Mental Health-Seeking Behaviours in Rural Communities: Insights from the Bushbuckridge Mkhuhlu Community, Mpumalanga Province

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Mental Health-Seeking Behaviours in Rural Communities: Insights from the Bushbuckridge Mkhuhlu Community, Mpumalanga Province

By

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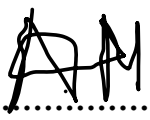
DECLARATION

I, *Ayanda Fiona Magagule (240901088)*, hereby declare that the *dissertation for the Master of Arts in Psychology by Research* is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another University or for another qualification.



…… (Signature)

Ayanda.Magagule

Date: 05 December 2025

I confirm that the above-named candidate carried out the work reported in this research under our supervision.

Prof Thoko Mayekiso

&

Dr Mercy Kutu

University of Mpumalanga

Date :

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Firstly, I would like to express my gratitude to God Almighty for the strength, wisdom, and grace that have guided me throughout this journey. Indeed, “I can do all things through Christ who strengthens me -Philippians 4:13.” This work serves as evidence of His constant faithfulness and direction in every aspect of my path. To my ancestors, your presence, protection, and guidance have been felt throughout this journey. May this accomplishment represent the strength that flows through me.

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ABSTRACT

Mental health is important, but it is often overlooked as a component of overall well-being in rural South African communities. This study investigated the complex factors that impact help-seeking behaviours among individuals in Mkhuhlu, Bushbuckridge, Mpumalanga. Situated within the Health Belief Model (HBM), Social Cognitive Theory (SCT), and the Theory of Planned Behaviour (TPB), it employed a mixed-methods, sequential, explanatory design. It utilised survey questionnaires and qualitative interviews. Data from 200 respondents were analysed using the non-parametric Kruskal-Wallis test to identify significant differences in mental health perceptions and behaviours across gender, age, and educational level. The qualitative data (n = 8) were analysed thematically, providing a richer context for the observed statistical trends. The results reveal that awareness of mental health, perceived obstacles, and sociocultural attitudes considerably affect help-seeking behaviours. The study found that mental health conditions were commonly framed as a "rich/white man's disease," indicating how socio-economic inequality and cultural beliefs influence understandings of mental health. Women and participants with higher educational attainment exhibited a better understanding and more favourable attitudes toward mental health services. It finds that a complex interaction of structural, cultural, and personal elements affects the behaviour of seeking mental health support in rural regions, thus leading to a strong dependence on traditional sources of support. It reveals that help-seeking behaviour is not homogeneous, with women, younger individuals, and those with higher education demonstrating a greater willingness and capacity to seek care. It recommends an integrated strategy that addresses challenges at both individual and community levels to promote a healthier environment for mental health across Mkhuhlu and Bushbuckridge. The study could influence mental health policies and the design of interventions in rural areas. It may provide guidance for developing culturally sensitive mental health education programs that account for local cultural and community norms. Future research should investigate collaborations between traditional and formal health systems and evaluate the long-term effects of community mental health literacy initiatives.

Keywords: **Mental Health** ; **Help-Seeking Behaviour**; **Rural Communities**; **South Africa**; **Stigma**; **Traditional Healing**

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CHAPTER 1

INTRODUCTION

1.1 Background to the Study

Mental health involves emotional, psychological, and social well-being (Puspitasari, Garnisa, Sinuraya & Witriani, 2020). It also supports individuals' well-being, helping them manage the stresses of life. However, taking care of one's mental health is important, as it enables one to function effectively and contribute to their community. Poor mental health is often defined by a combination of negative thoughts, feelings, behaviours, and toxic relationships with others (Puspitasari et al.,2020).

Experiencing poor mental health causes distress, increases the risk of social isolation, and endangers an individual's personal and overall well-being (Hlongwa & Sibiya, 2019). Despite recognising the importance of mental health, it is still a largely overlooked aspect of global public health. Mental health conditions like depression, anxiety, schizophrenia, and substance use disorders rank among the top causes of disability worldwide (Marinova, Calabria & Marks, 2025). The Global Burden of Disease study (2019) indicated that mental and substance use disorders made up approximately 7% of the overall global disease burden in terms of disability-adjusted life years and 19% of all years lived with disability. The findings showed that this burden is exacerbated by stigma, limited awareness, limited access to care, and insufficient policy focus (Sachdeva & Ahmed, 2025).

Within the realm of mental health, seeking help is described as the action of obtaining external support to tackle issues related to mental health. In brief, external support for mental health is termed psychosocial support. According to Sorsdahl, Naledi, Lund, Levitt, Joska, Stein, and Myers (2021), Mental Health with Psychosocial Support (MHPSS) encompasses any local or external assistance aimed at promoting or safeguarding psychosocial well-being or preventing or addressing mental health issues. Hlongwa and Sibiya (2019) emphasise that MHPSS should not be limited to a single sector; instead, it requires a multi-sectoral approach that includes collaboration among partners in education, health, and protection (including GBV, community-based protection, and child protection). The types of MHPSS that can be provided will depend on individuals' distinct needs and the resources available to them. Individuals may seek this support from external sources or within their local community. At times, specialised care and

professional caregivers are necessary. Nonetheless, MHPSS can also be delivered, regardless of specialised training, by volunteers and charitable workers (Hlongwa & Sibiya, 2019).

Research conducted by Berhe, Gesesew, and Ward (2024) indicates that in many sub-Saharan countries, mental health conditions are often misunderstood and said to be a result of witchcraft, spiritual punishment, or ancestral displeasure. These perceptions significantly impact how one views and reacts to mental health conditions. Additionally, there is a severe shortage of mental health professionals in the region (Danso-Appiah, Yankey, Appiah, & Twum, 2025).In many of these countries, there is only one psychiatrist for every 100,000 people, and mental health services are often concentrated in urban areas, making them inaccessible to rural populations (Boakye, Setordzi, Dzansi, & Adjorlolo, 2024). Moreover, health systems are under-resourced, with mental health budgets frequently accounting for less than 1% of total national health expenditures (Berhe et al., 2024).

In South Africa, studies indicate that mental health is one of the predominant health issues in the country (Hlongwa & Sibiya, 2019). According to research conducted by Sorsdahl, Peterson, Myers, Zingela, Lund, and van der Westhuizen (2023), many people in the country living with anxiety, depression, and substance abuse do not receive the treatment that they need. The South African Minister of Health, Dr Phaahla (2023), in his speech on Mental Health Day, stated that less than 30% of people who suffer from mental health issues receive treatment. This is thought to be concerning as it leaves at least 70% with unattended and unresolved mental health issues, which is a great cause for concern.

Although South Africa has made progress in enhancing its mental healthcare system, studies have shown that many individuals, particularly those from previously marginalised communities, continue to face challenges in accessing and pursuing mental health services (Sorsdahl et al., 2023). Klientjies and Schneider (2023) noted that, despite improvements in mental health services in South Africa, various barriers to care persist, particularly in rural and underserved regions. It has been observed that rural populations in South Africa face distinct challenges when seeking healthcare (Sorsdahl et al., 2023). These obstacles include, but are not limited to, a shortage of qualified mental health professionals, insufficient numbers of healthcare facilities, and competing health and socioeconomic issues such as food insecurity and unemployment (Bantjes, 2024). Prior studies have indicated that mental health disorders in rural communities are often viewed through cultural, spiritual, and traditional perspectives, which affect individuals' choices regarding where to seek assistance and how they interpret

mental health symptoms (Matsebula & Singwane, 2025). Therefore, it is vital to recognise the significant role that religious leaders and traditional healers play in addressing mental health-related issues in rural areas (Ranchod, 2025).

Stigma remains a prevalent barrier to mental health care within the rural context. The misconceptions and negative attitudes concerning mental health often lead to social exclusion, discrimination, and internalised stigma, which further discourage individuals from acknowledging symptoms and seeking help (Dikotla, Deka & Lelaka, 2025). Additionally, the deeply held beliefs about witchcraft or ancestral displeasure alongside limited public awareness and education about mental health further reinforce the negative perceptions (Ranchod, 2025).

