an outcome of wrong doing by the living against their ancestors. The healing process involves traditional healers and participation of other members of the clan in correcting what is perceived as collective wrong (Okello & Musisi, 2006).

In the light of the above, the Baganda perceived Western medicine as inappropriate for treatment of this condition, especially as it emphasised attention to individual brain problems and treatments. Even though the symptoms of depression were identified as an illness, the conceptualisation, name, causation, and treatment of the illness were not considered appropriate for the western psychiatric treatment. The Baganda community believes that the illness originates from challenges in a relationship between the living and the ancestor that has to be corrected (Okello & Musisi, 2006). This may further suggest that the Baganda understand mental illness from a cultural perspective. Their knowledge and beliefs about mental disorders is understood in as stemming from their cultural beliefs as opposed to the Western explanation of what constitutes mental illness.

According to Jorm (2000), correct labelling of mental disorders is an important aspect of mental health literacy as it increases the likelihood of individuals who seek professional assistance, whereas incorrect labelling of a mental illness, for example, as stress or a life problem can have a negative impact which may result into delays in treatment and/ or informal, less effective strategies to relieve symptoms. Reavley and Jorm (2011) propose that one's ability to identify the symptoms of mental disorders is considered as the first necessary step in facilitating psychological help-seeking. Jorm, Kitchener, O'Kearney, and Dear (2004) have also suggested that higher levels of mental health literacy have been associated with a decreased stigma towards mental illness, or the mentally ill, and those who suffer from mental illness are more likely to seek appropriate professional help for themselves and recommend help to others in need of the services. Similarly, Reavley, Morgan and Jorm (2014) also found that higher mental health literacy scores are predominantly linked with

lower stigmatising attitudes and a strong belief that mental illness is an illness as opposed to a weakness (Reavley, Morgan, & Jorm, 2014).

Most recently, Kutcher, Wei and Hashish (2016) stated that mental health literacy comprises of four different components; however, these components are related to each other. They include “understanding how to obtain and maintain good mental health; understanding mental disorders and their treatments, decreasing stigma; and enhancing help-seeking efficacy; that is, one’s ability to know when and where to obtain evidence-based mental health care as well as having competencies to enhance self-care” (Kutcher et al., 2016, p. 691).

Ganaseen, Parker, Hugo, Stein, Emsley and Seedat (2008) believe that Jorm’s definition of mental health literacy failed to specify that the kind of mental health literacy that is being referred to is knowledge regarding evidence-based mental disorders and their treatments. However, Ganaseen et al. (2008) stated that to be mental health illiterate may not only mean that one has little or no evidence-based knowledge of mental illness or of treatment but may also mean that the knowledge and beliefs that they hold may be derived from other sources, such as superstitions or cultural and personal beliefs about mental illness. For example, a South African study of Xhosa families of patients with schizophrenia found that a large proportion of participants believed schizophrenia to be caused by possession by evil spirits or witchcraft. Similarly, a Nigerian study of caregivers of patients with schizophrenia and major affective disorders revealed a high proportion of caregivers believing that supernatural elements have a role to play in psychiatric illness. Such beliefs in supernatural causes are common in many non-western countries and may influence the type of treatment that is sought (Ganaseen et al., 2008).

Sayarifard and Ghadirian (2013) believe that poor mental health literacy remains a barrier in providing psychological services to the less privileged. Such a barrier has also been found to be one of the major concerns in low and middle class countries, like Iran, where the services of mental health are said to be limited (Sayfari & Ghadirian, 2013). Thus, mental health literacy remains an important issue across countries. In addition, Sayarifard and Ghadirian (2013) stated that mental health literacy is a powerful tool that one needs and will assist in the prevention, recognition and management of mental illness. Sayarifard and Ghadirian (2013) also stated that people who have the knowledge about mental health are in a better position to prevent, recognise and manage mental illness.

Kelly, Jorm, and Wright (2007) outlined that the onset of mental disorders is usually during adolescence or young adulthood. Mental disorders have been reported as the largest proportion of the illness that affects the young population worldwide (Patel, Flisher, Hetrick & McGorry, 2007). Furthermore, Patel et al. (2007) stated that the onset of most mental disorders is during youth, between the ages of 12–24 years. The authors propose that young people are more vulnerable to the development of mental disorders as it is the stage where most mental disorders begin. In addition, they outlined that mental disorders begin during youth but are often detected for the first time during adulthood (Patel et al., 2007). Hunt and Eisenberg (2009) have suggested that students inhabit that developmental life stage where mental illnesses begin to affect individuals.

Coles, Heimberg and Weiss (as cited in McNeal, 2015), reported that about seventy five percent of mental illnesses develop by early adulthood, around the age of 24. Furthermore, according to Gulliver, Griffiths and Christensen (as cited in McNeal, 2015), it has been indicated that the young adult population has a greater prevalence of mental illness. The prevalence of mental illness amongst this age group along with their reluctance to seek help has been identified as a high risk factor for the development of mental health disorders (Gulliver and colleagues) as cited in (McNeal, 2015). According to McNeal (2015), there are a number of stressful developmental milestones that occur when one transitions into young adulthood. These developmental milestones incorporate the formation of relationships, self-identity, and independence (Maulik, Mendelson, and Tandon) as cited in (McNeal, 2015). The youth population is more likely to have mental health problems and their motivation to seek help is very low (McNeal, 2015). Furthermore, McNeal (2015) outlined that a relatively mild mental health challenge has a potential that can interfere with social, emotional, or cognitive functioning that can be problematic in adulthood.

Kelly et al. (2007) stated that mental disorders need to be recognised and treated as early as possible to increase the possibilities of better long-term outcomes. However, it appears that in practice, those in need of professional help often delay treatment or do not seek appropriate help (Kelly et al., 2007). Early recognition of mental disorders and appropriate help-seeking will only take place if the youth population and their significant others are able to identify the signs and symptoms of mental disorders, have knowledge regarding the kind of help available for them and how to access it (Kelly et al., 2007). The researchers further outlined that it is also essential that the supporters of those affected by mental disorders have knowledge on how to provide appropriate first aid and ongoing help

with regards to mental illness (Kelly et al., 2007). In addition, this type of knowledge and skills regarding mental health has been referred to as “mental health literacy” (Kelly et al., 2007). Finally, Lauber, Ajdacic-Gross, Fritschi, Stulz, and Rossler (as cited in McNeal, 2015) acknowledge that one’s ability to recognise mental disorders is deemed necessary as it is the major influence on one’s attitude and behaviour towards those with mental illness.

Following the above indications, Jorm, Angermeyer, Kartshnig, Korten, Jacomb, Christensen, Rodgers and Pollitt (as cited by Jorm, 2000) conducted a survey about mental health literacy of Australian adults and their findings showed that the Australian population has poor mental health literacy. It was therefore concluded that the Australian population has poor mental health literacy since the majority of the sampled participants were unable to recognise signs and symptoms of mental disorders such as depression and schizophrenia (Jorm, 2000). Similar findings from a study conducted by Tartani (2011) were found, which indicated that there is substantial room for improvement in the area of mental health literacy amongst Swedish adolescents. This is because the sample of Swedish adolescents they studied was found to be unable to recognise symptoms of schizophrenia and depression (Tartani, 2011). This suggests that there seems to be poor mental health literacy among young adults in Sweden. Given the above, it can be concluded from this section of the review that anybody who is unable to identify/recognize the signs and symptoms of mental disorders have a low level of mental health literacy.

2.2.3. Findings from different studies across countries

According to Murray and Lopez (as cited in Goldney, Fisher & Wilson, 2001), depression has been identified as a major public health concern and it imposes a considerable economic and emotional burden upon the community. Furthermore, Murray and colleague (as cited in Goldney et al., 2001) stated that some communities and institutions do not fully recognise depression and treat it appropriately. They further indicated that only half of the patients who seek help from general practitioners with depressive symptoms were properly diagnosed and various other studies have found shortcomings in its detection (Goldney et al., 2001). Findings from the study conducted by Goldney et al. (2001) show that there is evidence that the community lacks the ability to recognise the signs/symptoms of depression and has a limited understanding of the availability and effectiveness of standard treatments of depression (Golney et al., 2001). Goldney et al. (2001) further stated that this is so effective

even for those who have had an experience of depression. Moreover, those who have experienced depressive episode/s and previously had contact with a therapist were not influenced by such background in changing their beliefs about depression (Goldney et al., 2001). Their views about mental health were found to be similar to that of others in the community sample. Goldney et al. (2001) highlight that clinicians should not be the only ones to recognise and treat depression more adequately, the community members should also be equipped with such skills. In particular, those who suffer from depression need to be aware of the symptoms of depression and that effective treatment is available (Goldney et al., 2001)

Findings from Hugo, Boshoff, Traut, Zungu-Dirwayi and Stein (2003) indicate that the majority of their participants considered mental disorders to be stress related or a lack of will power. Moreover, findings from Mori, Panova and Keo (2007) show that Asians were amongst the most negative participants on their opinions of the mentally ill towards accessing mental health services. The male participants reported greater misconceptions of mental illness and held a more negative attitude towards psychotherapy than female participants (Mori et al., 2007). Similarly, findings from a study carried out by Kelly et al. (2007) show that approximately half the young people surveyed in a number of different studies demonstrated good mental health literacy around depression. Furthermore, young adults (18–25 years) were able to identify depression than adolescents, as were young women compared with young men (Kelly et al., 2007). According to the findings from Mori et al. (2007), Asians were more likely than Whites to believe that mental illness was as a result of predominantly organic causes and environmental stressors, rather than to personality factors. Asian participants were reported to express greater negativity with regards to the prognosis of the mentally ill, and had a strong belief that a lack of will power and dwelling on morbid thoughts were contributing factors into the onset of mental illness (Mori et al., 2007). These findings suggest that mental illness results from a lack of will power. Similarly, findings from Stansbury, Wimsatt, Simpson, Martin and Nelson (2011) show that the African Americans often believe that depression is a sign of a personal weakness that can best be addressed by faith and prayer for treatment purposes, rather than counselling and pharmacology.

