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Zulu cultural perspectives and experiences of mental health and occupational therapy in Kwa-Zulu Natal, South Africa.

Abstract:

Background: *Healthcare systems are formulated utilising worldviews, specifically in mental health, where norms are created dictating what is normal versus abnormal. The era of coloniality promoted western dogma over collectivist cultures. Occupational therapy practice must consider the client's context during assessment and intervention for the process to be client centred.* ***Methods:*** *A qualitative descriptive design was utilised. Purposive sampling was used to recruit 10 participants. Data was collected through semi-structured interviews. Analysis was guided by utilising Braun and Clark's six phases of thematic analysis.* ***Findings:*** *Three themes emerged from the data, personal perceptions, cultural perceptions and health-seeking behaviour. Sub-themes accompanied each. Personal perceptions explored how Zulu people made sense of mental health or related behaviours through a modern or traditional lens. It also explored the importance of the strength of the Zulu individual. This dissonance occurs when faced with cultural norms and personal needs. Their perspectives also altered through their experience with MI. Cultural perceptions were that problems were solved internally in families or communities, and progress was promoted as necessary for the Zulu individual. It also explored spiritual beliefs regarding mental illness, which could range between God, Ancestors or both and could be causal factors or healing mechanisms. Suicidality is seen as a weakness in the culture, and stigma was attached to MI. The final theme concerns the experience of the Zulu MHCU dealing with their MI. A cognitive dissonance is prevalent in all three aspects not merely due to the difference between westernised mental health treatment and traditional healing systems but also due to the value found in each. The method of sharing vulnerability or issues with an individual outside the family contradicts cultural norms. However, participants expressed that being understood in group discussions and sharing vulnerability significantly improved their healing.*

Conclusion: *Zulu individuals create their sense of self in an interdependent manner. The family and community are intertwined in their participation, reputation, and healing. There is an emphasis on strength and the following of norms in the Zulu culture, perpetuated by the importance of consulting elders or close family when faced with conflict. Disregarding these norms can outcast the Zulu individual who thrives on being included in the community. The study was conducted with a limited sample size and in an urban area. Further research within rural communities and diverse facilities would be beneficial. Occupational therapists working in communities such as KZN should understand the causal factors of MI for the Zulu MHCU and their personal beliefs around healing when designing interventions.*

Keywords: *Mental health; Mental illness; Zulu culture; Cultural Perspectives; Culturally appropriate healthcare.*

Introduction

Healthcare systems are formulated using worldviews, beliefs, customs and techniques for good health, appropriate diagnosis, and the prevention and cure of illness[1]. Systems such as these were created during the colonial era when power and privilege were afforded to western culture and created western hegemonic discourse[2]. The hegemonic discourse surrounding culture and its use in guiding practice has become critical to explore[3].

This necessitates reflecting on worldviews or cultural influences guiding practice, specific beliefs, attitudes, and definitions of normal versus abnormal. Worldviews are deeply connected to how people perform and the meaning they ascribe to their occupations; hence, culture is of great interest to the client-centred occupational therapy profession[3]. Considering mental health interventions specifically, these have been based upon attitudes and beliefs that govern or define what is normal and abnormal or requires intervention. These norms and ideals are essential to the development of theoretical models and frameworks that guide psychiatric intervention both globally, as well as locally in South Africa.

Culture refers to perspectives, beliefs, knowledge, values, attitudes, assumptions, norms, and customs associated with belonging to a specific group of people, which, in turn, guides thinking, understanding, and behaviour[4,5]. Cultural dimensions that may emerge need not be restricted to ethnicity or race but could include other factors of diversity such as class, gender, sexuality, and ability[4]. These divisions, which influence meaning attributed to occupation, also, unfortunately, render people unequal in society and affect the privilege, power, and opportunities they are afforded[4].

Analysing the theories in multicultural societies has become necessary for decolonizing occupational therapy theory and practice to incorporate diverse worldviews, mainly from the global South[6]. Decolonisation calls for disrupting the norm and questioning the appropriateness of practices. Occupational consciousness becomes a central concept for disrupting the cycle of oppression through occupation[2]. It entails building an awareness of the dynamics of hegemony and recognising how this might be sustained in everyday occupational performance[7].

Unfortunately, a wide variety of research thus far focused on the occupational therapist's challenge of working in diverse societies rather than understanding the client's culture and how it influences their understanding of health, health-related behaviour and experiences[5].

Furthermore, much research that looked at traditional theories of ill health has become outdated. One such study was done by Edwards et al. in Durban, South Africa. It highlighted various theories African clients presented of their psychiatric illnesses compared to western theory. They found differences between traditional and western theories but also congruency in the differentiation between psychotic and non-psychotic disorders[8]. A latter study by Crawford & Lipsedge[9] is highlighted later on in the study's literature review for its in-depth information about Zulu cultural definitions of illness. This study highlighted the role that ancestors are believed to play in the construction of illness among Zulu people.

When researchers engage in research with the utmost respect for the perspectives and experiences of diverse cultures, they will move toward culturally safe theories that are inclusive of the truths that clients hold[4]. This study will explore the mental health perspectives and experiences of mental health interventions among isiZulu-speaking, Black South African mental health service users (MHCUs). The research specifically aims at those who have participated in western-based occupational therapy programmes. Thus critical reflection will be engaged regarding the question: *are mental health services appropriate for this dominant cultural group*?