When exploring mental health care in rural regions, it is essential to consider South Africa's historical context. Therefore, it is essential to acknowledge the legacy of apartheid and its impact on the health infrastructure (Sherry, Ned & Engelbrecht, 2024). Rural regions were deliberately underdeveloped and marginalised during the apartheid era, leading to persistent inequalities in service delivery (Dikotla et al., 2025). These systemic disparities intersect with mental health in complex ways, affecting not only service availability but also trust in the quality of care (Matsebula & Singwane, 2025).

Klientjies and Schnieder (2023) also noted that, despite rural communities having higher prevalence rates of psychological disorders, they exhibit the lowest rates of seeking mental health assistance. Xin and Hsieh (2020) argue that the treatment gap in low- and middle-income countries (LMICs) is considerable. They concur that both supply-side and demand-side barriers exist. Furthermore, they emphasise the urgent need to identify the obstacles that prevent rural communities from accessing mental health support (Xin & Hsieh, 2020).

Despite national efforts to improve mental health services, as outlined in the Mental Health Policy Framework and Strategic Plan (2013–2020), implementation in rural regions falls short (Klientjies & Schneider, 2023). Without culturally, socially, and economically relevant interventions tailored to rural life, the mental health needs of these communities will largely go unmet. Thus, it is essential to understand the lived experiences of people in rural areas, the routes they take when seeking assistance, and the obstacles they face, to close the treatment gap and create fair mental health services across South Africa.

1.2 Problem Statement

Although there is a growing acknowledgement of the significance of mental health care, individuals living in rural areas frequently experience serious obstacles in accessing and utilising these services. The distinct features of rural regions, such as geographical isolation, limited resources, cultural influences, and stigma related to mental health, contribute to inequalities in the use of mental health care (Vergunst, 2018). Consequently, many people in rural communities may avoid seeking or receiving the mental health support they require, which can result in adverse outcomes like untreated mental health conditions, a lower quality of life, and increased strain on families and communities (Bila & Carbonatto, 2022).

While current research has highlighted the challenges faced by rural populations, a gap remains in understanding the specific attitudes, factors, and facilitators that influence individuals' decisions to seek or avoid mental health support in these communities (Winton, 2022). Simultaneously, it is feasible to create strategies that inform targeted interventions by addressing this gap. Nevertheless, the insufficient comprehensive understanding of the attitudes, factors, and facilitators that shape mental health-seeking behaviours in rural areas poses a significant obstacle to enhancing access and utilisation of mental healthcare in these regions. Tackling this gap is crucial for developing targeted strategies and interventions that effectively support individuals in accessing and obtaining the mental health services they need in rural settings.

Vergunst (2018) identified several reasons why people in rural areas struggle to access mental health services. Geographic isolation, limited resources, cultural influences, and stigma surrounding mental health are key factors. Although awareness of the importance of mental health care is growing, many barriers still prevent rural residents from seeking or receiving help. Bila and Carbonatto (2022) explain that this leads to people not getting the support they need. When mental health conditions go unmanaged or undiagnosed, they can harm both the individual and their loved ones, lowering quality of life and increasing stress for family and friends (Bila & Carbonatto, 2022).

While research has highlighted the challenges faced by those in rural areas, there remains a lack of understanding regarding the complex attitudes, factors, and facilitators that shape a person’s decision to seek help. Addressing this knowledge gap would enable the development of strategies to guide targeted interventions (Morales, Barksdale, & Beckel-Mitchener, 2020). Due to the inadequate understanding of the attitudes, factors, and facilitators affecting help-

seeking behaviours, it has proven challenging to enhance access to and utilisation of mental health care in rural areas. Considering all these points, it is crucial to address the identified gap by creating and implementing strategies that effectively help individuals seek and access mental health services.

1.3 Research Questions

i. What factors influence mental health-seeking behaviours among individuals in Bushbuckridge Mkhuhlu?

ii. How do the attitudes towards mental health care vary among community members?

iii. How do the intentions to seek help vary among individuals in Bushbuckridge, Mkhuhlu, South Africa?

iv. How do mental health beliefs impact the help-seeking intentions among individuals in Bushbuckridge Mkhuhlu?

v. How do the facilitators overlap with social networks, cultural norms and access to resources within the community?

1.4 Aim

This study aims to gain insight into the complex dynamics that shape help-seeking behaviours in the South African context by investigating the factors influencing mental health-seeking behaviours among individuals in rural South African communities.

1.5 Objectives

i. To identify the factors that influence mental health-seeking behaviours among individuals in Bushbuckridge Mkhuhlu.

ii. To examine how attitudes towards mental health care vary among community members in Bushbuckridge Mkhuhlu.

iii. To examine how the intentions to seek mental health support vary amongst individuals in Bushbuckridge Mkhuhlu

iv. To investigate how mental health beliefs impact help-seeking intentions among individuals in Bushbuckridge Mkhuhlu.

v. To investigate how facilitators of mental health seeking overlap with social networks, cultural norms and access to resources in the Bushbuckridge, Mkhuhlu community.

1.6 Hypotheses

(1a) Null Hypothesis (H0): There is no significant difference in attitudes towards mental health care, perceived social norms, perceived behavioural control and intentions to seek help among individuals living in rural communities in South Africa.

(1b) Alternative Hypothesis (H1): There is a significant difference in attitudes towards mental health care, perceived social norms, perceived behavioural control and intentions to seek help amongst individuals living in rural communities in South Africa.

(2a) Null Hypothesis (H0): There is no significant difference in factors influencing individual behaviour regarding seeking mental health care between the different demographic groups.

(2b) Alternative Hypothesis (H1): There is a significant difference in factors influencing the behaviours of individuals seeking mental health care between demographic groups.

(3a) Null Hypothesis (H0): The intentions to seek mental health care are not significantly influenced by perceived susceptibility, severity, benefits and barriers.

(3b) Alternative Hypothesis (H1): Intentions to seek mental health care are significantly influenced by perceived susceptibility, severity, benefits and barriers.

(4a) Null Hypothesis (H0): There is no significant difference regarding the facilitators encouraging mental health support across cultural norms, social networks and access to resources within the community.

(4b) Alternative Hypothesis (H1): There is a significant difference in facilitators encouraging mental health support across cultural norms, social networks and community resources.