According to Okello and Musisi (2006), the Baganda have different views about the causes of such illnesses. Findings from the study conducted by Okello and Musisi (2006) revealed that the Banganda understand mental illness from a traditional belief system. Similarly, findings from a study conducted by Ally and Laher (2008) indicates that the South African Muslim faith healers view mental illness from dualistic points of view, namely

biological factors, which in particular involves medical/ psychological issues and from spiritual inclined taxonomies. Moreover, findings from Sorsdahl et al. (2009) show that most of the traditional African belief systems, view mental health problems as due to ancestors or by bewitchment, and traditional healers and religious advisors are viewed as experts in this area regarding treatment. African traditional healers understand mental disorders as stemming from the ancestors as a punishment and bewitchment. The South African Muslim faith healers and the African traditional healers view mental illness differently (Ally & Laher, 2008; Sorsdahl et al., 2009). However, there seems to be commonalities within the Baganda, Muslim faith healers and the African traditional healers as it appears that their understanding of mental illness is drawn from the traditional belief system.

Findings from a study conducted by McCarthy, Bruno and Fernandes (2011) outlines that there is poor mental health literacy about depression and sufficient source of support in adolescents. From a study conducted by van 't Hof, Stein, Cuijpers and Sorsdahl (2011), although all vignettes were constructed according to DSM -IV criteria, only 37.5% were able to identify mental illness from the vignettes, while 44.6 % could not identify the the symptoms of mental illness rather perceived it as a normal response. Furthermore, van 't Hof et al. (2011) stated that the majority of the participants reported that they believed the described behaviour to be typical of weak character (55.4%) (van 't Hop et al., 2011). Moreover, stress (64.8%) and lack of willpower (57%) were most often reported as causes for the described behaviour. Psychosocial stressors were also frequently reported as causes (between 33.3% and 64.8%), followed by intrapsychic factors (31.5% and 57.4%), biological causes (between 29.6% and 44.4%), socialisation (22.2-29.6%), supernatural powers (9.3%-27.8%), and state of society (13-16.7%) (van 't Hof et al., 2011).

Mental health literacy of the participants from a study conducted by Mohamed-Kaloo and Laher (2014) was drawn from their academic knowledge; their understanding of mental disorders was based on the “Diagnostic Statistical Manual” (DSM) or “Internal Classification of Diseases” (ICD) classifications. Findings from Stansbury et al. (2011) suggest that the majority of the participants could accurately identify depression in the vignettes. It has been speculated that young adults (18-24 years old) have a heightened sense of depression due to the Internet, positive media portrayals of individuals with depression and/ or college campaigns promoting mental health awareness (Stansbury et al., 2011).

Researchers have reported that individuals who have the ability to recognise mental disorder are more likely to hold positive attitudes towards mental health and the mentally ill (Stansbury et al., 2011). In a study conducted by Stansbury et al. (2011), the majority of the participants believed that depression can be treated successfully through professional interventions. The participants endorsed professionals such as physicians, university counsellors, school psychiatrists, and social workers to treat depression (Stansbury et al., 2011). According to Stansbury et al. (2011), there is also a finding that family and friends were also perceived as helpful sources of support. This was not found to be surprising since, historically, African Americans often relied upon informal sources of support for mental health challenges due to lack of resources and opportunities in mainstream America. Respondents recommended other self-help interventions including “lifestyle” changes such as getting out more, participation in physical activities, and becoming more knowledgeable about the problem to alleviate depression.

However, long-standing psychiatric treatments (for example, electroconvulsive therapy) and pharmacological treatments (for example, antidepressants and antipsychotics) were not recommended (Stansbury et al., 2011). Reasons for African American college students’ scepticism toward psychopharmacologic treatments include side effects and dependency. Stansbury et al. (2011) stated that their finding that almost half of the respondents reported the Internet as useful for accessing information on mental illnesses was found to be consistent with that of Mond and colleagues (as cited in Stansbury et al., 2011). The increased use of the Internet has the potential to become a common source of information-seeking on depression.

Similarly, Loureiro et al. (2013) stated that depression is found to be common in adolescents and young adults; however, help seeking regarding treatment is low. Loureiro et al. (2013) are of the opinion that mental health literacy regarding depression is key in planning interventions that will improve help seeking behaviour. The results of their study also revealed that a quarter of the sampled participants had a difficulty to recognise depression in the vignette (Loureiro et al., 2013). Furthermore, a study conducted by Marcus and Westra (2012) explored mental health literacy of young adults between the ages of 18-24 years in comparison to the older adults between the ages of 25-60 years in a national survey of mental health literacy of Canadians. Findings showed that both groups reported to have demonstrated adequate mental health literacy, although young adults, especially males, preferred managing their own problems (Marcus & Westra, 2012).

Furthermore, there was an indication that male participants preferred to seek informal help from certain sources (for example, friends) rather than formal ones (for example, psychotherapy) (Marcus & Westra, 2012). Findings from Marcus and Westra (2012) support the importance of recognising that young adults have unique needs and preferences in order to improve help seeking behaviour within their group. Similarly, Mohamed-Kaloo and Laher (2014) also found that community members of the Muslim religion have a belief that one should deal with their own problems without consulting any professional. Similarly, on a study “to examine the relationship between mental health and depression in a population of Chinese adolescents” conducted by Lam (2014), a total of 16.4% of the participants demonstrated adequate level of mental health literacy as they were able to correctly identify depression and had an intention to seek help appropriately. Moreover, 23.4% of the study participants correctly identified depression as presented on the vignette. A further 14.8% of the sample was classified to have moderate to severe depression (Lam, 2014). This simply means that a certain percentage of the sampled population’s level of mental health literacy was found to be accurate; however, for some of them it was inaccurate.

Similarly, in a study conducted by Gibbons, Thorsteinsson and Loi (2015), male participants were reported to have poor mental health literacy skills in comparison to female participants; the males had a difficulty to identify mental illness, and mostly rated the symptoms presented as less serious. The male participants also perceived that individuals have greater control over symptoms of mental illness and were less likely to approve the need for treatment of anxiety or psychosis (Gibbons et al., 2015). Furthermore, the results show that 85.7% of the sampled population could not identify the presented symptoms of depression, followed by 56.5% for anxiety and 41.5% for psychosis. These findings may further suggest that the public in general has poor mental health literacy regarding anxiety and psychosis (Gibbons et al., 2015).

Findings from a study by McNeal (2015) revealed that African Americans have positive attitudes towards professional psychological help and they were able to recognise mental disorders from the vignettes. This may further imply that the African American possess good mental health literacy. In a survey conducted by the CDC (2011) (as cited in McNeal, 2015), some of the young adults had a belief that a person with a mental illness could eventually recover from the illness (McNeal, 2015). Kermode, Bowen, Arole, Joag and Jorm (2009) stated that mental health remains a neglected concern in most developing countries, particularly in rural areas where mental health services are not easily accessible and somehow

limited.. These findings were found to be similar from a study conducted in Iran which indicated that poor mental health literacy remains a barrier to access mental health services (Sayarifard & Ghadirian, 2013). Furthermore, it was reported that the majority of the participants demonstrated accurate knowledge about mental disorders in relation to the vignettes, even if they sometimes had a difficulty in giving a specific name for it (Kermode et al., 2009). The participants mostly labelled the disorder presented in the depression vignette as “Depression” and in cases of psychosis the participants commonly labelled it as “a mind/brain problem” (Kermode et al., 2009). This trend may suggest that the participants have limited knowledge about the mental health disorders. Moreover, Wang et al. (as cited in Kermode et al., 2009) (2013) believe that lack of treatment for mental illness, particularly in low- and middle-income countries as opposed to high-income countries (85% v. 54%), may be associated with either a lack or low community awareness regarding mental illness.

In a study conducted by Bird and colleagues, as indicated by Patel et al. (2007), results show significant differences on different levels amongst the students who were the study participants. The first-year students possessed higher levels of stigma in comparison to the fifth years (Patel et al., 2007). Moreover, young adults showed significant lower levels of stigma in comparison to the first and third years. The young adults are reported to be more likely to identify and seek help than any other age group (Patel et al., 2007). Kermode et al. (2009) further outlined that the participants considered socio-economic interventions provided by the society; for example, family, friends, and neighbours to be most helpful. In addition, psychiatrists were perceived as less helpful; however, the local village health workers and doctors were perceived as potentially helpful and this may possibly due to the negative attitude towards members of the family consulting a psychiatrist (Kermode et al., 2009). In addition to what has been outlined above, Kermode et al. (2009) stated that psychiatrists are not easily accessible in the village and the people from the village are expected to travel long distances for consultation with the psychiatrist which may be costly for them. Kermode et al., (2009) found that about half of the sample participants believed that handling their problems on their own would be helpful. Special diets, tonics, appetite stimulants and sleeping pills were also strongly endorsed, but the awareness of psychiatric medications was insignificant (Kermode et al., 2009). Similar findings were obtained from a study conducted by Mohamed-Kaloo and Laher (2014) that the Muslim community in Lenesia prefer dealing with their problems on their own and also preferred consulting general

practitioners who are also Muslim as they would be able to recommend traditional interventions.