Literature

The existing literature is divided into four sections, as shown in Figure 1 below:

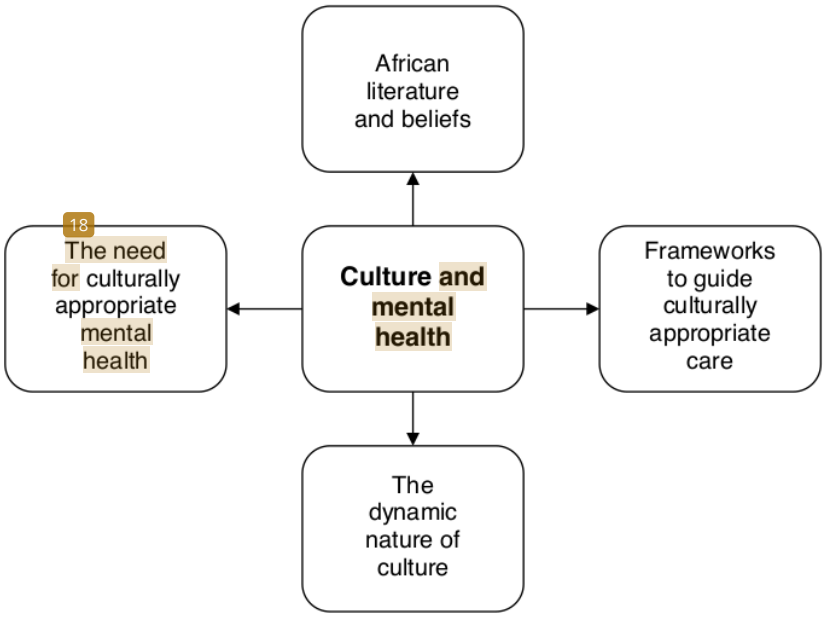

Figure 1: Architecture of the Literature Review

The dynamic nature of culture

Culture is dynamic, evolving and developing as the world evolves and develops, and as different cultures tend to coexist in shared spaces over some time[4] thus necessitating consistent re-thinking and re-exploration.

To comprehend what is of importance and relevance to the people, as well as to evaluate cultural safety and appropriateness of occupational therapy practices, information must come from the sources themselves[4]. This study aimed to gain insight into this for MHCUs from within the Zulu culture.

The need for culturally appropriate mental health

Preceding 1994, the apartheid government strongly disseminated the western worldview as the ideal[10]. This "epistemicide", or near destruction of indigenous terminology or explanations[11] did not result in the abandonment of traditional practices among Africans. Instead, it afforded a choice between both health systems[10], perhaps as a reflection of the meaning they still found in traditional practice.

Studies conducted globally have identified evidence of culturally inappropriate mental health services and their adverse effects on the people they were meant to serve[12,13]. These studies depicted the potential damage caused by well-intentioned services that neglected the client's perspective. Collectivist cultures see themselves as interconnected with their communities and place less emphasis on autonomy or independence[14]. Critical reflection and research are imperative before providing services for collectivist cultures, or it risks undermining traditional methods and meaningful cultural beliefs and practices.

In efforts to understand this diversity manifesting within mental health, five critical components from collectivist cultures were found to play a significant role:

- A reluctance to use talk therapy in the case that it would lead to more suffering;
- The shame of having a mental illness causing further reluctance to seek professional help;
- The power distance between therapist and client;
- Collectivism as the preferred method of support; and
- Religion or spirituality as the root cause or utilised as a coping mechanism[15,16].

Regardless of this knowledge of cultural diversity and mental health, most of the approaches toward intervention and counselling remain Eurocentric on a global level.

African literature and beliefs

A discourse analysis[17] solidifies the necessity of African research into cultural perspectives. Findings indicated a contradiction between traditional Zulu and western theories of mental illness (MI), leaving African individuals with the complex decision between two healthcare provision systems. The researchers suggest that colonial power perpetuated the ideology that resilience entails the passive acceptance of suffering among African people.

Stigma toward mental health care users (MHCUs), developed through cultural beliefs and attitudes, also significantly influenced how they were perceived and reacted within their communities. Moreover, this stigma caused individuals with MI to relapse, reducing their treatment adherence and health-seeking behaviours[18].

An older but relevant study in rural KZN identified that Zulu beliefs concerning ill health and suffering were closely linked to their religious beliefs, history, social relationships, and cosmology[9]. Beliefs around medical doctors were that they could understand and treat disorders known as "*umkhuhlane*", but other disorders known as "*ukufa kwabantu*" were only recognised and treated by traditional healers.

This ideology still exists in Molot's[19] study of western versus traditional treatment of mental illness in KZN. Explanations for the root causes of MI by traditional healers often included ancestors. Traditional healers also reported that they exclusively treated those bewitched or in trouble with their ancestors through methods such as burning *imphepho* (incense), cleansing, or traditional medicines. Ancestors are highly regarded and often linked to the wellness of the Black African individual and family[9,19,21]. Ancestors are the souls of the deceased elders who guide the living. When ancestors express displeasure or communicate with the family, they usually do so in the form of illness, suffering, dreams, or nightmares that must be appeased by specific rituals[21].

African culture reveres fundamental moral values such as patience, perseverance, modesty, industriousness, obedience, and respect for elders[22]. An individual creates their sense of self through others. The proverb "*umuntu ngumuntu ngabantu*", which translates to "a person is a person through other persons", is a good explanation of this[22]. Hence sources of motivation for the African individual include bringing honour to their name or clan, overcoming the limitations of their background, competing with others in their age group to achieve worth,

pleasing the ancestors, and having the desire to be part of a community and receive social support[22].

Frameworks to guide culturally appropriate care

Frameworks utilised in occupational therapy practice possibly achieved dominant status due to the influence and power accrued by the western culture[4]. Initially, cultural competence was utilised as a framework for mental health professionals to practise efficiently within culturally diverse settings. It required practitioners to become familiar with the cultural values, customs, and traditions of the people they served. However, research has indicated that these cultural competence models are insufficient and can be problematic due to their ignorance of the dynamics of power and oppression[4,15,24]. Cultural humility has been proposed as more appropriate as it requires therapists to become critical thinkers. This entails evaluating intersecting identities and scrutiny of generally taken-for-granted knowledge that is defined as truth and operated from. This redresses the power imbalance within a client-therapist relationship and enhances the therapy process[4,24].

Methodology

Study design

This study employed a qualitative descriptive approach. A qualitative design was best suited to the study that sought to enquire into concepts of meaning, experience or views from the participants' point of view in the healthcare system in KZN[25].

Selection and sampling strategy

Purposive sampling was used, where a group of people are intentionally selected to best answer the research question posed[26,27]. There were 10 participants in this study as data saturation was reached at this point of the data collection.