1.7 Significance of the Study

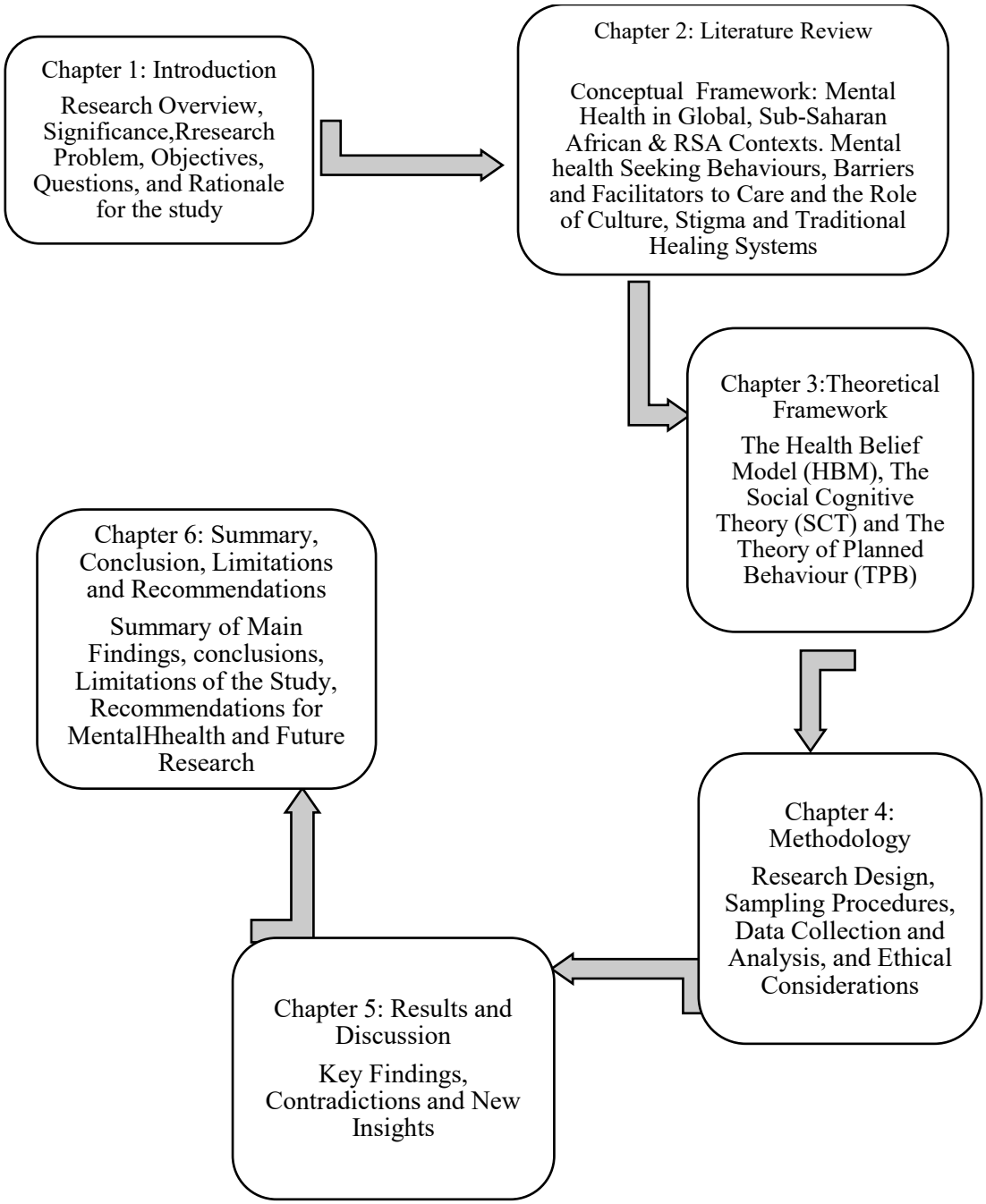
The significance of this research lies in its potential to enhance understanding and improve access to mental health services in rural areas. By investigating the attitudes, factors, and facilitators that influence mental health-seeking behaviours in these communities, the study seeks to support initiatives that raise awareness about mental health concerns. It emphasises the need for equitable access to mental health care services, which are frequently limited in rural regions (Benjamin, Vickerman-Delport & Roman, 2021). The study's findings will inform the development of new interventions and programmes tailored to the specific needs and

challenges of rural communities. Recognising the factors that affect people's decisions to pursue mental healthcare will enable stakeholders to develop strategies that effectively address obstacles and encourage constructive help-seeking behaviours. Additionally, the research will enhance understanding in this area by fostering and increasing awareness of mental health literacy in rural environments. It is essential for reducing stigma and promoting early intervention and treatment. This is achieved by examining viewpoints on mental health services in rural areas.

Furthermore, the study's results will inform stakeholders about the specific challenges and requirements faced by individuals residing in rural areas. Relevant parties can utilise the insights from the study to guide the development of policies and practices to improve mental health care services in these regions. Engaging community members in the research process can inspire them to advocate for improved mental health services and resources within their locality. The study has promoted community involvement by including local participants in both data collection and analysis, thereby enhancing understanding of mental health issues and facilitating sustainable changes and initiatives.

The research aims to enhance understanding of how individuals in rural areas seek mental health care. This is achieved through a mixed-methods approach based on theoretical frameworks. The study will provide insights that can deepen understanding and guide future investigations in rural mental health. In conclusion, the research is important because it could significantly improve access to mental health care, reduce stigma, and foster overall well-being in rural communities.

1.8 Conceptual Framework and Report Layout



Chapter 1: Introduction

This chapter introduces the research topic, outlines the background and significance of the study, presents the research problem, objectives, and key research questions, and highlights the rationale for the study.

Chapter 2: Literature Review

This chapter provides an overview of the current literature concerning mental health, emphasising worldwide patterns, low- and middle-income nations, Sub-Saharan Africa, and South Africa. It examines prior research on behaviours related to seeking mental health care, obstacles and enablers to obtaining mental health services, as well as the influence of culture, stigma, and traditional healing practices on responses to mental health issues.

Chapter 3: Theoretical Framework

This chapter outlines the theoretical underpinning of the study. It discusses key theories and models relevant to understanding health-seeking behaviour (The Health Belief Model, Theory of Planned Behaviour, and Social Cognitive Theory). It explains how they are applied to interpret the behaviours and attitudes explored in the study.

Chapter 4: Research Methodology

This chapter outlines the research design and methodology, including the research approach (mixed methods), sampling methods, data collection techniques (interviews and questionnaires), and data analysis procedures. It also addresses ethical considerations.

Chapter 5: Results and Discussion

This chapter presents the study's key findings. It also provides a discussion that interprets the results, considering existing literature and the theoretical framework, and highlights patterns, contradictions, and new insights into mental health-seeking behaviours in rural South Africa.

Chapter 6: Summary, Conclusions, Limitations, and Recommendations

This chapter summarises the main findings, reflects on the study’s implications for policy, practice, and future research, and offers concrete recommendations for improving mental health access and awareness in rural communities. It also revisits the research objectives to assess how they were addressed and the study's limitations.

1.9 Summary

In summary, this chapter outlines the study's background and context, introduces the research problem, and highlights the significance of exploring mental health-seeking behaviours in rural South Africa. Due to the significant impact of unaddressed mental health issues and the intricate social and cultural factors involved, it is crucial to comprehend how people in rural regions

view and react to mental health conditions. The next chapter will review the existing literature to further contextualise the study and identify gaps that this research aims to address.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter will explore how cultural norms, historical backgrounds, and societal perspectives influence individuals' behaviours when seeking mental health care. Drawing on previous studies, the review aims to identify the challenges communities face in addressing mental health issues and highlight existing knowledge gaps. The chapter will begin by examining mental health-seeking behaviours within both global and national contexts. It will address barriers and facilitators to seeking help. Moreover, it is important to consider how stigma affects mental health and the significance of mental health literacy. This review will examine mental health-seeking behaviours in underdeveloped and developing countries that share similarities with South Africa, including government spending, wealth distribution, and access to social services. The objective is to illustrate how the cultural backgrounds in these regions often diverge from Western models of diagnosis and treatment. To further address the challenges posed by limited mental health resources, the review will incorporate data from higher-income countries, offering a more comprehensive perspective. It will discuss mental health within various contexts and analyse the barriers and facilitators to accessing care.

2.2 Global Context of Mental Health

Mental health with psychosocial support has become increasingly recognised globally due to its substantial impact on disease burden and mortality rates. Consequently, contemporary diagnostic categories are consistently developing to guide more effective and ethical treatment protocols. These categories include a variety of conditions, such as mood disorders, psychotic disorders, personality disorders, substance use disorders, and neurodevelopmental disorders (Moitra et al., 2023). An important component of the worldwide MHPSS initiative emphasises raising awareness, conducting anti-stigma campaigns, and protecting human rights. The field of mental health and psychosocial services is expected to grow due to problems like gaps in care, human rights issues, and the extra challenges from the mental health effects of the COVID-19 pandemic (WHO, 2022).

Mental health is essential for living a healthy life. Unfortunately, many people around the world battle with feelings of anxiety, fear, isolation, and depression, often without access to good mental health care and support (Lombardo, Jones, Wang, Shen & Goldner, 2018). Mental health and psychosocial support issues are prevalent at global, regional, national, and local levels,

impacting every community. However, Patel (2023) highlights that a huge portion of the population does not receive the mental healthcare they require. This is often due to obstacles such as a lack of resources, both human and material, as well as social stigma, which create substantial barriers to accessing treatment.

Bemme and Kirmayer (2020) contended that while more than half of Americans pursue mental health services, a considerable and often crippling social stigma still exists surrounding mental health conditions. A national survey conducted in 2021 found that one in three Americans worry about how others perceive their mental health, and 21% of individuals have lied to avoid telling friends or family about their pursuit of mental health services (Lipson, Phillips, Winquist, Eisenberg, & Lattie, 2021).