According to Kermode et al. (2009), the most common response from the scenario that looked at the participants' understanding of depression and help seeking behaviour was that giving each other love and affection was helpful as treatment approaches. Kermode et al. (2009) further reported that the second most common response provided by the participants was to assist financially to the person in need or in distress. Only a minority of the participants reported that they take the individual with problems to the doctor or hospital (Kermode et al., 2009). The authors further indicated that the participants' responses on the open ended questions with regards to the psychosis vignette were significantly different. The most preferred response amongst the village health workers was giving love and affection, but accompanying the individual to the doctor or hospital was favoured by the community members. The results show that the community members and village health workers adequate knowledge of mental disorders, but their knowledge and understanding of effective responses and treatments were limited (Kermode et al., 2009).

Chandra and Minkovitz, Pinto-Foltz, Hines-Martin and Logsdon (as cited in Pinto-Foltz, Logsdon, Myers, 2011) stated that previous research findings have confirmed that adolescents have reported moderate levels of stigma towards mental illness and their mental health literacy is poor. Furthermore, Corrigan and the U.S. Department of Health and Human Services (as cited in Pinto-Foltz et al., 2011) indicated that high stigmatisation attitudes attached to mental illness and low mental health literacy are main factors that contribute to premature termination of mental health treatment for adolescents who enter mental health treatment (Pinto-Foltz et al., 2011). Moreover, Moses (as cited in Pinto-Foltz et al., 2011) outlined that mental health treatment seeking in adolescents is mostly influenced by the opinions of peers and adults who are involved in their social life. Pinto-Foltz et al. (2011) reported that studies conducted amongst adolescents have found that adolescents have preferences when expected to discuss their mental health related issues and it is mostly with their peers. However, they are not willing to do so because they fear stigma attached to mental illness (Pinto-Foltz et al., 2011).

Brown and Palenchar, and Cooper et al (as cited in Pinto-Foltz et al., 2011) outlined that a number of well-known barriers to mental health utilisation exist. These barriers to mental health utilisation contain stigmatisation attitudes, cost of treatment, lack of availability

of services in the area, and inability to identify symptoms of depression and other mental disorders (Pinto-Foltz et al., 2011). Moreover, Mohamed-Kaloo and Laher (2014) also found that the stigmatising attitudes towards mental illness remains a barrier in utilising mental health services within the community of Lenesia. In addition, findings from Ofuani (2015) also showed that stigma around mental illness results into underutilisation of mental health services.

The results from a cross-sectional study conducted by Mahfouz et al. (2016) amongst undergraduate students, show that the largest proportion of the student participants (90.3%) have intermediate mental health literacy. The students agreed that genetic inheritance (45.8%), poor quality of life (65%), and social relationship weakness (73.1%) were the main causes of mental illness with regards to the aetiology of mental illness (Mahfouz et al., 2016). The majority of the participants were of the opinion that mentally ill people are not capable of true friendships (52.5%) and that anyone can suffer from a mental illness (49.4%) (Mahfouz et al., 2016). Furthermore, it appeared that the attitudes of students towards psychiatric patients were mixed, with 68.7% reporting that they could maintain a friendship with a mentally ill person and that people with mental illness should have the same rights as anyone else (82.5%) (Mahfouz et al., 2017). Moreover, Mahfouz et al. (2016) suggest that there is an urgent need to change the students' attitude regarding mental health and the schools may be helpful in running such educational programmes. According to Ofuani (2015), comorbid diagnoses, such as substance abuse related disorders, in people who suffer from mental illness usually occur. Ofuani (2015) is of the opinion that mental illness is a public health issue rather than an individual concern as it is related to many unfavourable physical health outcomes.

2.3. Research/ operational hypotheses

The mental health literacy of the students of the university was studied. The researcher worked on the assumption that the students have their own perceptions on what constitutes mental illness. It was assumed that the students would be able to share with the researcher, through the use of a questionnaire, their knowledge and beliefs about mental health disorders.

2.4. Summary

The present chapter presents a review of literature on mental health literacy of South African youth and worldwide. The review showed that the mental health literacy concept was pioneered by an Australian researcher Dr A. Jorm. Through his research Dr. Jorm brought understanding into the concept of educating the public about mental health. This is deemed beneficial to the public as it assist in identifying the symptoms, treatment and management. The review also showed that other researchers have pointed out that people understand mental illness differently. A review of results from extant studies shows that people understand mental illness from a dualistic point of view: from Western and African perspectives respectively. For example, studies from other parts of Africa such as among the Baganda of Uganda suggested that among them mental illness is understood as arising from lack of will power or from a wrong doing against, or as a punishment from the ancestors. Based on the above, it would be relevant to find out whether the student participants in this study will tend to see the source of mental illness as arising from limitations within the individual patient (as understood in the West) or from outside the individual concerned, in the form of punishment from the ancestors, as seen from among the Baganda of Uganda.

CHAPTER THREE

METHODOLOGY

3.1. Introduction

The methodology employed in the current study will be presented. Firstly, the researcher discusses the research design followed in implementing the study. Secondly, the researcher discusses the quantitative research method implicated in the study to clarify the approaches used to collect data, including issues about the target population, sample size and sampling technique, inclusion and exclusion criteria, research instrument, validity and reliability, ethical considerations, as well as data analysis used in the study. The chapter provides a systematic and logical understanding of the research process for a more holistic understanding of the mental health literacy of the undergraduate students.

3.2. Design of the study

3.2.1. Research design

The researcher employed a non-experimental research design. By definition, a non-experimental research design involves variables that are not manipulated by the researcher; instead these variables are studied as they exist (Belli, 2009). The present study made use of University of KwaZulu-Natal students as the participants and studied them as they exist rather than manipulating them. In this regard, the researcher used a survey research design in implementing the study. Through this design, the participants' level of knowledge of mental health disorders (or their mental health literacy) was assessed. According to Babbie (1992), survey research assists the researcher in understanding a particular phenomenon and in collecting a lot of information from many people. It is also less costly to the researcher. Therefore, in the current study, survey research assisted the researcher in understanding the students' level of mental health literacy by collecting information from a fairly large sample of students.

3.2.2. Quantitative research method

The study employed a quantitative survey methodology in implementing the research. The quantitative survey methodology was used because quantitative researchers try to

understand facts of research investigations from an outsider's perspective (Welman, Kruger & Mitchell, 2005). This makes it possible for the researcher to remain objective in presenting the results (Struwig & Stead, 2001). Quantitative research can be defined as "a formal, objective, systematic process in which numerical data are used to obtain information about the world" (Burns & Grove, 2005, p. 23). The results of such studies are presented in numerical form and analysed through the use of statistics. In addition, quantitative research methodology assumes the objective reality of social facts (Struwig & Stead, 2001), such as in the case of the present study; the mental health literacy of the students of the University of KwaZulu-Natal.

3.2.3. Research paradigm

The research paradigm for this study was positivism. Positivism is associated with quantitative research which involves hypothesis or assumption testing, geared at obtaining an objective truth about what is studied. Positivism emphasises that human knowledge exists and is researchable and could be generated through the use of appropriate data collection instruments (Struwig & Stead, 2001). In line with such a paradigm, the researcher wished to be able to objectively explore the mental health literacy of her study participants through a structured questionnaire.

3.3. Location of the study

The present study was conducted at the University of KwaZulu-Natal, Pietermaritzburg Campus.

3.4. Study population

The target population for the study consisted of the black undergraduate students of the University of KwaZulu-Natal, Pietermaritzburg Campus. This included black students from different colleges such as Humanities, Agriculture, Engineering and Science, Education, as well as Commerce, Law and Management Studies Colleges within the university and at different years of study.

3.4.1 Inclusion and exclusion criteria

The study focused mainly on the undergraduate students of the University of KwaZulu-Natal, Pietermaritzburg Campus, who were between the ages of 18-35 years. The postgraduate students were excluded in this study. In addition, non-Black students were also excluded in this study. This was because the researcher intended to focus only on Black undergraduate students.

3.5. Sampling techniques and sample size

A convenience sampling technique was used in drawing the sample for the present study. According to Durrheim and Painter (2006), a convenience sample is one where the participants for inclusion in the sample are easily accessible. Through a convenience sampling method, black students from the LANs of the University of KwaZulu-Natal (Pietermaritzburg Campus) were recruited into the study sample. The researcher aimed to sample up to 140 undergraduate students, from first year to third year students. This included a total of 70 male and 70 female black students. The students were recruited through the use of posters around the campus that invited students to participate in the study (See appendix C, page 65). In order to obtain the first participants for the pilot study, the researcher approached undergraduate students of the University of KwaZulu-Natal (Pietermaritzburg campus) at the LANs. The actual participants of the study were also accessed from the LANs but did not include those that participated in the pilot study round of the study. The result of the pilot study was used to monitor and evaluate the adequacy of the study instrument in terms of its linguistic accessibility and comprehensivity to students.

On the whole, the researcher was able to draw a sample of 141 students to take part in the main study. However, only 128 participants returned valid and usable questionnaires; the remaining were spoilt.