Table I: Participant Demographics

Participant	Gender	Age	Occupation	Pseudonym
1	M	30	Lifeguard	Thabani
2	F	44	Educator	Gugu
3	M	34	Police Officer	Muzi
4	F	57	Former Crèche Owner	Mbali
5	F	28	Educator	Ntokozo
6	F	36	Administrative Clerk	Zandile

7	M	38	Student Advisor	Bheki
8	F	50	Receptionist	Thokozile
9	M	42	Police Officer	Menzi
10	M	33	Plumber	Sifiso

Research setting

This study occurred in the KwaZulu Natal province of South Africa, specifically the city of Durban. The predominant cultural group residing in KZN is the Zulu people. IsiZulu is also the most commonly spoken language of the 11 official South African languages[28].

The study focused on MHCUs from the Zulu culture previously admitted to a psychiatric facility. The facility is based in one of the more upmarket areas of Durban, usually inhabited by people with a higher socio-economic standing in terms of income and standard of living. However, the client population arises from all over the city and country. MHCUs seeking assistance at the clinic may present with depression, anxiety disorders, PTSD and psychotic disorders, among others.

Data collection procedure

A semi-structured interview schedule drawn up by the researcher was used to guide the conversation. Open-ended questions were designed to elicit responses relevant to the research question and allowed participants to diverge into new concepts that arose within the conversation. Interview questions explored attitudes and beliefs surrounding mental health, mental-health-related practices and experiences of current mental health programmes. A pilot study was conducted with 2 participants to ensure that questions would be understandable to participants and that they would elicit the responses required to answer the research question. The pilot study revealed that the questions were appropriate. An interviewer matching the description of a Black, isiZulu-speaking South African was contracted to conduct the interviews. Thus creating a more comfortable interview space for the participant and allowing them to express themselves when it proved difficult to translate from isiZulu to English and vice versa.

Trustworthiness

The semi-structured interview schedule questions were utilised to redirect participants who strayed off the topic. Questions were rephrased to confirm or enhance the understanding of either interviewer or the participant. Participants reserved the right to withdraw their participation at any time before disseminating the results. Thus, they would only have participated out of willingness. Peer reviews occurred, where informed peers commented on

the processes and data gathered or analysed. The researcher carried out triangulation by working through transcriptions and interpretations multiple times, as well as debriefing with informed peers. The researcher engaged in reflection through journaling to evaluate her positionality as an Indian female who was an outsider to the Zulu culture, to uncover preconceived personal ideologies and identify how it may impact interpretations of the data. A detailed description of the methodology is provided. An audit trail of the recordings and transcriptions was kept for evaluation. The detailed description of the context can be utilised to decipher the contexts in which it may be generalizable.

Ethical considerations

This research study was approved by the Biomedical Research Ethics Committee (BREC) at the University of Kwa-Zulu Natal (Ref. no. BREC/00002882/2021). The research process was carried out according to the research guidelines to ensure scientific integrity. Gatekeepers' permission was obtained from the facility, and participation in the research study was voluntary. Telephonic or virtual interviews were more cost-effective. Individual interviews provided participants with confidentiality as they were blind to each other. Participants' stress was minimised by fully informing them about the study. Participant names and any other identifying features are not included in reporting. Participants were treated and responded to with respect and sensitivity, and their cultural viewpoints were respected.

Data analysis and Findings

Data Analysis

A thematic analysis of the data was conducted. Thematic analysis has the potential to reflect the current reality and uncover what underlies this reality which is in line with the aim of this research. The six steps of thematic analysis were followed as outlined by Braun & Clark[29]. Thereafter a deductive analysis was conducted.

Table 2: Thematic Analysis

Thematic Analysis	
Step 1 Familiarising yourself with data	Raw data were collected in the form of audio recordings of the interviews that were conducted between the interviewer and participants. These audio recordings were then transcribed into a document by the researcher. The researcher immersed herself in the data Transcriptions were a verbatim account of the conversation and were combined with non-verbal cues noted by the researcher.

Step 2 Generating initial codes	Coding was completed so significant parts of the data could be extracted and organised. The researcher conducted coding manually, allowing for further immersion and context maintenance.
Step 3 Searching for themes	Codes were grouped into themes, allowing codes to fit into more than one theme
Step 4 Reviewing themes	A thematic map was generated. The researcher returned to the research question and matched the data to the explored concepts. Sub-themes emerged as similar codes were grouped.
Step 5 Defining and naming themes	Immersion continued as the researcher re-read through the data set actively and searched for meaning. Themes were reviewed and refined by re-reading through the data and the codes to verify patterns initially detected.
Step 6 Producing the report	Findings were written into a report with verbatim quotes to support the themes and sub-themes.

Findings

This section will present the themes that emerged in the study. Three themes emerged, Personal perspectives, Cultural perspectives, and Health-seeking behaviour. Each theme is accompanied by sub-themes, as described in the diagram below.