Mental health in Africa is often surrounded by significant stigma and cultural misconceptions, as revealed by Moitra et al. (2023). It was highlighted in their research that in many communities, mental health conditions are not widely understood in medical terms; instead, they are frequently associated with spiritual or supernatural causes. It was shown in a study conducted in Ghana that individuals experiencing mental health challenges often turn to traditional healers, religious figures, or family elders rather than seeking help from mental health professionals (Kola et al., 2021). Furthermore, it has been indicated by research that most African countries have fewer than one psychiatrist per 100,000 people, reflecting a systemic underinvestment in mental health services (Moitra et al., 2023). As a result, access to formal care is severely restricted due to a combination of the limited availability of qualified mental health workers, social stigma, and poverty.

Nguyen, Kim, and Aronowitz (2024) revealed that open discussions about mental health are often discouraged by cultural values that emphasise family honour, emotional restraint, and collectivism. In India and China, for example, many people still rely on traditional medicine systems such as Ayurveda or Traditional Chinese Medicine, sometimes in place of psychiatric care (Balakrishnan, Ng, Kaur & Lee, 2022). Nguyen et al. (2024) also highlighted the important role that family plays in decision-making. This can either support or hinder an individual's treatment. Despite its advanced healthcare system, Japan still faces unique challenges where mental health is concerned, including a high suicide rate and a tendency toward silence and stigma in addressing depression and anxiety, particularly among men and working professionals (Nguyen et al., 2024).

Contrastingly, countries in Western Europe demonstrate a more progressive and open approach to mental health according to Patafio, Miller, Baldwin, Taylor and Hyder (2021). The United Kingdom, Germany, and the Netherlands are among the few countries that have successfully integrated mental health services into their public healthcare systems and regularly run awareness campaigns to reduce stigma (Koschorke, Oexle, Ouali, Cherian, Deepika, Mendonça & Kohrt, 2021). In these countries, mental health support is made accessible and funded through their national health insurance, which provides services such as counselling, therapy, and digital mental health tools (Patafio et al., 2021). However, disparities are still reported to exist. In parts of Eastern Europe, mental health conditions may still be associated with institutionalisation or weakness, and stigma persists, although awareness is gradually improving (Ahmed, Barnett, Greenburgh, Pemovska, Stefanidou, Lyons & Johnson, 2023).

2.3 Mental Healthcare in Low-Middle Income Countries

According to Naslund and Deng (2021), low- and middle-income countries, which make up 85% of the world's population, experience a considerable burden of disease and a high demand for mental health care, despite having fewer resources than wealthier nations. Freeman (2022) notes that, on average, domestic general government health expenditure in these countries accounts for only 1.1% of the total national expenditure. Most of this funding is allocated to psychiatric facilities. Additionally, Freeman (2022) states that 70% of African countries and 50% of Southeast Asian countries spend less than 1% of their health budgets on mental health care.

Krendl and Pescosolido (2020) revealed that stigma and cultural adaptability, along with sparse, centralised mental health facilities, make it challenging to ensure mental health care in these countries. Krendl and Pescosolido (2020) suggest that locally led research is crucial for addressing this issue and developing effective service provision models in areas with limited financial resources. While it is crucial to ensure access to mental health care, untreated mental health issues can lead to suicide, which is a significant cause of death among young people (WHO, 2022). Similarly, recognising how people view mental health care when they are seeking or contemplating it is crucial. To enhance the likelihood of seeking help in low- and middle-income nations, the WHO suggests exploring the relationship between users and the services, policies, and practices available to them (Krendl & Pescosolido, 2020). An important aspect of the mental health programmes is focusing on the crucial areas of awareness, anti-stigma campaigns and human rights protection.

2.4 Mental Health Within the Sub-Saharan Region

Mental health disorders have been among the top ten contributors to the global burden of disease since the 1990s, showing no signs of decline (Mabrouk, Mbithi, Chongwo, Too, Sarki, Namuguzi, & Abubakar, 2022). Statistics indicate that in 2019, 970 million people worldwide received a mental health diagnosis (Kumar & Nayar, 2021). In 2020, due to the COVID-19 pandemic, this number increased significantly. Approximately 10% of people with mental health conditions reside in the Sub-Saharan region, where misconceptions and stigma surrounding mental health conditions complicate the already complex process of seeking help (Mabrouk et al., 2022). The COVID-19 pandemic has greatly influenced mental health in Southern Africa, intensifying existing challenges. Trauma, conflict, and poverty have been identified as critical contributors to these issues.

Research by Semo and Frissa (2020) shows that there is an increase in the prevalence of mental health issues. Lewis et al. (2021) reported that there has been a significant increase in conditions such as anxiety, depression, and post-traumatic stress disorder (PTSD). Nguse and Wassenaar (2021) revealed that individuals who already had mental health conditions experienced heightened symptoms of anxiety and depression due to factors such as lockdowns, social isolation, and financial strain. Among vulnerable populations, the pandemic itself triggered trauma-related reactions. Additionally, it caused disruptions in healthcare access, as the lockdowns and a lack of healthcare resources seriously impeded access to vital mental health therapies. With many patients being stopped from seeking treatment or continuing it because of shortages in medications, transportation issues and fear of getting the virus at medical institutions (Waumans et al., 2022).

People and cultures have different explanations for mental health conditions and their causes. Research carried out in three African nations, Burundi, South Sudan, and the Democratic Republic of Congo, uncovered a diverse range of identified factors contributing to mental health problems in each area. These causes ranged from supernatural beliefs to psychosocial factors and physical or biological explanations (Waumans et al., 2022). Adepoju (2020) emphasised that worries, loss, environmental influences, and supernatural factors were considered root causes of locally identified mental health conditions in these African contexts. Kleinman's explanatory models suggest that different cultures have distinct health belief systems that outline the causes of illness, its progression, and available treatment methods. These models also identify the individuals who should be involved in the treatment process. The model defines a somatic illness network as a set of symbols and experiences that typically

co-occur among individuals within a society (Kleinman, 1962; Creed, 2023). Adepoju (2020) suggests that mental health is defined by diverse societal perspectives, making the concept of being mentally healthy and the interventions socially constructed. Furthermore, effectively addressing the complex spectrum of mental health conditions requires the use of culturally appropriate care methods (Creed, 2023). Considering regional cultural practices and beliefs is a primary objective of culturally sensitive mental health care (Adepoju, 2020).

The majority of the research conducted in African communities found that people usually turn to traditional and religious healers for help, as mental health conditions are considered to be supernatural or said to be God's will. Formal therapy is typically regarded as a last resort (Semo & Frissa, 2020). According to reports, stigma and prejudice, traditional beliefs, understanding how to get treatment, perceptions of the adverse effects of antipsychotic medication and awareness of mental health conditions all have an impact on formal mental health-seeking behaviour (Thompkins, Goldblum, Hansell, Barclay & Brown, 2020). Like other African cultures, the people of Zanzibar seek out alternative therapies (such as traditional and spiritual healers) for mental conditions before turning to Western treatments when the patients' conditions worsen. The delay in receiving professional help may harm patients, their families, the community, and the healthcare system (Thompkins et al., 2020).

2.5 Mental Healthcare in South Africa

Many individuals in South Africa struggle with mental health conditions. This problem comes from several reasons, such as a history of social and political unrest, poverty, unemployment, substance abuse, HIV/AIDS, and childhood trauma. The country is facing high levels of trauma, including abuse and violence. These experiences can lead to mental health problems. Craig et al. (2022) highlight these issues. A study by the Institute for Health Metrics and Evaluation shows that about one in eight people around the world has a mental health condition, with anxiety and depression being the most common (IHME, 2022).