3.6. Research instrument

The instrument for the current study consisted of a structured survey questionnaire focused on assessing the mental health literacy of the university students studied (See Appendix B, page 62). The questionnaire was adapted from existing questionnaires of the

related study conducted by Siu, Chow, Lam, Chan, Tang and Chiu (2012) aimed at obtaining “information about basic knowledge towards mental disorders and to evaluate public attitudes towards mental health disorders in the Hong Kong Chinese Population”. The questionnaire was adapted and adjusted to improve the adequacy of the instrument for the purpose of the study. The scale appeared to be less sufficient to meet the objectives of the current study. Consequently, a total number of five questions regarding the signs and symptoms of mental health disorders were added to the total of ten questions that were directly obtained from the questionnaire. These five questions were added to improve the validity and serve the objectives of the current study properly. The ten questions that were adapted from the questionnaire mainly comprised of the public perceptions and attitudes towards mental disorders. However, some of the ten questions from the original questionnaire were rephrased to be in line with the language and level of the participants of the current study.

The adapted questionnaire was given to student participants to complete. Recourse to the use of such a questionnaire was deemed necessary in that a quantitative survey questionnaire was said to be needed when a study, like the present one, aims at questioning a large group of people about their attitudes, beliefs, or knowledge on a given theme (Struwig & Stead, 2001). Amongst the benefits of such a questionnaire was that with it, vast amounts of information could be collected from a large population in a short period of time; could be used by the researcher or by any number of people with limited affect to its validity and reliability; could be analysed scientifically and objectively more than other forms of research; and could be used to compare and contrast results from other related research as well as to measure change when data is quantified (Welman et al., 2005). The students’ protest had a negative impact during data collection which extended the expected time frame for data collection. This also prevented the researcher from obtaining 160 participants to prevent unforeseen circumstances, such as a huge number of spoilt questionnaires.

3.6.1. Validity and reliability

According to Pickard (2007), data from a quantitative research methodological approach can be regarded as reliable if it can yield similar results at different times and different researchers using the same methodology. Reliability itself can be defined as the extent to which results under a study can be reproduced (Pickard, 2007). In other words, reliability is concerned with the consistency, stability, and repeatability of the informant’s

accounts as well as the investigators' ability to collect and record information accurately (Sellitiz, Wrightsman, Cook, Balch, Hofstetter & Bickman, 1976). Validity in research is concerned with the accuracy and truthfulness of scientific findings (Le Comple & Goetz, 1982). A valid study should demonstrate what actually exists and a valid instrument or measure should actually measure what it is supposed to measure. Hence, according to Pickard (2007), validity determines whether the researcher truly measures that which it was intended to measure or how truthful the research results are (Pickard, 2007). These understandings guided the researcher's effort in composing the questionnaire used in the data collection for the present study. Efforts were made to ensure that the study's questionnaire is reliable and measured what it was intended to measure.

In specific terms, to enhance the validity of the study, extra care was taken in the construction of the questionnaire, making sure that the language used was clear enough, and that all ambiguities were cleared, and that the items truly address the theme of mental health literacy or knowledge of mental health disorders. Another technique introduced for improving the validity of the study was the use of the pilot study. According to Welman et al. (2005), a pilot study can be defined as a trial run done in preparation for the complete study. It is a specific pre-testing of the research instruments to collect data (Welman et al., 2005). In this case, the researcher used structured questionnaires as her instrument to collect data. The researcher also believed that through the use of the structured questionnaire to collect data, the same results would be reproduced. In order to test the questionnaire, a pilot study was conducted to check if it measures what it is intended to measure and that it can be used in future studies to yield similar results from a similar population.

To promote the reliability of the study, the researcher used the technique of *triangulation*. To implement this technique both male and female students were recruited into the study sample. This means that the study included more than one gender of black students in its sample population. Also, different colleges and students' year of study were used. In this way, participants were selected from undergraduate students from different colleges of the University of KwaZulu-Natal, Pietermaritzburg campus, as previously indicated. This means that both genders of black first, second, and third year students were considered eligible for inclusion in the study.

3.6.2. Pilot study

A pilot study was carried out to determine the appropriateness of the research instrument. A total of 14 undergraduate students were selected from the LANs, for the purposes of including them in the pilot study. The questionnaires were distributed amongst them after explaining the purpose of the study and the reason for a pilot study. The results showed that the instrument was relevant and appropriate for the study's purpose, and was consequently valid and reliable for the study population. The study participants were able to understand and respond to the questionnaire appropriately and without any constraints.

3.7. Data analysis

Struwig and Stead (2001) defined data analysis as the process of inspecting, cleaning, transforming, and modelling data with the goal of discovering useful information, suggesting conclusions, and supporting decision making.

In the present study, descriptive statistics were employed to analyse the data through the use of frequency tables and graphs. According to Struwig and Stead (2001), descriptive statistics consisted of numbers/figures that are used to summarise and describe data. The word "data" refers to the information that has been collected from an experimenter survey or historical records, and questionnaires (Struwig & Stead, 2001). This technique was made use of in the present study as descriptive statistics were used to describe the basic features of the data aimed at providing an inventory of the mental health literacy of the students studied. With studies such as the present one, descriptive statistics provide a simple summary about the sample and the measures. With descriptive statistics, graphs and tables were used to illustrate data. Descriptive statistics also helps the survey researcher to simplify large amounts of data to make sense of it (Struwig & Stead, 2001).

According to Struwig and Stead (2001), descriptive statistics provide statistical summaries of information and uses measures of central tendency. The measures of central tendency consist of a mean, mode, and median (Struwig & Stead, 2001). The mean is the sum of the study data divided by the total number of data (Welman et al., 2005). The mode is the most frequently occurring number (Struwig & Stead, 2001). The median is the middle value in a set of data (Struwig & Stead, 2001). According to Pickard (2007), the measures of central tendency are useful to summarise an entire distribution by using a single score to show the grouping of figures around some central point in the data, the most commonly used term is the average.

In the present study, the researcher analysed her data by looking at the frequency distribution and the measures of central tendency. In this study, the frequency distribution was a graphic or tabular representation in which the variables are plotted against the number of times they occurred (Durrheim & Painter, 2006). The scores are presented in rank orders from the highest to the lowest. The Statistical Package for Social Sciences (SPSS) version 23 was used to analyse the data. With this approach, it became easier to not only determine the mental health literacy level of the students, but also to develop a hierarchy of black students' knowledge of mental health disorders, namely what they know best and least about mental health disorders.

3.8. Ethical considerations

According to the University Research Degrees Committee (2008), the researcher must first obtain informed consent from the University gatekeeper should he or she uses the students as his or her research participants. After informed approval to conduct research using the students as participants has been obtained, the researcher must obtain informed consent from his or her participants. Approval to conduct the current study was obtained from the Ethics Committee of the University of KwaZulu-Natal (see appendix E, page 67) and this was after permission was granted by the Registrar of the university regarding the use of students as the researcher's participants (See Appendix D, page 66). According to Struwig and Stead (2001), one must ensure that the participants are willing to take part in the study before conducting a study. Informed consent was also obtained from the participants before they participated in the present study (See Appendix A, page 58 regarding the consent form presented to the participants). Furthermore, the participants must be informed that they are free to withdraw from participation at any point in the research process and understand that there will be no negative consequences for them should they not wish participate. This is also supported by Houstin (2016) as they outlined that one of the six key principles for ethical research is that whenever possible; participation should be voluntary and appropriately informed. Struwig and Stead (2001) further pointed out that consent should not only be obtained from authorities when conducting research in an institution, but the researcher also needs to obtain permission from the study participants.

Furthermore, according to the University Research Degrees Committee (2008), it is the researcher's responsibility to explain as fully as is reasonable and appropriate, more meaningful to the participants; a) the aim and nature of the research, b) who is undertaking it,

c) who is funding it, d) the duration it may take, e) why it is undertaken, f) the possible consequences of research, and g) how the results are to be disseminated before the participants can take part in the study (University Research Degrees Committee, 2008). In the present study, information about the study and an invitation to participate was provided to participants to ensure the trustworthiness of the study; a) the title and aim of the study as well as the ethics involved were presented on the informed consent form and b) an advert for the invitation for participation in this study was distributed on the University of KwaZulu-Natal notice boards to ensure that all the students had access to it.

Struwig and Stead (2001) outlined that researchers need to respect the confidentiality/privacy of the study participants who are involved in one's study. If confidentiality cannot be fully guaranteed or can only be partially maintained, the participants must be informed before commencing with the study (Struwig & Stead, 2001). Furthermore, Struwig and Stead (2001) believe that confidentiality can be observed by requesting the participants not to write their names on the questionnaires or not providing their names to the researcher. The University Research Degrees Committee (2008) outlined that the anonymity and privacy of research participants should be respected and personal information relating to the research participants should be kept confidential and secure. To ensure the privacy and confidentiality of the research participants, the participants were requested not to write their names on the research questionnaires or mention their names to the researcher. The questionnaires will be locked into the supervisor's cabinet for five years.

Struwig and Stead (2001) believe that the participants must not be misled into participating on the study; they must not be coerced or manipulated to participate in any way. Each participant of this study was given a consent form to sign in order to show that they participated in this study voluntarily. They were informed that they can withdraw from participation in this study should they wish to do so at any stage without penalty. Struwig and Stead (2001) further pointed out the issue of plagiarism and stated that one needs to acknowledge the sources of information should they use other people's work in their research study. The authors or sources of information used in the present study were acknowledged to avoid plagiarism. The researcher was also mindful that the participants were treated with respect and dignity.

3.9. Summary

The methodology employed in the present study was presented in this chapter. Quantitative research methods were discussed to clarify the methodological approach used in the current study aimed at exploring the mental health literacy of the university students. The researcher further discussed the data collection methods, techniques and process, as well as the sample size and the target population, location of the study, the research instrument utilised, inclusion and exclusion criteria, data analysis, validity and reliability, as well as the ethical considerations followed in the study. The following chapter (4) presents the results of the study.