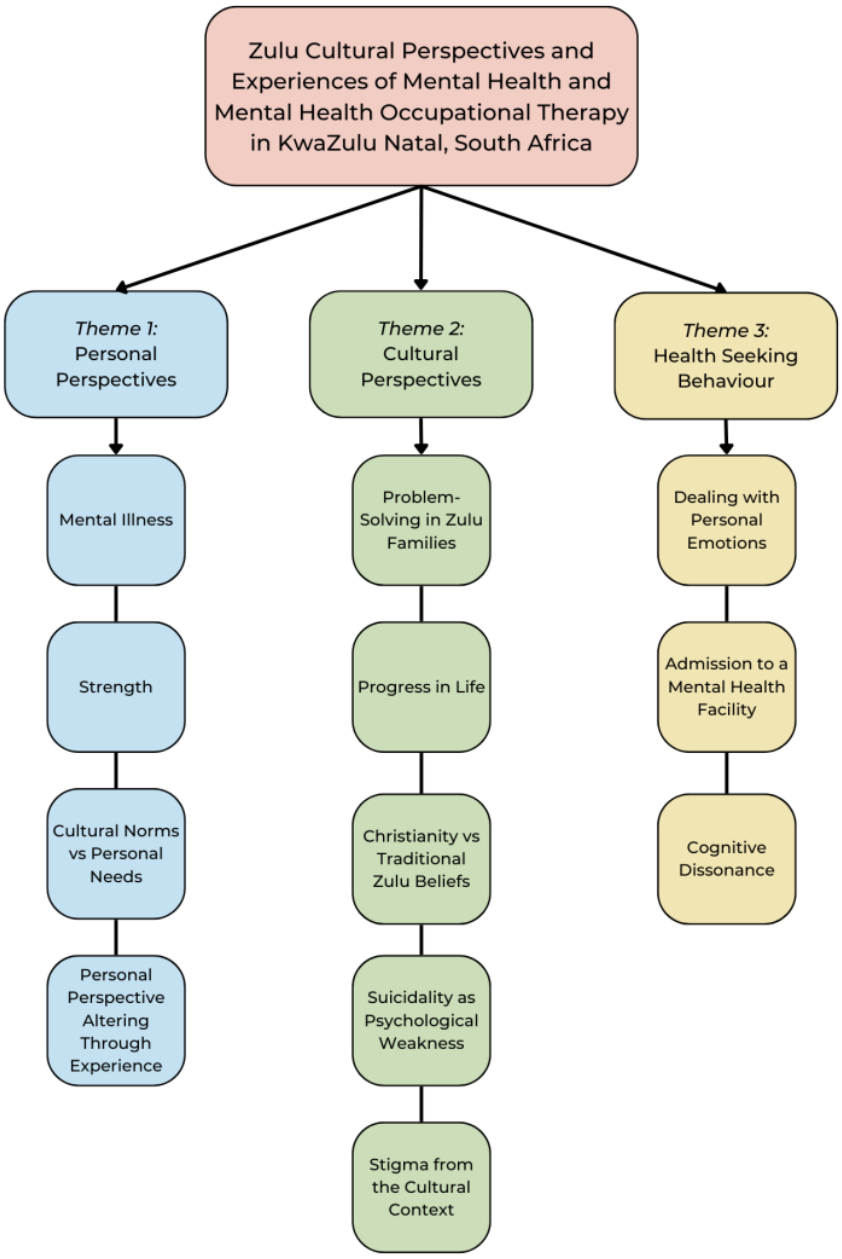

Figure 2: Thematic map

Theme 1: Personal Perspectives

This theme considers the aspects of the Zulu individual's perspectives concerning mental illness and some of the causal factors described by participants. The sub-themes that emerged under this theme were mental illness, strength, cultural norms versus personal needs and personal perspective altering through experience. These sub-themes will be discussed individually.

Mental illness

The concept of mental illness does not naturally emerge in Zulu culture and is regarded as a western concept. This makes it difficult for MHCUs to be understood and supported as needed.

Healthcare for physical ailments is recognised, but mental health services are not. Many are not aware that the western medical model includes these services.

> *"Oh, before I came here, I didn't understand, I didn't know that there was a hospital that was meant for mental health. The only thing that I know is that you just go to hospital when you are sick."* (Thokozile)

This lack of recognition of MI within their communities can turn into invalidation for the Zulu MHCU.

> *"That is why I am here, my husband wasn't supporting me, he started not speaking with me, he started ignoring me, he started telling me…he started like rejecting me because I was suffering from depression and anxiety and he told me that "No you don't have a problem, it's just that you want attention from us and you won't get it".* (Zandile)

Mental health, when recognised, is seen as a white person's problem.

> *"Then when it comes to mental health, according to our culture there is no such a thing called stress or depression, if you said you are stressed or you are having a depression, they think that you are having a drama, you are westernised, you are colonised, they think all of those things, they think maybe you think you are a better person than them."* (Thokozile)

Strength

Strength is presented as a core quality required of the Zulu individual. It is expected to be displayed in different ways by each gender.

In traditional Zulu families, the eldest male is regarded as the family's provider, decision maker and leader. Male participants expressed that this role required them to present as emotionally strong and thus worthy of respect. A man must not disclose incapacity to lead the family or handle situations that arise lest he loses respect.

> *"…in difficult moments as a male you're not supposed to cry. People are looking up to you and must find hope in you so you must find a coping mechanism. If you're the one crying, what about the children, what about the wife, the sister or someone. So if you cry, you go into a corner somewhere and cry alone. But in front of everyone, everything should be ok."* (Bheki)

Strength in a female was defined as sustaining their marital household despite any hardship experienced. Weakness would be described as leaving the marital relationship. Even in times of injustice, Zulu females were expected to remain as caregivers and submissive wives. While this ideology is still present, they are currently afforded opportunities to education and work, supporting themselves and their families.

> *"I think it's because most of the Zulus' mothers, they are housewives, that's why…not now before it used to be that they are housewives. Most of them now they are working, they can stand for themselves."* (Zandile)

With temporal shifts, the expectation of financial provision is no longer restricted to males, as females now have the opportunities to education and work and are expected to provide for their families financially. This occurred even when fellow household members earned salaries, and irrespective of responsibilities, the female, has beyond the family.

> *"Like this month I said I won't buy groceries for them at home because I was staying with my in-laws for the whole holidays so I have to buy for my in-laws because I was using their food. But when I got home there was nothing, no food, nothing and my sisters will tell me ooh I bought this jersey it's so…Serious! You bought a jersey while there is no food in the fridge!"* (Ntokozo)

Thus both males and females are held to the expectation of being strong and not expressing hardship.

> *"...to us in our culture, mental illness does not exist, it does not exist because we have this belief or this expectation that nothing is bigger than you, nothing is impossible, we are like warriors."* (Bheki)

Cultural norms versus Personal needs

Culture promotes collectivism and the practice of *Ubuntu* which can override or conflict with the needs of an individual in this interdependent culture.

It was expressed that in a Zulu family, people were raised to be givers and helpers. A popular act was self-sacrificing for the well-being of others, even when one was not in a position to assist. Participants, therefore, struggled with setting healthy boundaries.