Many individuals with mental health conditions do not get the treatment they need, even though these conditions are common and can greatly affect their lives (Craig et al., 2022). Craig et al. (2022) revealed that approximately 75% of individuals in South Africa who experience common mental health issues, like anxiety, depression or substance abuse problems, do not pursue treatment. Hlongwa and Sibiya (2019) highlighted that individuals receiving treatment often do not stay in care. They also struggle to consistently access good services and effective therapies. The estimate of the treatment gap rises to 92 % when persons with severe mental

health conditions are included (Docrat, Besada, Cleary, Daviaud & Lund, 2019). Docrat et al (2019) emphasised that fewer than one in ten South Africans with a mental health issue gets the care they need. South Africa's socio-political history influences the mental health care system and should be considered when describing services at various levels (Morar, Breedt, Mdaka, Maaroganye & Robertson, 2024). According to Morar et al. (2024), the public-private model, mental health services in non-health sectors, public-sector funding, neglect of specialisation, and the lack of specialist mental health providers are prominent features. To address these issues, risk-sharing models in mental healthcare need to be implemented (Sorsdahl et al., 2023).

South Africa has taken steps to improve mental health services through a public health approach. This began with the revision of the Mental Health Care Act (17 of 2002) to place greater emphasis on patient rights. Next, the National Mental Health Policy Framework and Strategic Plan (2013-2020) was developed to include mental health care into primary health care, following the WHO guidelines to address the consequences of untreated mental health conditions (Temane, Manamela & Poggenpoel, 2022). However, there is limited evidence that this policy has been successfully implemented, especially regarding service integration. A tragic incident occurred in 2017 when nearly 150 individuals with mental health issues died after being moved from Life Esidimeni Hospital to unauthorised facilities (Temane et al., 2022).

In the 2016/17 fiscal year, only about 5% of the health budget was allocated to mental health. This totalled approximately USD 615.3 million (Sorsdahl et al., 2023). This translates to USD13.3 per capita for the uninsured population. A huge portion (86%) of mental health care costs went to inpatient care, and half of that spending occurred in psychiatric hospitals (Klientjies & Schneider, 2023), with most admissions being for severe mental health issues. Approximately 8% of the budget allocated for mental health is directed towards primary care. This includes minimising hospital referrals for individuals with severe mental health conditions to clinics and community health centres, along with the expenses related to medications. The great bulk of primary mental health expenditure, like inpatient care, is spent on treatment for persons with severe mental issues. As a result, despite the great frequency of common mental health issues, little money is spent on persons suffering from them. Furthermore, considering the high percentage of the health budget allocated to inpatient care, remarkably little is spent on prevention and promotion (Klientjies & Schneider, 2023).

2.6 Mental Health Care in South African Rural Communities

Rural health has not been a focal point in health research (Nguse & Wassenaar, 2024). Nonetheless, interest in this area has risen in recent years, as rural health was previously considered a vague concept centred on medical care in non-urban settings. It is now gaining greater recognition and comprehension (Shisana, Stein, Zungu & Wolvaardt, 2024).

In South Africa, rural health is perceived to address issues of poverty and unfairness. Hence, it incorporates a substantial component of social justice, social responsibility, and advocacy, in addition to the conventional technical aspects of geography and distance (Van Rensburg, 2021). However, there is no uniform definition of rurality in South Africa and diverse stakeholders define it using a range of criteria, or not at all (Palomin, Takishima-Lacasa, Selby-Nelson & Mercado, 2023). The lack of clear information has made mental health care even more difficult to access. The 2015 South African Rural Mental Health Campaign Report describes the situation as 'dehumanising.' Research shows that rural areas, which make up nearly half of the country's population, are the most neglected and marginalised (StatsSA, 2015).

Mental health and psychosocial support services are not evenly distributed between urban and rural areas in South Africa. According to Van Rensburg (2021), there are 3.6 times as many psychiatrists in or near the largest city as in the national average. The number of mental health nurses in these areas is poorly documented, according to Van Rensburg's findings. The Mental Health Care Act, recognised internationally and focusing on rights, aims to improve local access to mental health care. However, it faces challenges, especially in rural regions (Benjamin et al., 2021).

It is important to understand how a shortage of human resources affects mental health services in South Africa. The state sector has only 0,31 psychiatrists per 100,000 people, with a significant difference between rural and urban areas (Temane et al., 2022). In some rural provinces, there are only 0.08 psychiatrists per 100,000 people. Only three out of nine provinces have child psychiatrists in the state sector, showing a critical shortage of specialists for children. Around 50% of state hospitals that provide psychiatric care lack a psychiatrist, and 30% lack a clinical psychologist (Nguse & Wassennar, 2020).

Kemp, Mntambo, Weiner, Grant, Rao, Bhana, and Petersen (2021) found that implementing primary mental health care in rural South Africa has proven highly challenging. One major issue is that mental health care users often bypass established screening and referral channels. Personnel shortages and inadequate patient care have led to the use of physical or

pharmacological restraints (Van Rensburg, 2021). Additionally, nurses have limited interactions with patients and face high turnover in community settings. The analysis reveals a concerning shortage of mental health professionals in rural areas (Pillay, Pienaar, Barron & Zondi, 2021). Only 62 out of 160 facilities have mental health nurses, totalling just 116 nurses (MacLean & Wetherall, 2021). Furthermore, these nurses are responsible for the care of approximately 17 million people, resulting in a low ratio of 0.68 mental health nurses per 100,000 individuals in rural South Africa (Pillay et al., 2021).

Pillay et al. (2021) indicate that research on mental health care in rural South Africa is scarce due to the complicated pathways to accessing care, which can involve both conventional Western medicine and traditional informal medicine. According to Inouye (2023), almost half of individuals in rural regions report minimal or no interactions with formal healthcare services. This highlights the crucial role of informal care providers in these settings (Inouye, 2023). It also implies that interventions that extend beyond formal health services, such as self-help and peer support, are essential in these communities. Even where rural mental health services are integrated into policy plans, access barriers persist (transport, limited staffing, stigma), reflecting a contradiction between stated objectives and observed realities in service utilisation (Pillay et al., 2021).

Mboweni, Mphasha, and Skaal (2024) studied Matsafeni Village in Mbombela, Mpumalanga Province. Their research showed that family and community support play a key role in the well-being of people with mental health conditions. Participants highlighted the importance of emotional, physical, and practical support from family, neighbours, and other community members. These support systems are important not just for comfort but also for recovery and daily management of mental health issues. MacLean and Wetherall (2021) noted that in rural areas, informal support systems are a vital lifeline and recommend a focus on community-based approaches. Taking part in community events helps people feel they belong and improves the mental well-being of those with mental health challenges (Mboweni et al., 2024).

Mboweni et al. (2024) found that individuals actively involved in community social and cultural practices had better coping mechanisms and greater community acceptance. This finding underscores the importance of creating inclusive environments that integrate people with mental health challenges into everyday communal life.

Atwoli et al. (2022) propose a transition from pacifying care to activating care, which encompasses a broader perspective that extends beyond healthcare. They contend that the

support offered to those with mental health challenges should focus on prevention and the enhancement of mental well-being. A diverse and all-encompassing strategy is considered the most appropriate (MacLean & Wetherall, 2021). This method incorporates a blend of scientific medicine, community-oriented strategies, traditional health practitioners, and organisations outside the traditional healthcare framework, such as religious groups, NGOs, families, and the broader community (Atwoli et al., 2022). Furthermore, traditional healers are acknowledged as important contributors who can significantly impact the nation's mental health care system (Thani & Louw, 2021).

Despite progressive mental health policies, implementation in rural areas remains uneven, with resource shortages and reliance on non-specialist providers (Atwoli et al., 2022). Existing literature often assumes that biomedical service utilisation is the benchmark for help-seeking. However, cultural explanatory models (e.g., supernatural or traditional beliefs) significantly shape local interpretations of mental distress and preferred pathways to care, something that quantitative surveys alone rarely capture (Thani & Louw, 2021).

2.7 Use of Telehealth and Digital Tools for Rural Mental Health Support

Rural communities face challenges in accessing mental health services due to geographic isolation, a lack of healthcare providers, and poor infrastructure (Watanabe, 2023). This often leads to individuals not receiving timely care, creating a significant treatment gap. Telehealth and digital tools offer promising solutions to improve access to mental health support in these areas (Nelson, Inghels, Kenny, Skinner, McCranor, Wyatt, Phull, Nanyonjo, Yusuff & Gussy, 2023). According to Nelson et al. (2023), telehealth, which encompasses online video consultations, telephone support, messaging platforms, and mobile apps, has the potential to overcome traditional barriers to care by delivering services to individuals in their homes or local communities. In parts of Sub-Saharan Africa and rural Australia, mobile-based mental health interventions have enabled communities to engage with professionals and receive guidance without incurring travel costs or long waiting times (Watanabe, 2023). This suggests that telehealth programmes have the potential to improve access to and continuity of care in rural areas. As the world becomes increasingly digital, the incorporation of telehealth into rural mental health strategies offers a vital path toward equitable and scalable support systems (Baumans, Fiedler, Wunsch, Woll & Wollesen, 2022).