CHAPTER FOUR

RESULTS OF THE STUDY

4.1. Introduction

In this chapter, the results of the study will be presented. The presentation will be organized around the three major research questions investigated. This will be preceded by the presentation of the demographics of the sample of black students that participated in the study.

4.2. Descriptive analysis of the distribution of respondents' demographic characteristics

The mental health literacy questionnaire was used to measure the level of mental health literacy of the KwaZulu-Natal students between the ages of 18 and 30 years. A total of 141 completed questionnaires were collected from the University of KwaZulu-Natal undergraduate students. However, 13 of the completed questionnaires were excluded from further analysis on account of incongruent level of education (which is "Masters" [n=1]) as the study only focused on Undergraduates, and those with missing data (n=12). Consequently, the researcher only retained 128 completed surveys for the analysis of the data.

With regards to the distribution of age among the sampled students, the mean age was found to be 20.82, the median was 20.00 and the mode was 19; with a standard deviation of 2.075. The range of the age of the participants was 12 with a minimum of 18 and a maximum of 30. Most of the study participants were between the ages of 19 and 22 with 19 years being the most frequently reported age (Table 1).

Table 1: Distribution of the study participants by age

Age	Frequency	Valid percentage
18	5	3.9
19	34	26.6
20	29	22.7
21	22	17.2
22	19	14.8
23	5	3.9
24	7	5.5
25	3	2.3
26	1	0.8
27	1	0.8
28	1	0.8
30	1	0.8
Total	128	100

Furthermore, as shown in Figure 1 below, the gender distribution of the study participants is as follows: 65 female participants (50.8%) and 63 male participants (49.2%).

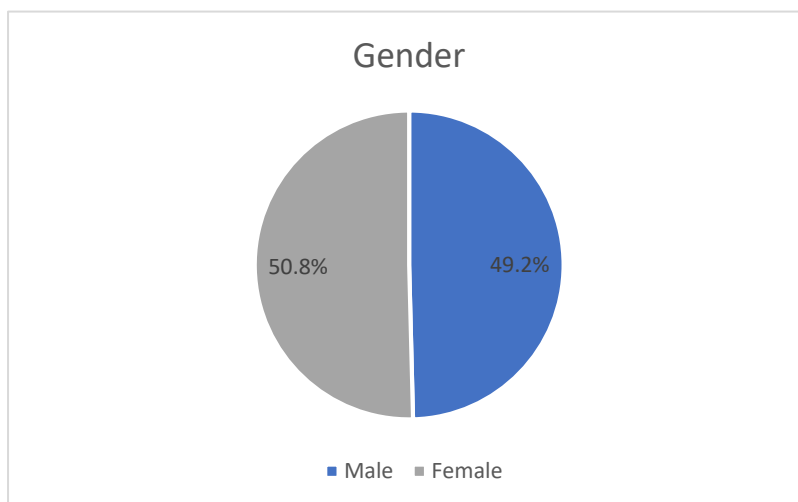


Figure 1: Gender Distribution of the participants

The level of study of the participants identified was 1st, 2nd, 3rd and 4th years. The majority of the participants were from the 2nd year (47.7%) followed by participants from the 3rd year (28.9%) category, and the 1st year students (22.7%). There was only one study participant from the 4th year class; which is considered as a postgraduate student in the College of Education within the University of KwaZulu-Natal (Pietermaritzburg Campus). The 4th year student was included in the sample as a matter of curiosity to know if there was anything new from her different from what the rest of the sampled participants shared with the researcher. It was obvious to the researcher that the participant was not a Masters student which may imply that she was not too far away from the rest of the sampled participants. Thus, the researcher was interested to know if the participant has certain opinions different from those of others in the sample.

Table 2 below presents the participants' level of study

Table 2: Level of study of the research participants

Level of study	Frequency	Valid percentage
First year	29	22.7
Second year	61	47.7
Third year	37	28.9
Fourth year	1	0.8
Total	128	100

The study's demographic data further included information on participants distribution according to the colleges. In this regard, the trend shows that majority of the study participants came from the College of Humanities, n=80, identified as 62.5% of the study participants. A total of 25 participants were drawn from the College of Commerce, Law and Management. The College of Education was least represented in the study, with only one participant come from there; as indicated in the information in Table 3 below.

Table 3: Distribution of Participants according to College

College	Frequency	Valid percentage
Agriculture, Engineering and Science	22	17.2
Commerce, Law and Management	25	19.5
Education	1	0.8
Humanities	80	62.5
Total	128	100

Data presented in the above Table shows that majority (80) of the study participants came from the College of Humanities.

In addition, this analysis included information on the area of residence of the study participants. Table 4 indicates that 51 participants were from the rural areas and this amounted to 40.2% of the study participants. 38 participants hailed from semi-urban areas (29.9%), and a further 38 participants were identified as urban residents. One participant did not respond to the question pertaining to residence. These details are summarized in Table 4 below.

Table 4: Participants area of Residence

Area of residence	Frequency	Valid percentage
Rural area	51	40.2
Semi-urban area	38	29.9
Urban area	38	29.9
Total	127	100

4.3. Preliminary analysis

The questionnaire that was adapted from a related study conducted by Siu et al. (2012) and adjusted to the researcher's objective was used to measure the mental health

literacy of the university students. This was done through the use of statements about certain mental disorders to measure the students' knowledge and understanding of the mental disorders. Furthermore, the statements presented focused on determining the extent to which their perceptions of mental illness are accurate or inaccurate. Essentially, the researcher wished to determine the proportion of the sampled students who could accurately identify the symptoms of mental illness. The participants' scores had the potential to range from 1 to 5. A score of 1 represented 'strongly agree', 2 for 'agree', 3 for 'don't know', 4 for 'strongly disagree' and 5 for 'disagree'. These scores could be reversed depending on the content of the statement being responded to. The research instrument consisted of 15 items about a description of mental health disorders and the perceptions of mental illness.

4.5. Presentation of results

The results of the current study will now be presented research question by research question, starting with Research Question One as follows.

Research question 1: What is the extent of students' knowledge of symptoms of common mental health disorders?

The results of the study in relation to the above question are presented in Table 5 below.

Table 5: Extent of students' knowledge of symptoms of common mental health disorders

		RESPONSE CATEGORIES				
	Items	SA	A	DON'T KNOW	D	SD
11	An excessive use of substances such as alcohol and drugs may be symptoms of mental illness.	13 (10.2%)	37 (28.9%)	43 (33.6%)	13 (10.2%)	22 (17.2%)
		50 (39.1%)		43(33.6%)	35 (27.4)	

12	Impairment in social, academic, relationships and emotional functioning may indicate the presence of a mental illness	15 (11.7%)	39 (30.5%)	51(39.8%)	16 (12. %)	7 (5.5%)
		54 (42%)		51 (39.8%)	23 (17.5%)	
13	Difficulty in concentration, poor decision making and poor memory could be one of the symptoms of mental illness	15 (11.7%)	44 (34.4%)	39 (30.5%)	19 (14.8%)	11(8.6%)
		59 (46.1)		39 (30.5%)	30 (23%)	
14	Difficulty sleeping, excessive sleeping and loss of appetite may be one of the symptoms of mental illness	14 (10.9%)	21(16.4%)	34 (26.6%)	37 (28.9%)	22 (17.2%)
		35 (27.3%)		34 (26.6%)	59 (46.1)	
15	Non-stop experiences of headache without medical cause explanation could be another symptom of	14 (10.9%)	22 (17.2%)	41(32.0)%	33 (25.8%)	18 (14.1%)

	mental illness.					
		36 (28.1%)	41(32.0)%	51(39.9)		

Information in Table 5 above, show that although a good number of the participants appear to possess enhanced level of mental health literacy; however, most of the students studied showed poor level of mental health literacy as they were unable, from their responses to the statements put to them, to identify the symptoms of common mental health disorders. Those who showed poor mental health literacy are those who responded “don’t know”, “disagree” and “strongly disagree” to these statements, when the answer should have been “agree” or “strongly agree”. For example, in the case of symptoms related to an excessive use of substances, a good number of students comprising 39.1% of the sample with a frequency of 50 were able to identify it as depicting one of the symptoms of mental illness as they agreed with the statement. However, most of the student participants reported that they ‘don’t know’ (33.6%) or ‘strongly disagreed’ with that statement (27.4%).

This same discouraging trend can be seen repeated in the participants’ responses to the rest of the items in the Table (5), above. In each, the indication is that most of the participants were unable to recognise statements that highlight the common symptoms of mental health disorders.

Research question 2: To what extent are the students’ perceptions of mental illness accurate or inaccurate?

The results of students’ responses in relation to this question summarized in Table 6 below.