> *"What I can say about what led me here is firstly I wanted time out. I give and I give and I give and I give until there is no me."..."We call it in isiZulu, nika nika."* (Ntokozo)

This also materialised as "black tax, " defined as an unspoken obligation to help others or extended family when you have achieved well yourself[29].

> *"Black tax is when you, they feel you are, same word, obligated to do certain things because you are earning more or you are more educated. Black tax is like blackmail towards your mind, towards your soul and how you see things. "Ey but you know", they will look up, "Ey but you know the ceiling is not there" and then you like "Eish, I need to buy ceiling next month" and then you put the ceiling up."* (Ntokozo)

Due to the Zulus being a collectivist culture, informational support usually came from someone in their network who had experienced the facility or mental health services. Alternatively, they would get referred to a traditional healer.

> *"Uhh, okay, to me, one of my friends told me, cos we uh, especially I was getting lot of headaches, not sleeping at night, maybe I will sleep like an hour or two at most"* (Sifiso)

Personal perspective altering through experience

Participants saw a need to adapt their mindsets after their experience of a mental health service.

> *"We are not in the era where our grannies, grandfathers and ancestors were. We are in an era whereby we need to use the tools that are there, yeah. So we need to shift our mindset, not forget our roots but shift our mindset and try to accommodate the new change that is around us."* (Ntokozo)

Going through the programme at the facility altered their perceptions of mental illness from being non-existent within Zulu culture to being existent and treatable.

"Uhm mental health for me…Uhm I think it's going to be different now for me because I've been to a mental institution, like a mental health institution so obviously my perspective now is a little bit different compared to uhm before I went there." (Muzi)

The older generation, who had different educational opportunities or grew up in rural contexts, were not easily convinced about the benefits of seeking mental health services.

"I don't think I'd even try with him (participant's father) *because that absolutely… it never existed in his mind so I think now with the younger generation the more we go to school… eh…the better we understand. But with the elderly people or with the people especially from rural areas… like real real rural areas, they'll not attend a psychologist. I don't think you can convince one to attend."* (Bheki)

Theme 2: Cultural perspectives

The following theme considers how Zulu people are socialised to behave by their cultural context, specifically when it concerns hardship or mental illness. The sub-themes that emerged were problem-solving in Zulu families, progress in life, Christianity versus traditional Zulu beliefs, suicidality as a psychological weakness and stigma within the cultural context. These will be discussed individually.

Problem-solving in Zulu families

Problems are dealt with collectively within the Zulu culture. Maintaining honour and reputation in a family are important[21], and thus issues would not be expressed outside of the family space. This is contradictory to the westernised mental health system.

Issues experienced by the Zulu person must be taken to the elders, who will advise that they must be dealt with internally. Discussing problems with an individual external to the family is regarded as shameful.

"Normally the elders they come together and then they said this things should be for the family and must not go out". (Thokozile)

As noted above, it was also expressed that, often, the elders in the family would instruct them to remain silent about what they were experiencing:

"...they don't want, like outsiders to know what is happening in the family… they pretend as if everything is okay while everything is not okay until maybe that person comes out saying

that no enough is enough. And then when you said that (revealed the problems*), they will say that you are mad.*" (Thokozile)

Progress in life

Zulu individuals and, subsequently their families value progress in terms of social status, finances and assets. The progress of the individual means progress for the family. Thus there is an unspoken expectation and drive to progress.

The pressure is felt through subtle societal expectations or comparisons with their age mates.

"...you want to progress in life. Can you imagine you grew up and you 35 or 40 years and you still stay at home? That's not right, by that time you need to have your own house, have your own family." (Menzi)

Debt is sometimes accumulated to be deemed as progressive in society

"I am in debt, there are things I cannot afford, I am turning 30 in December and I don't have a car and I know a car, it doesn't mean anything but you know it's something which I wish I could have. I don't have a car and I don't have the finest and nicest clothes ever and I'm always making ends meet…" (Ntokozo)

Christianity vs Traditional Zulu beliefs

Each participant expressed some form of spiritual and belief system.

Many behavioural shifts or changes in a person are initially attributed to spiritual causes in the Zulu culture.

"Oh! They think maybe you are crazy or you are a witch because they don't know anything about mental illness." (Gugu)

Spirituality is an essential concept to all Zulu people, some believing in God, some in ancestors and others combining the concept of God and ancestors. For some individuals, a conflict exists between cultural beliefs and God, which is seen as a western concept.

"Some people chose to pray only to God and then obviously the majority uh, stayed with the ancestors and the rituals. Uhm, and then a part of the people would just mix the two, they would have like, they would pray to God, for God to help them connect with their ancestors or the other way around…" (Muzi)

Ancestors were either regarded as protectors and providers or as negotiators between the tangible and intangible realms or God.

> *"We do these things to make sure they protect us from sicknesses, illnesses…"* (Menzi)

> *"Our thing is they negotiate. They are like the negotiator between us and God. It's how we grew up."* (Ntokozo)

Participants who believed in their ancestors, believed that they could express dissatisfaction with them through mental illness and specific rituals needed to be completed to appease them.

> *"…there were certain things that were done at home, rituals and maybe now you are the older one or you have your own family we are not following those proceeding stuff so whatever that is not right that is happening to you, it might be pinned to that…if she can do this and this because it's what was required to her, then things will come back to normal.*

Whether they described themselves as Christians or revering ancestors, most participants had expressed a sense of respect for their ancestors. Some combined the belief systems, while others merely acknowledged their ancestors.

> *"I am a Christian. But praying to God but that doesn't mean I cannot do uh our cultural things… there are things that as Zulu nation you need to do… whether you are Christian or not, you need to do it, it's a must."* (Menzi)

> *"The only thing that I believe is that there is God, and if you pray, you will receive what you are praying for."* (Thokozile)

Suicidality as psychological weakness

The unavailability of coping skills and adequate support leads to a sense of hopelessness and possibly suicidality which is then deemed a weakness in the Zulu culture.