According to Brower (2021), one of the significant advantages of telehealth and digital tools is their ability to provide convenient yet effective care, often matching or surpassing traditional

face-to-face interventions in terms of outcomes and user satisfaction. Recent studies suggest that cognitive behavioural therapy delivered online, referred to as iCBT, along with mobile counselling services and mental health applications, can notably reduce the symptoms of depression, anxiety, and stress (Brower, 2021).

Baumans et al. (2022) reported that, due to the privacy these telehealth platforms offer, they have become preferable for many, especially in small, tight-knit communities where stigma remains high and anonymity is valued. Barrow and Thomas (2022) highlighted that digital mental health services have been associated with higher treatment adherence in some rural populations, partly because they allow individuals to engage with therapy on their own terms and schedules.

The implementation of digital mental health tools in rural areas suggests challenges, despite promising developments (Watanabe, 2023). The digital divide is identified as the most significant barrier; this term refers to the unequal access to reliable internet connectivity and digital devices (Steinman, Heang, van Pelt, Ide, Cui, Rao, LoGerfo & Fitzpatrick, 2020). Many rural areas, especially in low- and middle-income countries, still lack the infrastructure needed for high-quality video conferencing or real-time data sharing. Even in high-income settings, broadband speeds in rural areas often lag those in urban counterparts, and not all residents have smartphones or computers capable of running telehealth applications. Additionally, digital literacy is another critical issue (Steinman et al., 2020). Older adults, individuals with lower levels of education, or those unfamiliar with technology may struggle to navigate digital platforms, leading to frustration or abandonment of services. Additionally, the lack of training in telehealth delivery, coupled with limited funding, poses a challenge for healthcare providers in rural areas. Basile et al. (2024) emphasise the importance of coupling technological innovation with broader capacity-building efforts to ensure that telehealth truly enhances access to health, rather than exacerbating existing disparities. Looking forward, the successful integration of telehealth and digital tools into rural mental health care will require more than just technological solutions; it will demand thoughtful planning, sustainable funding, and inclusive policies (Baumans et al., 2022).

Basile et al. (2024) highlight that, in rural mental health care in the South African context, it remains deeply fragmented and under-resourced, with digital tools emerging as a potential lifeline for communities historically excluded from formal psychiatric services. Mindu (2023) highlighted that outside of urban areas, the public mental health system, which is already

understaffed and geographically dispersed, provides few specialised services. In the rural provinces such as Limpopo, Eastern Cape, and Mpumalanga, enormous inequities can be identified, with many communities missing even basic mental health clinics. Telepsychiatry and mobile health (mHealth) projects have gained traction in these situations as low-cost, scalable options (Mindu, 2023). Lagarde (2024) revealed that during the COVID-19 epidemic, the need to innovate prompted the implementation of WhatsApp-based counselling services and telephonic support lines, such as those offered by the South African Depression and Anxiety Group. These platforms aimed to bridge important gaps by offering rural users accessible emotional support and referral services, frequently in their own language, without the need to travel to urban hospitals (Lagarde, 2024).

Even with these advancements, several obstacles remain before digital mental health technologies can be successfully utilised in rural South Africa. The nation's digital infrastructure gap is one of the most pressing problems; rural families have significantly lower rates of smartphone ownership, internet connectivity, and digital literacy than their urban counterparts (Lagarde, 2024). In 2022, less than 10% of rural households in some provinces had access to stable internet, making video-based telepsychiatry impractical (Morris, 2022). Furthermore, electricity load-shedding and network instability frequently interrupt services, adding another layer of difficulty (Mindu, 2022). Language and cultural relevance remain significant considerations. Most digital mental health tools are written in English or urban dialects, failing to capture the linguistic diversity and cultural worldviews seen in rural regions (Blocker, 2024). This gap underscores the need for culturally appropriate, multilingual platforms co-designed with local stakeholders and community health providers who understand the complex mental health needs and beliefs of rural communities (Blocker, 2024).

Nevertheless, the potential for telehealth to reshape rural mental health care in South Africa is significant, particularly if integrated into existing community-based care models (Blocker, 2024). Task-sharing approaches involve lay health workers and community health workers offering basic mental health services. These methods have already shown success in HIV and maternal health programs in rural South Africa. By equipping these frontline workers with digital tools, such as mental health screening apps, referral algorithms, and mobile counselling platforms, they could serve as a bridge between underserved rural communities and overstretched mental health professionals (Atewologun, 2025). Pilot programmes in KwaZulu-Natal and the Eastern Cape have demonstrated that when digital tools are combined with human support, they enhance early detection, reduce stigma, and increase follow-up

engagement (Morris, 2022). Atewologun (2025) notes that telehealth has the potential to become a long-term component of South Africa's rural mental health care system, provided it is supported by the correct funding, infrastructure, and training, thereby promoting resilience, equity, and culturally sensitive treatment.

2.8 The Role of Informal and Traditional Sources in Rural Mental Health

Ndetei, Mutiso, Musyimi, and Nyamai (2021) argue that family members, community leaders, religious leaders, and traditional healers are important informal and traditional support sources that serve as entry points for mental health care in many rural areas worldwide. Structurally, rural areas often lack accessible psychiatric services, meaning that formal care systems are frequently unavailable, distant, or costly. For instance, in parts of Zambia, up to 70–80% of people with mental health issues consult traditional healers before seeking conventional treatment (Lynch, Moorhead, Long & Hawthorne-Steele, 2023). Similarly, in several African nations, traditional and religious healers are often the first port of call; many individuals' help-seeking pathways involve multiple providers, including traditional, faith-based, and biomedical, either consecutively or simultaneously (Ndetei et al., 2021).

These informal networks fill key gaps in mental health care by providing culturally appropriate explanations, prompt responses, and emotionally meaningful interactions, which formal programmes often lack (Szota et al., 2024). The substantial presence and legitimacy of traditional healers in rural communities are grounded in profound cultural alignment and social trust (Lynch et al., 2023). In South Africa, approximately 60% of the population consults traditional healers, many of whom employ a combination of herbal treatments, spiritual insights, and ritual activities to manage mental and emotional difficulties (Bila & Carbonatto, 2022). In Nigeria, the presence of traditional healers, approximately one per five hundred population, compared to one medical doctor per 40,000, makes them more accessible and affordable than formal practitioners (Anjorin & Wada, 2022). In addition to medicinal herbs and prayers, they provide easily accessible, culturally grounded care that often includes counselling, family reconciliation and group rituals (Anjorin & Wada, 2022). Due to these qualities, traditional healers are essential, especially for rural populations who may not be well-educated or knowledgeable about biological psychiatry, or for whom formal services seem stigmatising or foreign (Anjorin & Wada, 2022).

Berhe, Gesesew, and Ward (2024) note that the preference for informal sources among people in rural areas is primarily due to trust and alignment with explanations. While up to 40% of

biomedical consultations in Zimbabwe do not explain the ailment, over 90% of traditional healer consultations for common mental health conditions include a spiritual explanation (Williams, Baldeh, Bah, Dennis, Robinson & Adeniyi, 2025). This distinction is significant because traditional healers provide narrative coherence, helping address existential concerns about illness in ways that formal systems often overlook. However, many people's paths to obtaining help are multifaceted; patients may simultaneously subscribe to explanations that combine spiritual and biological causation (Anjorin & Wada, 2022). Thus, seeing contemporary medicine as an adjunct to, rather than a replacement for, conventional methods (Berhe et al., 2024). This pragmatism emphasises the necessity for complex, integrated mental health pathways that respect explanatory variety, considering both cultural adaptability and the constraints of available resources (Williams et al., 2025).