Table 6: Extent of accuracy or inaccuracy, of participants’ perceptions of mental illness

	ITEMS	SA	A	DON’T KNOW	D	SD
1	Everyone has a chance to develop mental illness.	41 (32.0%)	53 (41,4%)	26 (20.3%)	6 (4.7%)	2 (1.6%)

		94 (73.4%)		26 (20.3%)	8 (6.3%)	
2	People who have a relative or a family member, suffering from mental illness would be looked down upon by others.	15 (11.7%)	40 (31.3%)	16 (12.5%)	35 (27.3%)	22 (17.2%)
		55 (43%)		16 (12.5%)	57 (44.5%)	
3	In my own view, young people cannot develop mental illness.	0 (0.0%)	8 (6.3%)	10 (7.8%)	55 (43.0%)	55 (43.0%)
		8 (6.3%)		10 (7.8%)	110 (86%)	
4	I believe that most people who have mental illness are dangerous.	9 (7.0%)	27 (21.1%)	30 (23.4%)	41 (32.0%)	21 (16.4%)
		36 (28.1%)		30 (23.4%)	62 (48.4%)	
5	I find it difficult to communicate with people who have mental illness.	10 (7.8%)	35 (27.3%)	31 (24.2%)	42 (32.8%)	10 (7.8%)
		45 (35.1%)		31(24.2%)	52 (40.6%)	
6	I find it difficult to predict the behaviours and mood of people with mental illness.	21 (16.4%)	59 (46.1%)	21 (16.4%)	20 (15.6%)	7 (5.5%)

		80 (62.5%)		21 (15.6%)	27 (21.1%)	
7	At times I am afraid to talk to people with mental illness.	15 (11.7%)	53 (41.4%)	25 (19.5%)	26 (20.3%)	9 (7.0%)
		68 (53.1%)		25 (19.5%)	35 (27.3%)	
8	I believe that a majority of people with mental illness can be assisted, through psychiatric attention to recover from the illness.	69 (53.9%)	42 (32.8%)	11 (8.6%)	4 (3.1%)	2 (1.6%)
		111 (86.7%)		11 (8.6%)	6 (4.7%)	
9	I believe that the society should treat people who have mental illness with respect.	73 (57.0%)	39 (30.5%)	7 (5.5%)	4 (3.1%)	5 (3.9%)
		112 (87.5%)		7 (5.5%)	9 (7%)	
10	It would be advisable to have a mental wellness centre in the university.	80 (63.0%)	36 (28.3%)	4 (3.1%)	4 (3.1%)	3 (2.4%)
		116 (91.3%)		4 (3.1%)	7 (5.5%)	

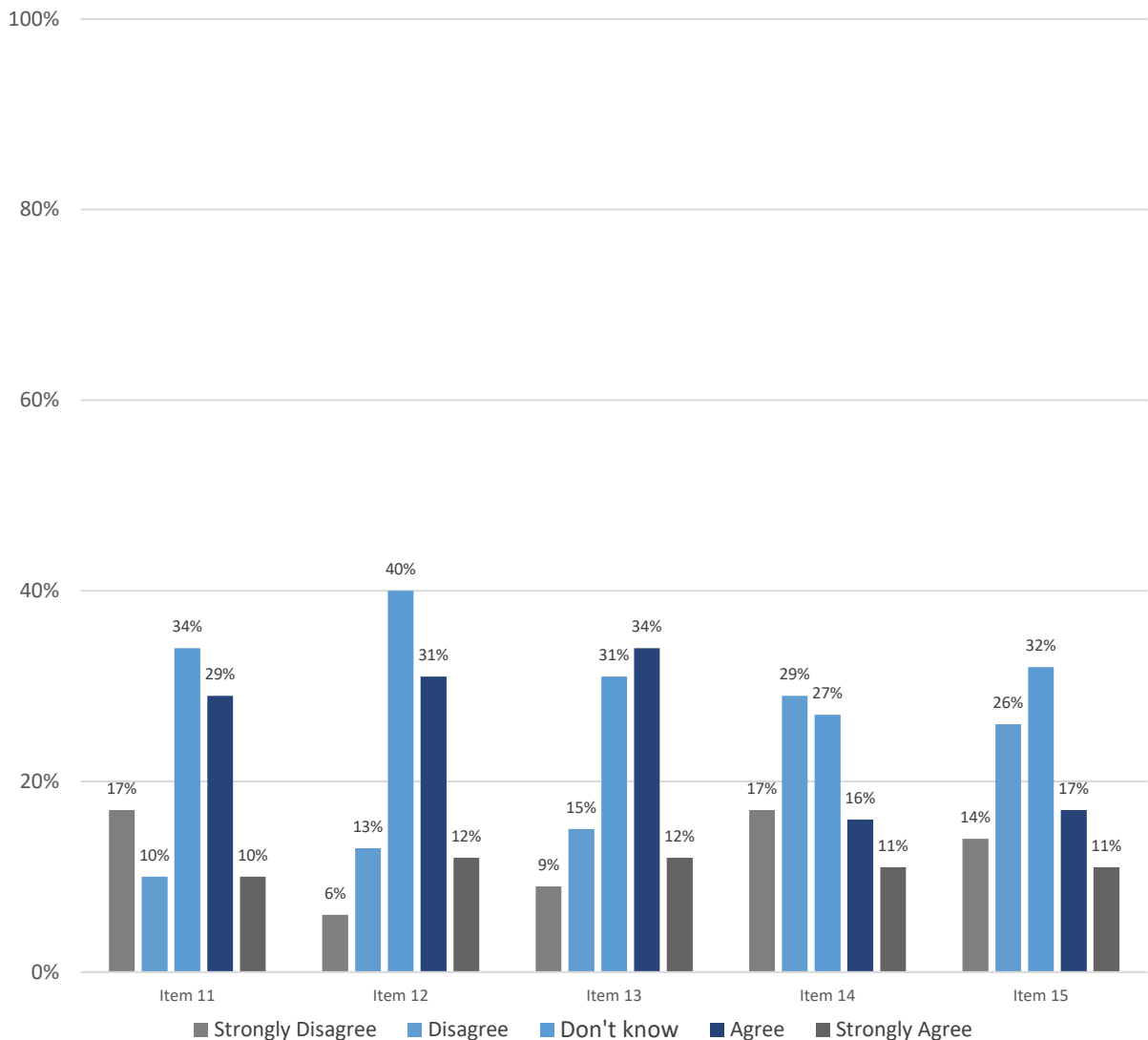
Information in Table 6 above shows that most of the student participants have accurate perceptions about mental illness while a lesser proportion of the students demonstrated inaccurate perceptions about mental illness. For instance, majority of the participants (94) or 73.4% of them agreed to the statement that “Everyone has a chance to develop mental illness”, which is true. This trend is also in their response to statement 9,

namely, “I believe that the society should treat people who have mental illness with respect.” to which the response of ‘Agree’ or ‘Strongly Disagree’ is a correct answer.

Research question 3: What is the proportion of the sampled students who can accurately identify major symptoms of major mental illnesses?

Similar to the first research question, statements of the symptoms of mental disorders were presented to the participants to determine their accuracy or not, in terms of identifying the symptoms of mental disorders from the statements given to them. The graph below presents the results of the study in relation to this question.

Figure 2: Clustered bar chart of items answering the third research question



For example, overall, 92% of the participants disagreed with the statement (15) which proposes that “Non-stop experiences of headache without medical cause explanation could be another symptom of mental illness.” Yet an accurate response to that statement is expected to tick ‘Agree’ or ‘Strongly Agree’ to it.

4.6. Summary of findings

In sum then, the results of the present study show that most of the participants demonstrated poor knowledge of common mental health disorders as they were unable to identify with statements that depict the symptoms of common mental disorders; all of which are indicative of poor mental health literacy. Nevertheless, a minority of the student participants showed an enhanced level of mental health literacy.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1. Introduction

This chapter presents a discussion and interpretation of the results of the present study. It also presents the summary of the study and the conclusions emanating from the findings, as well as some recommendations for future research.

The discussion will be organized around the three major themes investigated as follows:

5.2. Discussion of results

Theme 1: Extent of students' knowledge of symptoms of common mental health disorders

The first research question of the study focused on determining the extent of students' knowledge of symptoms of mental health disorders. Statements about the symptoms of mental health disorders were presented to the students through the use of a structured questionnaire. It was expected that those who are mental health literate should be able to respond accurately to these statements. However, as shown in the data presented in the previous chapter, this was not the case for majority of the students. The results of the study rather showed that majority of the student participants do not have an accurate knowledge of symptoms of common mental health disorders.

This result could be interpreted from the perspective of Lev Vygotsky's (1978) social developmental theory that was further elaborated by Kozulin (2003), which proposes that the community plays a central role in the process of making meaning in one's world; and that the environment in which one is born and raised greatly influences how one thinks and what one knows about several issues that affect their lives. Following this understanding, it would appear that the poor mental health literacy of majority of the participants as discovered in this study should be seen as a product of the type of community from which the participants came. This is because it is possible that the students' responses were guided by the nature of their community's understanding of mental health disorders; which they the students have internalized. Indeed, as Okello and Musisi (2006) had remarked, from an African perspective,

mental illness is understood as culturally related, where the community members may not refer to an illness as mental illness as the Westerners would do.

This, perhaps, is quite understandable as the quality of what individuals know about issues that affect people's such mental illness cannot be understood without reference to the social and cultural contexts within which they are entrenched (Vygotsky, 1978). Thus, the revelation that stigma is attached to mental illness as demonstrated in the current study may be viewed as being influenced by the participants' communities' perspective of mental illness. A large number of the participants demonstrated the presence of stigma towards the mentally ill as they reported that "they find it difficult to predict the behaviours and mood of people with mental disorders and at times they are afraid to talk to people with mental illnesses." (See data in Chapter 4, Table 6).

Similarly, most of the participants from the present study could not recognise the symptoms of common mental disorders in relation to depressive symptoms and this may have been influenced by the way they were brought up to think about the symptoms that were presented to them. Fortunately, a smaller proportion of the participants were able to identify the symptoms of mental disorders, which may have possibly been due to the fact that they learned about them during their course of study in the field of psychology. Some of these participants may also have come from developed communities where access to mental health services is available.