Due to the requirement to be emotionally strong and the expectation for one to persevere through hardship, it is difficult to ask for help. Suicide is a major concern stemming from this, as many people turn to it after feeling there was no way out of their problems. Multiple participants expressed that suicide is seen as a weakness, and the underlying causes are often overlooked

> *"...some people they even commit suicide you know. Because whatever that they going through they think they can handle it until they cannot handle it anymore and then their only solution is to take their life."* (Menzi)

Participants expressed that a specific ritual of beating the dead body of a person who commits suicide must be carried out to ensure that the spirit of the person who committed suicide does not infect the other family members. This solidifies the concept of suicide being seen as a weakness instead of an act of hopelessness.

> *"Like for example if someone dies in your family by suicide and then they believe that the person, they have to beat that person, the dead body so that there will be no other person in the family does same thing."* (Muzi)

Stigma within the cultural context

Participants expressed that stigma within their cultural context emerged in the form of names to describe MI.

Names for MI include

"uhlanya", (Zandile), which translates to crazy,

"islima", (Zandile), which translates to stupid,

"ustupito", (Zandile), which also indicates stupid,

"ziyarara", (Zandile), which is understood as a person having bees buzzing in their head,

"domorosa", (Thokozile), which translates to "you are *dom"* (stupid),

"uyatagata", (Mbali), which translates to someone practising witchcraft.

These words encompass stigma, misrepresent MI and outcast the MHCU. MHCUs are labelled by these words and are often not taken seriously due to these labels. Therefore most Zulu MHCUs do not disclose their mental illness.

Adverse or invalidating reactions to emotional expression adversely impacted participants' mental health.

> *"They will think that you are a dramatic person, you just want attention."* (Thokozile)

Theme 3: Health-seeking behaviour

This theme outlines the task of dealing with mental illness for the Zulu individual when it became overwhelming and difficult to ignore. The sub-themes discussed hereafter include dealing with personal emotions, admission to a mental health facility and cognitive dissonance.

Dealing with personal emotions

This subtheme looks at how overwhelming emotions were dealt with by the Zulu MHCU prior to admission.

Initially, the Zulu MHCU will attempt to cope with their mental illness in isolation. Often this can manifest in unhealthy coping mechanisms.

> *"Yeah but sometimes alcohol, it helps me to sleep. Cos' when I'm drunk I sleep the whole night and wake up at 5 or 6 o'clock and look at the time and…. oh it's time to go to work…but when I'm sober… ah it's difficult… cos I'm dealing with a lot, yeah."* (Sifiso)

Another primary coping mechanism, especially displayed by Zulu males, was aggression as an outlet for their emotions.

> *"Because if your father comes home and was upset about something or something didn't go right. Whatever wrong that is happening here, it's a fight. Then they will burst in anger. But it's not because they're generally…like that. It's because there's too much pressure. They are keeping it inside."* (Bheki)

Many participants reported that they only noted a decline in their health once they experienced physical symptoms of MI or irregular behaviours such as isolating themselves.

> *"...losing weight, having headache, not feeling to talk to other people, most of the time I was sleeping, not wanting to talk to anyone…They didn't find what make me sick until they brought the psychiatrist."* (Thokozile)

These symptoms are what often prompt health-seeking behaviour.

Admission to a mental health facility

This subtheme details the experience of Zulu MHCUs who were admitted to an inpatient programme.

Zulu individuals were initially reluctant to access the mental health services they learnt about, and when they did, they described an internal conflict.

> *"The first time I attended a psychologist, I felt terrible in a sense. I asked myself, am I ok? What's wrong with me? Something's wrong with me. I'm attending a psychologist and now I need to say and open up to someone and maybe that person will also see me and think "No, this guy is weak"."* (Bheki)

A profound response from each participant was that they were astounded by the fact that they were not alone in what they were experiencing.

> *"I think I realised that it, it's like whatever that I'm going through I'm not alone in this and all these people are also dealing with so many things and that's why they are here."* (Muzi)

Participants felt relief at the validation they received from each other.

> *"So they uhm, they talk about things and they share and you find yourself laughing and nodding and saying that is true and stuff."* (Sifiso)

They found that understanding the problem and solving it practically with support was helpful. Speaking to someone who can provide perspective or understanding improves their wellbeing.

> *"...it makes me feel better. Too much. I am feeling better because of it. Those activities as well as the talking with others, but before I went to* (the facility), *I don't get to do all that."* (Mbali)

The facility was seen as a healthy distraction from their challenging or sometimes toxic environments, and they could think more rationally.

> *"...you forget because the whole idea is to get away from people who are causing you more stress and then just be yourself, and that is where you think clearly and that is where you make decisions and then you starting already I need to try this… and I need to try this …and try this."* (Muzi)

The facility needed to be a safe space to express their vulnerability, where someone would listen attentively, care about what was being expressed and be non-judgemental.

> *"She* (psychologist) *was listening to everything I was saying and she would ask me a question about what I said and I'm thinking maybe she is not listening but no, she was, and there was no situation where she was judgemental so she is open-minded."* (Ntokozo)

Participants found value in the diversity of group therapies available.

> *"I think they cover everything cos' when you go to the different classes you learn something to each class."* (Mbali)

The facility allowed and encouraged a focus on the self, specifically allowing them to express themselves without fear of criticism or judgement for going against cultural norms.

"And I get a chance to learn about so many things that will boost my self-esteem and also that will help me find out who I was and what I really want." (Thabani)

Participants recommended that spirituality be integrated into the care they received due to it being so pivotal to most of their lives. However, this is acknowledged as difficult to navigate due to the diversity of spiritual beliefs.

"Yes, spirituality, yes yes yes. We need that, it's lacking, but I think so…not exactly Christian but someone must be fair…you can't just bring Christianity and leave others. We need some spirituality. Yes, I would suggest that." (Zandile)

There are culturally specific issues that need to be expressed. To truly express oneself, the isiZulu language is necessary.

"Yes language plays a huge role, you know English is not our mother tongue so there are things that we want to say or express but we can't express them in English… So what happens now? You keep quiet… So you come to (the facility) *with a problem, you go home with the very same problem."* (Menzi)

Participants felt a need for an increased length of stay in the facility to enhance their understanding, identify problems, and improve their skills and coping strategies. There is also a need for support external to being admitted in the facility.