However, depending on conventional and informal sources of assistance is not without its complications. Due to their low mental health literacy, many traditional healers in rural Africa may misdiagnose conditions or use dangerous techniques (Berhe et al.,2024). There are even concerning reports of human rights violations occurring during traditional treatments, such as physical restraint or neglect, particularly when communities lack mental health legislation or oversight (Komu et al., 2025). Moreover, patients may delay accessing formal care if their initial encounters with healers reinforce the notion of spiritual causation or discourage them from seeking biomedical referrals. According to research conducted in Malawi, patients referred by traditional healers were more likely to have delays in psychosis treatment, sometimes reaching six months, compared to those recommended by conventional practitioners (Berhe, Gesesew & Ward, 2024). These findings underscore the need to integrate informal and formal care systems through respectful, collaborative frameworks.

Scholars and practitioners are increasingly calling for traditional healers and formal health specialists to collaborate (Williams, Baldeh, Bah, Dennis, Robinson, & Adeniyi, 2025). Traditional healers, according to South African specialists, could play a key role in treating distress and mild mental diseases if they are integrated into more complete treatment models. They may offer informal counselling and assistance, while referring more serious instances to medical physicians (Sequeira, Singh, Fernandes, Gaikwad, Gupta, Chibanda, & Nadkarni, 2022). The need for formal systems in long-term recordkeeping, capacity building, and referral protocols that include traditional healers in mental health interventions is emphasised in policy-oriented reviews from Nigeria (Anjorin & Wada, 2022). Despite ongoing trust difficulties in Uganda, traditional healers indicate that they are eager to collaborate if mutual legitimacy and

value are established and referral mechanisms are made explicit (Komu et al.,2025). A successful collaboration could enhance patient outcomes, eliminate risky practices and increase diagnostic accuracy while leveraging the accessibility and cultural resonance of traditional healers. These integrated models should also include referral mechanisms, biological specialists providing supportive monitoring and healers receiving basic mental health literacy training.

2.9 Social and Economic Impacts of Mental Health

Mental health conditions significantly affect one's ability to function in their daily lives, resulting in long-term social and economic consequences. Individuals with mental health conditions may face negative impacts on their social relationships, educational opportunities, and employment prospects (Braghieri, Levy & Makarin, 2022). For children and adolescents with untreated mental health issues, academic challenges can lead to early school dropout, reduced lifetime earnings, and a greater reliance on social support systems. Many adults with mental health issues like bipolar disorder, depression, or anxiety struggle at work. They often lose productivity and miss more workdays (Shim, 2021). The World Health Organisation (2022) states that depression is the top cause of disability around the world. People with severe mental illnesses can live 10-20 years less than others, often due to preventable health problems.

Furthermore, the impacts of mental health conditions on society manifest in areas such as family breakdown, homelessness, and incarceration (Lu & Lin, 2021). According to research, a considerable proportion of persons who are homeless or incarcerated have underlying mental health concerns that are neglected (Shim, 2021). Prisons have become de facto mental health facilities in many countries, not because of inadequate care, but because of institutional deficiencies in addressing mental health conditions in the broader population (Shim, 2021). Because social stigma isolates people and inhibits them from seeking care, it exacerbates the effects. Further marginalisation occurs, increasing the likelihood of violence, discrimination and social isolation (Arias, Saxen & Verguet, 2022).

2.10 The Role of Gender, Education and Age in Mental Health-Seeking Behaviours

Numerous studies have demonstrated that women are more likely than men to seek help for psychological distress, indicating that gender significantly influences the behaviours of those who seek mental health help (Tijimuine, 2023). Socialisation, gender norms and variations in the perception and expression of emotional vulnerability all contribute to this discrepancy. In general, women are more willing to talk about emotional problems, more likely to identify

signs of mental health conditions, and more likely to look for support from both formal (mental health experts) and informal (friends, family) sources (Khatib, Alyafei & Shaikh, 2023). These behaviours are influenced by social norms that permit, or even promote, women's emotional expressiveness, which, in turn, increases the social acceptability of asking for help (Khatib, Alyafei & Shaikh, 2023).

Males, on the other hand, frequently face significant barriers to accessing mental health care, many of which come from traditional masculinity ideals. In many cultures, seeking help is viewed as a sign of weakness or failure, as men are expected to be self-sufficient, stoic and emotionally regulated (Mohan, Jawahir, Manual, Abdul Mutalib, Mohd Noh, Ab Rah & Amer Nordin, 2025). Men may so underreport symptoms, postpone seeking care, or altogether avoid it, even in circumstances of severe psychological distress. Men are less likely to seek help, yet they have higher rates of substance abuse and suicide (Mohan et al., 2025). This propensity adds to the quiet tragedy. The mismatch between need and behaviour is particularly evident among younger and middle-aged men, for whom mental health struggles may be masked by anger, irritability, or risky behaviour rather than more "typical" symptoms like sadness or anxiety (Tijimuine, 2023). Younger and middle-aged males are especially affected by this mismatch between need and behaviour, since their mental health issues may be concealed by risky behaviour, aggression, or irritability instead of more "typical" emotions like melancholy or anxiety (Tijimuine, 2023).

Gender and structural barriers also interact in intricate ways. Even though women are more likely to seek assistance, they may still face gender-specific barriers, such as medical professionals discounting their worries, over-pathologising emotional reactions, or neglecting to take into consideration problems like reproductive health or gender-based violence (Tijimuine, 2023).

One of the strongest social factors influencing health is education, which significantly impacts individuals' views, understanding, and responses to mental health issues. Higher education is positively correlated with a higher likelihood of obtaining mental health treatment, according to numerous studies (Husain & Riasat, 2022). Education enhances mental health literacy, which encompasses one's ability to recognise mental health symptoms in others and oneself, as well as knowledge of available treatment options (Odufuwa, Olaniyan, & Okuonzi, 2022). Additionally, education enhances critical thinking and self-efficacy, two qualities that are

crucial for receiving the proper care, as they enable individuals to advocate for themselves and navigate health systems (Tijimuine, 2023).

One of the primary ways that education influences people's decision to seek help is through mental health literacy, which refers to a person's understanding and beliefs about mental disorders that support their identification, treatment and prevention. According to Khatib et al. (2023), persons with lower levels of education are frequently less educated about mental health terminology, more likely to normalise or misattribute symptoms and less sure where or how to seek therapy. For example, they may regard chronic sadness as "just stress" or believe that anxiety is a regular part of life rather than a medically curable condition. As a result, they may postpone seeking treatment or only do so when their symptoms become unbearable. Conversely, those with greater levels of education are more likely to recognise behavioural or emotional symptoms as signs of a mental health problem and seek early professional assistance (Khatib et al., 2023).

Stigma and cultural stereotypes may be more deeply embedded in persons with lower levels of education as well. In some communities, mental health conditions are seen as divine retribution, moral weakness, or even witchcraft (Tesfaye, Agenagnew, Anand, Tucho, Birhanu, Ahmed, Getnet & Yitbarek, 2021). People with less formal education may be more likely to depend on spiritual or traditional explanations, leading them to seek assistance from traditional healers or religious leaders instead of mental health professionals (Tesfaye et al., 2021). Although this is not always a terrible thing, it can delay evidence-based treatment if it is not integrated into the formal healthcare system. In this case, education aids decision-making by connecting cultural belief systems to biological understandings of mental health (Gabrani, Schindler & Wyss, 2021).

Educational attainment has an influence on how one accesses healthcare as well as their socio-economic status (Gabrani et al., 2021). According to Khatib et al. (2023), a lower level of education is typically associated with lower income, unstable employment and limited access to affordable care or health insurance, all of which serve as real-world barriers to seeking help. Even when those with less education seek help, they may face logistical challenges, such as transportation concerns, the inability to take time off work, or anxiety about high medical expenses (Odufuwa, Olaniyan & Okuonzi, 2022). People with higher levels of education, on the other hand, are often in a better socioeconomic position to navigate complex healthcare systems or receive care through employer-sponsored health insurance. This creates a cyclical

disadvantage in which individuals who are most in need of mental health support are the least prepared, both cognitively and materially, to obtain it (Gabrani et al., 2021).