These findings were in concord with the results of the first research study that was conducted in Australia by Jorm (2000) about mental health literacy. That study showed that majority of the students studied were not mental health literate. Furthermore, the findings of this study concur with the results of the studies conducted by a number of researchers such as Gibbons et al. (2015); Goldney et al. (2001); Jorm (2000); Lam (2011); Mahfouz et al. (2016); McCarthy et al. (2011); McNeal (2015); Stansbury et al. (2011); and van 't Hof et al. (2011) . In each of these studies, it was discovered that students' participants' knowledge of symptoms of mental health disorders was poor. However, a minority of the participants in this study could recognise the symptoms of common mental disorders in relation to substance use disorders and in relation to a decline in one's functioning in areas such as academic, relationships, and emotional functioning. Yet, the overall trend emanating from the present study is that majority of the participants, were unable to identify these experiences as symptoms of common mental health disorders. This is because most disagreed, and some of

them, even strongly disagreed or responded that they ‘don’t know’ to the questionnaire statements presented to them; all of which are indications of poor mental health literacy among majority of the students studied.

Given the above, one can therefore conclude that majority of the student participants in this study demonstrated poor mental health literacy.

Furthermore, the results of the present study as recorded in Table 5 in the last chapter also revealed that 39.9% of the participants do not believe that non-stop experiences of headaches without any medical explanations may be symptoms of mental illness. At the same time, 28.1% of the respondents believe that non-stop experiences of mental disorders without any medical explanation may be a symptom of mental disorders. With this section of the result, again, one can conclude that most of the study participants have poor mental health literacy.

Theme 2: Extent to which students’ perceptions of mental illness are accurate or inaccurate

According to the results of the present study as presented in the previous chapter under Table 6, it appears that majority of the participants have accurate perceptions about mental illness. The large number of participants who demonstrated positive attitudes towards mental illness and the mentally ill shows this. This trend is illustrated by the results of the present study, which show that most of the participants (73.4%) believe (correctly) that “everyone has a chance to develop mental illness.”

However, some of the participants have inaccurate perceptions of mental illness. Among these are those who either disagreed/strongly disagreed (6.3%) or reported that they ‘don’t know’ (20.3%) anything about the above statement of mental health, which indicates inaccurate perception about mental illness on their part.

On another note, the results of the present study suggest that 86% of the participants indicated that, in their own view, young people can also develop mental illness. These findings were found to be similar with the findings by Mahfouz et al. (2016) which indicated that the participants believe that everybody has a chance of developing mental illness. However, 6.3% of the participants believe that young people cannot develop mental illness, while 7.8% of the participants replied ‘don’t know’ to this issue about the possibility of

development of mental illness in young people. This may further imply that the minority group of the study participants (14.1%) have inaccurate perceptions about mental illness.

Again, on the positive side, the results of the current study show that a sizable number of the participants (44.5%) demonstrated accurate perceptions of mental illness as they believed to the view that “people who have a relative or family member who suffer from mental illness would not be looked down upon by others as a result of mental illness.” However, 43% of the participants believe that others would look down on people who have a relative or a family member suffering from mental illness upon. This may suggest that these participants have inaccurate perceptions about mental illness and this may have been influenced by their background in terms of their cultural upbringing as outlined in Vygotsky’s theory (Kozulin, 2003). It may also suggest that there is stigma attached to mental illness in the context of some of the study participants’ upbringing. In addition, 12.5% of the participants replied ‘don’t know’ to this statement. And when this number is added to the 43% others who believed that people who have a relative or family member suffering from mental illness would be looked down upon, one can reasonably conclude that the majority (about two-thirds) of the study participants have inaccurate perceptions about mental illness.

The results of the present study, however, revealed that 87.5% of the participants believe that people with mental illness should be treated with respect, regardless of their mental illness condition. This result is in agreement with the findings from a study conducted by Mahfouz et al. (2016) which indicated that the study participants believed that people with mental illness should be treated with respect and have the same rights as everybody else. However, 7% of the participants in the present study demonstrated inaccurate perceptions about mental illness as they disagreed that people with mental illness should be treated with respect. In addition, 5.5% of the participants responded ‘don’t know’ with regard to the statement about the need for treating people who have mental illness with respect. This may be an indication of an internalization of stigma attached to mental illness, based, of course, on inaccurate perceptions about mental illness on the part of these participants.

Similarly, the results of the present study show that 86.7% of the participants demonstrated accurate perceptions about mental illness regarding the management of mental illness with regards to psychiatric treatment. These participants believe that the majority of people who suffer from mental illness can still recover from their condition through psychiatric treatment. This concurs with the findings by McNeal (2015) who discovered that

the students studied believe that a person with mental illness can eventually recover from the illness. In the present study, however, 4.7% of the participants were of the opinion that people with mental illness cannot recover from their condition through psychiatric treatment. In addition, 8.5% of the participants reported that they ‘don’t know’ whether the management of mental illness through psychiatric treatment will lead to recovery or not. This may imply that the minority group of the participants (13.2%) in the present study has inaccurate perceptions regarding treatment of mental illness while the majority demonstrated accurate perceptions about management of mental illness in this regard.

Furthermore, the results of the present study suggest that 53.1% of the participants are afraid to talk to people with mental illness; which suggests that there is still stigma attached to people with mental illness as understood by these participants. However, 27.3% of the participants reported that they are not afraid to talk to people with mental illness, while 19.5% of the participants reported that they ‘don’t know’ if they have fears with regards to talking to people with mental illness. Given these indications, one can conclude that there is an element of stigma attached to mental illness based on the current findings as can be discovered from these trends.

Yet, the results of the current study show that 40.6% of the participants agree that they do not find it difficult to communicate with people who have mental illness. On the other hand, some 35.1% of the participants indicated that they find it difficult to communicate with people who have mental illness, while 24.5% of the participants reported that they ‘don’t know.’ This may imply that the majority of the participants have difficulty communicating with people who have mental illness. This is understandable when seen against the point of view of 28.1% of the participants who agree to the statement that “most people with mental illness are dangerous.” However, 50.4% of the participants were of the opinion that most people with mental illness are not dangerous. In addition, 23.4% of the participants reported that they ‘don’t know’ about the dangers of people with mental illness.

On a different note, 62.5% of the participants indicated that they have a difficulty in predicting the moods and behaviours of people with mental illness, while 21.1% of the participants indicated that they ‘do not have any difficulty in predicting the moods and behaviours of people with mental illness.’ However, 16.45% of the participants responded ‘don’t know’ to this statement. This may imply that there is an element of stigma attached to mental illness from the perspective of a good number of these participants. This trend concurs

with the findings from studies such as those conducted by Kermode et al. (2009); Pinto-Foltz (2011); and Ofuani (2015), that there is stigma attached to mental illness as revealed by their participants.

It is against the background of the above findings that one can begin to see the relevance of the aspect of the present study, which showed that 90.6% of the participants were of the opinion that it would be advisable for the university to have a Mental Health Wellness Centre within the university premises. Such a Centre will help to clear some of the wrong perceptions which some of the students have regarding mental illness and how to relate with people with mental illness.

Theme 3: Proportion of sampled students that could accurately identify major symptoms of major mental illnesses

According to the results of the present study, 39% of participants were able to identify the major symptoms of common mental disorders concerning the excessive use of substances. This may suggest that a good number of the participants have accurate knowledge about mental health disorders regarding substance use. Furthermore, the results of this study show that only 42% could accurately identify the symptoms of mental illness as represented by the impairment in areas such as social, academic, relationships and emotional functioning. This may further suggest that a sizable number of the participants have adequate knowledge about mental illness in this regard.

However, only 46% of the participants could accurately identify a difficulty in concentration, poor memory, and poor decision making as symptoms of mental illness. In addition, only 27% of the participants could accurately identify a disturbance in sleeping patterns and a change in appetite as symptoms of mental illness. These trends corroborate the findings by Goldney et al. (2001); McCarthy et al. (2011); van 't Hof et al. (2011); and Gibbons et al. (2015), who reported that most of their participants were unable to identify the symptoms of mental illness in relation to depressive symptoms. In line with their findings, the results of the present study equally show that only 28% of the participants could accurately identify the non-stop experiences of headache without any medical explanation as symptoms of mental illness.

5.3. Summary of the study

The purpose of the current study was to investigate the mental health literacy of the University of KwaZulu-Natal undergraduate Black students. The intent was to monitor the level of the students' mental health literacy as a prelude to determining the extent to which there is need to promote the students' constant awareness of their mental health status. The researcher drew inspiration and insight on how to go about the study to achieve the aforementioned aim, from the related works by Jorm (2000, 2011) and Jorm et al.(2006) who understand mental health literacy as referring to knowledge and beliefs about mental disorders which aids their recognition, management and treatment (Jorm et al., 2006) as cited in (Jorm, 2011, p. 231). A quantitative research method was employed in implementing the study. A total sample of 128 participants was included in the data collection process. A survey questionnaire consisting of 15 questions about mental health disorders and people's perceptions of mental illness served as the study's instrument for data collection.

The results of the present study show that, on the whole, the mental health literacy of majority of the students is poor. Thus, although about 39.1% of participants were able to identify the major symptoms of common mental health disorders, majority of the students were unable to do so. Indeed, some of the participants ticked 'do not know' to many of the mental health statements they were presented with, while a good majority of them responded 'disagree' or 'strongly disagree' to accurate mental health statements they were presented with; all which of reveal that the mental health knowledge of majority of the students were inaccurate. The results of the study also show that although about 28.1% of the participants could accurately identify 'the non-stop experiences of headache without any medical explanation as a symptom of mental illness', the overall trend shows that majority of the participants lacked sufficient mental health literacy, and still hold negative beliefs and stereotypic attitudes to persons suffering from mental illness.