"It's a lot of things that are, are, you are given within a short space of time and then you have, you still need to go out there and practise these things, things that you learned within just two weeks (laughs)." (Muzi)

This type of experience is more accessible in private rather than public facilities, side lining those without access to medical aid or funds.

"…maybe they look at the kind of services that the government has and then they feel like what's the point." (Muzi)

Cognitive dissonance

Zulu MHCUs who had experienced a western mental health service expressed that cultural norms and the perspective or experience gained at the facility differed.

This cognitive dissonance caused participants to express anger at their culture for not acknowledging and educating them about mental health and illness.

"Black culture! Black culture, what I can say…they are emotional abusers." (Zandile)

Participants felt that culture acknowledged the change in tangible aspects but did not readily recognise or adapt according to intangible factors like mental illness.

"For example, like uhm having lobola, lobola used to be walking cows, it was a must that it must be walking cows. Now I live in (the city)*, there is no grass (laughter). I can't make it a cow, it will be like eyoh what is she doing and the cows will be gone in the morning. So what do I do? You must give me money instead of the cows. Each cow has its own money value so we adapt…change. Why can't we adapt to that change and adapt to all changes concerning culture. When it comes to money we are like yes, yes its fine but when it comes to uh certain things like mental health- no, no, no it's not okay."* (Ntokozo)

Participants further expressed a need for education and awareness surrounding mental health.

"...its awareness. I just…the more we get people aware of these things, the more they can get help, the more they can be able to understand what really is going on with themselves." (Muzi)

Beyond the treatment of the Zulu MHCU, there is a need for education with families who are core to their environment.

"So what I would suggest, we need to go back to the families, to teach them about depression and anxiety and about triggers" (Ntokozo)

Discussion

The findings of this study were viewed through the lens of the Ecology of Human Performance model. The basic tenets of the model include the person, the context and the task[20]. In this section, findings relating to these concepts will be integrated and discussed.

Participants expressed that experiencing mental illness and participating in westernised treatment conflicted with their perceptions and restorative to their state of mind. Mental illness and mental health services were described as unfamiliar to most Zulu people. Explanations for the behaviours related to mental illness were often linked to the belief in a spiritual dimension. These spiritual dimensions differ however, each participant expressed a form of spirituality, either revering God, ancestors or a combination. This confirmed their belief of a human and spiritual plane in which activity occurs[21]. Rituals participated in ranged from traditional, where the use of a *sangoma* or an *inyanga* was required, to religious offerings,

where the church and prayer to God were leaned upon for wisdom. Personal spiritual beliefs were a source of strength and a coping mechanism for the African individual[15,16]. Treatment in the facility often did not include spirituality being included. Participants felt strongly enough about this to recommend that it be introduced.

Another critical concept of the Zulu culture was the ideology that each individual must possess strength. Participants in this study specifically referred to an individual's emotional/psychological strength. It was found that each gender was expected to display strength in different ways. Traditionally, Zulu males feel the pressure to present as symbols of strength. They believe they are not to express emotions or vulnerability in front of others as this is considered a weakness[31]. Males generally dealt with their emotions through substance use which was seen as more acceptable or displayed aggression as an emotional outlet. Female strength was measured by persevering through marriage and family. Women are traditionally required to be submissive and dependent on the Zulu patriarch and are subjected to silence when enduring injustice for fear of loss of provision. With temporal shifts in the context, females now have access to education and work that they did not always access previously. Educated females then faced the issue of having to assume the role of the male and bear similar expectations of provision and strength within the household. However, educated females who provide for their families still do not receive the respect or honour afforded to a male provider.

The expectation of strength further tied in with the need to progress and improve the family's reputation. This progress would be measured in terms of the status, financial position or assets of the individual. However, the Zulu individual's reputation is linked to their family or community's reputation[22]. They are therefore required to follow customs or norms[22] lest they bring shame to their collective name. The issue arose where the need to progress in life is so entrenched that it necessitates creating more hardship to maintain the image of progression. An inability to admit to experiencing adversity emerges and, consequently a sense of helplessness. With a reluctance to ask for help and an inability to cope, some might turn to suicidal acts. Suicidality is not considered an act of helplessness but rather a weakness within the person. Participants expressed that they could not explain mental illness or psychological distress to their families. The Zulu individual creates their sense of self concerning their community[22], thus, silence and isolation can be counterproductive to the Zulu MHCU's healing.

Experiencing emotional hardship is thus not easily admitted to or spoken about. However, when admitted to the facility, talking about their issues and developing solutions were seen as an enhancement to their state of mind. If there is a need to talk about an issue, the Zulu

individual must approach their close family, especially their elders. Elders in the Zulu culture pass on rich cultural knowledge but an insufficient understanding of mental health. Being a historically marginalised group, the effects remain evident. Elders whose voices are central in advising or problem-solving promote strength and coping through endurance, strategies they were forced to implement under the apartheid regime and continue to pass on[17]. Thus, revealing issues within a mental health facility conflicted with their cultural norms.

This was concerning as family or community-related issues are often causal factors of MI for the Zulu community. Zulu people are raised to be helpers and givers, with the spirit of Ubuntu instilled within them[33]. However, this sometimes translated into a lack of boundaries and being taken advantage of by those who do not reciprocate the concept of Ubuntu. 'Black tax' emerging is an example of this. If you were advancing in your career or earning well, you were obligated to provide for the extended family, despite your capacity[30]. Participants expressed that this placed a significant burden on them but they did not know how to put in boundaries to manage taking care of their own needs versus their community's'.

The importance of forming part of a community was emphasised by participants. Stigmatised names within the community context, attached to MI, caused more reluctance to reveal illness or seek help for the Zulu individual[18]. Due to the fear of being cast out or labelled and not valued in their communities, many would remain silent. For younger or urban participants, perspective could alter through experience, but more entrenched cultural beliefs exist within rural communities and older generations. To avoid the loss of community, the Zulu individual may attempt to manage emotions in isolation. When negative emotions overwhelmed the Zulu individual, and no outlet for expression was available, they had to be suppressed. As previously described, unhealthy coping mechanisms were employed, such as substance use or displays of aggression.