5.4. Implications/Conclusions of the study

The above findings suggest the following implications and conclusions:

1. Majority of the research participants possess poor mental health literacy.

2. The knowledge and beliefs about mental health disorders of majority of the research participants are inaccurate.
3. Most of the study participants still hold stereotypic images of, or negative attitudes towards patients with mental illness.
4. University students are not uniform in their knowledge and beliefs about mental disorders.
5. Some proportion of the students manifested, in their responses, signs encouraging accurate knowledge and beliefs about mental disorders.
6. Majority of university of students are in dire need of mental health education /literacy.
7. Overwhelming majority of the participants (90.6) accepted the proposal that a Mental Health Wellness Centre is needed at the University of KwaZulu-Natal to improve the mental health literacy of the students.

5.5. Recommendations for policy and practice

Based on the above conclusions the following three recommendations are made for enhanced policy and practice in relation to improvement of university students' mental health literacy.

Firstly, it is recommended that Mental Health Wellness Centre be established at the University of KwaZulu-Natal.

Secondly, the Directorate of Student Affairs of the university should consider encouraging the formation of Students Mental Health Literacy Club. This is to serve as an avenue for helping to organize Mental Health Literacy seminars and invited speeches for the benefit of university students.

Thirdly, there is need for awareness campaigns about mental health disorders to be conducted as outreach programmes for the students to increase their level of mental health literacy and reduce the stigma attached to mental illness. This drive is expected to encourage help seeking regarding mental health problems that can beleaguer university students.

5.6. Limitations of the study

Recognizing that the sample for the current study was drawn from only one university in South Africa, it has a number of limitations when it comes to the challenge of generalizing its findings to students from other South African universities. Indeed, the present researcher does not claim that the findings of this study are widely generalizable in this particular sense. Yet it is important that the mental health literacy of university students throughout South Africa be studied.

Additionally, the present study had derived its sample participants only from the undergraduate student population. This means that its findings could not be generalized beyond this limited sample universe to the postgraduate population.

5.7. Recommendations for further research

Given the above limitations of the present research, the following recommendations are made for purposes of future research:

Firstly, it is recommended that another study of the mental health literacy of university students be carried that could be more national in coverage.

Secondly, a special study of the mental health literacy of university postgraduate students is recommended in order to enable a comparison to be made between the mental health literacy of postgraduate and undergraduate students. With such a study it becomes easy to see whether people's mental health literacy is a phenomenon that grows with education and age.

Thirdly, a comparative study of the mental health literacy of the students from different African countries could be undertaken to enable a conclusion to be made whether people's mental health literacy is related to the country of their origin, and to know which students from which country/s are more provided in this regard.

Lastly, there is a need to conduct a qualitative study to understand the interpretations from the students' perspectives of what the symptoms of mental illness mean to them and the socio-cultural meanings attached to it.

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APPENDICES

Appendix A: Consent form

UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)

APPLICATION FOR ETHICS APPROVAL

For research with human participants

Information Sheet and Consent to Participate in Research

Date: 23 May 2016

Dear prospective participant

My name is Constance Thulsile Zita, a Master of Social Sciences (Clinical Psychology) student from the School of Applied Human Sciences of the University of KwaZulu-Natal, Pietermaritzburg Campus, and can be contacted at 072 892 2432 or constancezita@yahoo.com.

You are being invited to consider participating in a study that involves research on “**Mental Health Literacy of Young People in South Africa: A Study of the University of KwaZulu-Natal Students**”. The purpose of the study is to explore and determine the level of students’ knowledge of mental health, with particular reference to the students of the University of KwaZulu-Natal in Pietermaritzburg Campus.

The study is expected to enroll a total number of one hundred and forty (140) undergraduate students’ participants: drawn from the different faculties of the university. A total of seventy (70) male and seventy (70) female black students will be selected. A questionnaire that will take approximately 30 minutes to complete will be used to collect data.

There will be no direct benefits and harm that would result from participating in this study. However, this study might give us an opportunity to understand the students’ knowledge of mental health and illness. The researcher will disclose in full any appropriate alternative procedures and treatment etc. that may serve as possible alternate options to study participation.

This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number: HSS/0887/016M).

In the unlikely event of any problems or concerns/questions arising from your participation in this study, you may contact the researcher at constancezita@yahoo.com or 072 8922 432 and nwoye@ukzn.ac.za or 035 260 5100 or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Participation in this research is voluntary and participants may withdraw participation at anytime, should they wish to do so, and in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled to.

The steps that will be taken to protect confidentiality of personal/clinical information are as follows:

- Only the researcher and her supervisor will have access to the raw data collected from the participants.
- Data collected will be kept in a locked cabinet with access restricted to the researcher and her supervisor.
- In case of electronic data, a password will be used.
- The research data and research materials will be kept by the supervisor for a period of five years.
- The questionnaires and all confidential data will be shredded after five years.
- If you would like feedback on the findings of the study, a copy will be made available at the University KwaZulu-Natal Library, Pietermaritzburg.

CONSENT

I have been informed about the study titled “Mental Health Literacy of Young People in South Africa: A Study of the University of KwaZulu-Natal Students” by the researcher, Constance Thulsile Zita.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any of the benefits that I usually am entitled to.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at constancezita@yahoo.com or 0728922 432 and nwoye@ukzn.ac.za or 033 260 5100 as well as the HSSREC.

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

Tel: 27 31 2604557 - Fax: 27 31 2604609

Email: HSSREC@ukzn.ac.za

Additional consent, where applicable

I hereby provide consent to:

Signature of Participant

Date

Appendix B: Questionnaire

Title: Mental Health Literacy of Young People in South Africa: A Study of University of KwaZulu-Natal Students

Appendix B: Research Questionnaire

Dear Research Participant,

It would be highly appreciated if you could offer some time to respond to the following questionnaire. Remember that the information given will be treated with utmost confidentiality.

Thank you

Constance

SECTION A

Please make a cross on the relevant box for your response

Age

--	--

Gender

M	F
---	---

Level of Study

College

Demographic details	Urban Area	Semi-urban Area	Rural Area
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SECTION B

Mental Illness perceptions	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
	5	4	3	2	1
1. Everyone has a chance to develop mental illness.					
2. People who have a relative or a family member, suffering from mental illness would be looked down upon by others.					
3. In my own view, young people cannot develop mental illness.					
4. I believe that most people who have mental illness are dangerous.					
5. I find it difficult to communicate with people who have mental illness.					
6. I find it difficult to predict the behaviours and mood of people with mental illness.					
7. At times I am afraid to talk to people with mental illness.					
8. I believe that a majority of people with mental illness can be assisted, through psychiatric attention to recover from the illness.					
9. I believe that the society should treat people who have mental illness with respect.					

10. It would be advisable to have a mental wellness centre in the university					
11. An excessive use of substances such as alcohol and drugs may be symptoms of mental illness.					
12. Impairment in social, academic, relationships and emotional functioning may indicate the presence of a mental illness.					
13. Difficulty in concentration, poor decision making and poor memory could be one of the symptoms of mental illness.					
14. Difficulty sleeping, excessive sleeping and loss of appetite may be one of the symptoms of mental illness.					
15. Non-stop experiences of headache without medical cause explanation could be another symptom of mental illness.					



**ATTENTION 1ST, 2ND AND 3RD YEAR STUDENTS OF THE
UNIVERSITY OF KWAZULU-NATAL**

INVITATION TO PARTICIPATE ON A STUDY TITLED

**MENTAL HEALTH LITERACY OF YOUNG PEOPLE IN SOUTH AFRICA: A
STUDY OF THE UNIVERSITY OF KWAZULU-NATAL STUDENTS**

THE STUDY AIMS TO MONITOR THE MENTAL HEALTH LITERACY STATUS OF THE UNIVERSITY STUDENTS. THE RESULT WILL ENABLE US TO DETERMINE IF THERE IS A NEED TO RAISE AWARENESS OF THE IMPORTANCE OF MENTAL HEALTH LITERACY AMONG UNIVERSITY STUDENTS.

QUESTIONNAIRES WILL BE AVAILABLE AT THE LANs.

CONFIDENTIALITY IS GUARANTEED!!!

Appendix D: Gatekeeper approval letter



26 May 2016

Ms Constance Thulsile Zita (SN 208513227)
School of Applied Human Sciences
College of Humanities
Pietermaritzburg Campus
UKZN
Email: constancezita@yahoo.com

Dear Ms Zita

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN), towards your research paper, provided Ethical clearance has been obtained. We note the title of your research project is:

"Mental Health Literacy of Young People in South Africa: A Study of University of KwaZulu-Natal Students".

It is noted that you will be constituting your sample by handing out questionnaires to students on the Pietermaritzburg campus.

Please ensure that the following appears on your questionnaire/attached to your notice:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

Data collected must be treated with due confidentiality and anonymity.

Yours sincerely


MR S S MOKOENA
REGISTRAR






Office of the Registrar

Postal Address: Private Bag X54001, Durban, South Africa

Telephone: +27 (0) 31 260 8005/2206 Facsimile: +27 (0) 31 260 7824/2204 Email: registrar@ukzn.ac.za

Website: www.ukzn.ac.za



Founding Campuses:  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

Appendix E: Ethical Clearance