Despite this reluctance to admit to experiencing hardship, this displays that support, in whichever form, is primarily sought from each other in the Zulu culture[16]. In communities, considering it a spiritual issue was often more acceptable than acknowledging it was mental health related. Thus Zulu individuals and their families would seek help from their spiritual community. For the Christian Zulu, this would be their pastor; for the traditional Zulu, it would be a *sangoma* or traditional healer. As previously discussed, rituals or prayers that were performed did have a positive impact on the mental state of most Zulu individuals. Referral to westernised mental health services occurred either when symptoms manifested physically, such as headaches or poor appetite, and did not improve; or when experienced peers with mental health noticed their predicament. Being admitted to the facility left these isolated individuals relieved by the feeling of "I am not alone". Solidarity is advantageous to the Zulu

MHCU's healing[32,] and this was found in the facility. Moreover, the facility presented healthy distraction and a safe space to learn, share and heal through vulnerability.

The cognitive dissonance was then heightened when realising they experienced mental illness, thus arousing anger toward their own culture when faced with western versus traditional healthcare systems. Mental illness, initially regarded as 'a white person's problem', was found to exist in theirs as well. Zulu culture cannot be blamed for the lack of recognition of mental health, especially when it was introduced by a culture that neglected to take their worldviews into account and silenced their voices[17]. However, considering it a white person's illness builds stigma and was preventative to health-seeking behaviour for the MHCU. Understanding that it exists within all cultures but can be treated differently due to the different causal factors and healing processes enhances health-seeking behaviour.

Time in the facility was often reported as minimal as the process of altering perspectives and improving their mental state, for the Zulu individual, is a more complex and time-consuming task. Many Zulu individuals expressed the need for more time to learn about mental illness, understand its causes and apply it directly to themselves before learning contextually appropriate skills. Most participants verbalised that their two-week stay was insufficient. This indicated a need for outpatient or community level mental healthcare services and resources.

Furthermore, the isiZulu language was inseparable from the culture and the interconnected issues they experience could, at times, only be efficiently described using the language. Being primarily isiZulu speaking, there were culturally specific issues that needed to be expressed in their home language. Participants expressed that there were cultural concepts that were interrelated with their wellbeing. One such concept was that of 'black tax' described earlier.

This kind of mental health service was not easily available in the government facilities and excludes those without access to medical aid. Thus, a large proportion of the Zulu community are unable to access healthcare for issues such as depression and anxiety. It was deemed that only the individual with 'very severe' psychotic features belonged in a public mental healthcare facility. This has the ability to perpetuate the discourse that mental health is a "white persons' problem" and does not fit into their range of resources to utilise.

The Zulu culture has been subjected to adaptation with temporal shifts. However, the tangible adaptations tend to be more easily integrated, such as female and male roles, as well as payment forms like *Lobola.* Intangible shifts, such as the understanding of mental health, tend to be viewed as out of their control and not sufficiently recognising the intangible is a stumbling block to change.

To execute change, there came a significant outcry for the dissemination of mental health awareness and resources within the Zulu community as a result of their experiences. While the causal factors and healing activities may differ for the Zulu culture, the understanding of mental health could significantly enhance the Zulu MHCUs mental health seeking and treatment. Both systems of healing, western and traditional, seem to be beneficial to the Zulu MHCU.

Implications

- It is a strongly collectivist culture where the individual and their participation cannot be understood in isolation to their family or community as their issues are inextricably linked back to their context and so is their healing. The family cannot be left out of the intervention of the Zulu MHCU.
- There is an ingrained idea of strength through silent endurance of hardship, which was appropriate under the apartheid regime, but is no longer beneficial to the Zulu community whose voices must be highlighted. The development of resilience and healthy coping strategies should be promoted in line with the cultural context.
- Spirituality should be considered in therapy for the Zulu individual and the related practices respected. Each individual will differ in belief, and therapists can explore this as a coping mechanism for their clients.
- There are defined gender roles in the Zulu culture, and each has different issues. Groups or programmes, including gender-specific discussions, are necessary.
- Mental health awareness and resources need to be disseminated at the community level to decrease the doctrine of isolation and helplessness when experiencing MI. This will also enhance perspectives into MI and prove beneficial when admitted to a facility. The Zulu client can empower themselves by comprehending their situation and taking control of their healing.
- There is scope for further investigation into the link between strength of the Zulu individual and methods used to handle negative emotions.
- The isiZulu language is essential to the expression of issues experienced, and resources or therapies carried out in isiZulu would be beneficial.
- There is scope for research within rural communities to compare their constructs of mental illness to urban communities.
- Group centred therapy has been beneficial for Zulu MHCUs admitted to the facility, and these are an appropriate mechanism to foster healing.

Conclusion

Culture contributes to creating norms related to these dimensions and subsequently provides occupational constraints and opportunities depending on the person's identity. It must be anticipated that when exploring culture, these dimensions may emerge in discourse. It will be essential to understand how this interacts with mental health and related occupational performance. A significant cognitive dissonance occurs for the Zulu individual whose cultural norms differ from westernised mental health services. While these health services are beneficial, the Zulu MHCU risks going against cultural norms and does not want this to impact their inclusion into their communities. The privilege of safely and acceptably practising occupation in a way that is seen as appropriate within culture depends on the power afforded to that culture and the acceptance of it in society as well as the positionality of the person concerned. Zulu individuals certainly create their sense of self and engage differently from the western culture. This study helps therapists in contexts populated by Zulu people understand factors that affect the Zulu MHCU's mental health and how to better equip them with skills while maintaining cultural appropriateness in intervention. It is understood that the Zulu MHCU cannot be treated in isolation. Their community or families are essential to include within intervention, and confidentiality as well as healthy relationships are important to consider as therapists. With consistent research into the perspectives and experiences of the Zulu community an understanding of their participation can be built. This contributes to enhanced service provision and does not risk perpetuating the marginalisation of their viewpoints and knowledge.

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