On a social level, people with higher average levels of education are more likely to seek public mental health services, advocate for mental health more vigorously, and have more progressive views about mental health (Gabrani et al., 2021). This can significantly affect financial distribution, national policies, and the integration of mental health into primary care. Therefore, boosting health literacy, increasing access to treatments, decreasing stigma, and funding public education are all necessary long-term mental health strategies to address school-related inequities in mental health-seeking behaviour (Khatib et al., 2023).

Age also plays a key role in how people seek mental health care, and various age groups exhibit quite distinct help-seeking behaviours. Despite experiencing significant levels of psychological distress, younger people, particularly teenagers and young adults, are less likely to seek formal treatment for mental health issues (Mahajan, Meyer & Neiterman, 2022). On the other hand, stigma, generational views, or the tendency to blame issues on ageing may cause older people to postpone seeking care. Every age group has unique structural, social and psychological factors that influence their perceptions of mental health conditions and willingness or ability to seek therapy. Understanding these age-related changes is crucial for developing effective, age-sensitive mental health therapies (Sojli, Tham, Bryant & McAleer, 2021).

Mental health issues are common among teenagers and young adults, yet they frequently go untreated (Sojli et al., 2021). The World Health Organisation (2021) revealed that half of all mental health issues begin before the age of fourteen, yet the majority are not diagnosed or treated until later. Young people frequently face stigma, fear of judgment, a lack of faith in adults or health-care systems and a poor awareness of their own mental health (Botha & Schoeman, 2023). Furthermore, many depend on peer networks or social media, where disinformation and the trivialization of mental health might prevent real help-seeking. (Mahajan, Meyer & Neiterman, 2022). Youth may also have limited access to confidential, youth-friendly resources or think that adults would dismiss their concerns. As a result, even if their symptoms are severe, people may delay or avoid seeking professional help (Botha & Schoeman, 2023).

Focus groups with university students and counsellors in countries with low to middle incomes, such as Ukraine, have identified several systemic obstacles that hinder students from accessing mental health care. These obstacles include a lack of facilities, inconvenient locations, time

constraints, financial barriers, insufficient interpersonal skills, and a lack of confidentiality (Naslund & Deng, 2021). Conversely, middle-aged individuals, typically aged 30 to 60, are more likely than teenagers to seek assistance, particularly if they have steady employment, health insurance, or greater life experience navigating healthcare systems (Botha & Schoeman, 2023). However, there are differences based on financial level, gender, culture and education, even within this group. Adults may also experience pressures, including financial strain, caregiving obligations, or work pressure, which can make it more challenging to seek help and raise the risk of mental health problems (Wilson, Lee & Shook, 2021). According to Wilson et al. (2021), this group occasionally prioritises the welfare of others over their own, postponing care until symptoms significantly impair day-to-day functioning.

Where mental healthcare is concerned, older people (60+) have a particular set of challenges. Many elderly persons suffer from mental health issues such as depression, anxiety and cognitive impairments, which are typically caused by physical illness, loss of independence, loneliness, or bereavement (Jadav & Bal, 2022). However, mental health services are frequently underutilised by this demographic. Generations commonly view mental health conditions as a sign of weakness or something to be accepted in quiet (Thomas, Erving, Hargrove & Satcher, 2022). Furthermore, patients and physicians may misdiagnose symptoms as age-related phenomena, such as fatigue, memory loss, or irritability. Poor computer literacy (for telehealth), a lack of transportation and mobility issues all contribute to this population's limited access to care (Bruine de Bruin, 2021).

Lastly, help-seeking behaviours are also influenced by intergenerational disparities in mental health literacy and attitudes. Particularly through social media and schools, younger generations are typically more exposed to advocacy initiatives, candid discussions and mental health education (Bruine de Bruin, 2021). As a result of this exposure, stigma decreases and willingness to ask for help increases. However, it is possible that older generations were raised in settings that stigmatised mental health conditions or viewed them as a moral failing. Without focused outreach and culturally competent interventions, it may be challenging to dispel these firmly held ideas (Jadav & Bal, 2022).

2.11 Barriers to Seeking Mental Health Care

Many people delay or avoid seeking professional care, especially in low- and middle-income countries (LMICs), despite the increasing prevalence of mental health conditions worldwide (Muhorakeye & Biracyaza, 2021). Research consistently shows that most individuals with common mental health issues, such as depression or anxiety, do not pursue formal treatment. When they do seek help, it is often after a significant delay (Muhorakeye & Biracyaza, 2021). These behaviours are not merely personal choices; they are heavily influenced by factors such as service availability, levels of awareness, stigma, affordability, and societal norms regarding mental health and psychosocial support (Drew & Martin, 2021).

A significant difference exists in mental health-seeking behaviour based on geographic and economic access to care. In many regions, particularly in rural or underserved areas, mental health services are either limited or absent (Hellstrom & Beckman, 2021). Where services do exist, individuals often encounter long travel distances, a lack of transportation, or high out-of-pocket costs, all of which discourage them from seeking help (Drew & Martin, 2021). Over 75% of individuals with mental illnesses in low- and middle-income countries do not receive any treatment, partly because services are overly centralised or prohibitively expensive. Consequently, many people turn to informal or traditional healers, spiritual leaders, or family members for support, often delaying professional care until their symptoms worsen or reach a crisis point.

Stigma and cultural attitudes significantly influence whether and where people seek care. Many cultures see mental health issues as moral failing, spiritual punishment, or human weakness (Tambling, D'Aniello & Russell, 2023). As a result, people may become emotionally ashamed (self-stigma) or fear social rejection (public stigma), making it difficult for them to confess their symptoms or seek care. In some cultures, people may refrain from seeking help to protect their family's reputation or to avoid being labelled "crazy" (Thomeer, Moody & Yahirun, 2023). Even in affluent countries, people may hide their problems out of fear of workplace or medical facility prejudice (Randles & Finnegan, 2022).

Differences in mental health literacy and knowledge also impact help-seeking behaviour. People in certain groups might not identify their symptoms as indicators of a mental illness, particularly if their experiences differ from the way mental illness is depicted in the media or in public discourse (Muhorakeye & Biracyaza, 2021). Young people, members of minority groups and elderly adults are especially susceptible to misattributing symptoms to stress, age,

or spiritual factors (Thomeer, Moody & Yahirun, 2023). People who receive less mental health education are less likely to recognise or understand where to find the right kind of support. Additionally, the help-seeking gap can be widened by the absence of language- or culturally responsive services, which can make formal care seem irrelevant or inaccessible (Hellstrom & Beckman, 2021).

Lastly, differences become apparent in how people are managed once they request assistance. People occasionally encounter healthcare professionals who are condescending, undertrained, or ill-prepared to meet their individual needs (Wijeratne, Johnco, Draper, & Earl, 2021). For instance, LGBTQA+ people may encounter discriminatory attitudes within healthcare institutions and women who report trauma-related symptoms may be ignored or pathologised (Tambling, D'Aniello & Russell, 2023). These unfavourable encounters may cause people to lose faith in services and be less likely to ask for assistance in the future.

Carbonell, Navarro-Pérez, and Mestre (2020) conducted a World Health Organisation (WHO) assessment on barriers to accessing mental health treatment across twenty-four nations. The study included 12 high-income nations, 6 upper-middle-to-middle-income nations, and 6 low-middle-income nations. The evaluation revealed that stigma and a low perceived need for care were the most significant obstacles globally. Barriers to accessing financial resources and services were more significant in developing countries and in some higher-income nations. Most research on help-seeking behaviour has primarily focused on European and North American populations, particularly adolescents and young adults aged 13-25. Wijeratne, Johnco, Draper, and Earl (2021) point out that individuals in this age group encounter various attitudinal obstacles when it comes to seeking mental health care, including a sense of independence, societal stigma, and limited understanding of mental health, as well as potential financial limitations.

A study conducted in Australia on help-seeking behaviour among adolescents found that individuals experiencing suicidal thoughts or depressive symptoms reported greater psychological difficulty in seeking help. This implies that mental health conditions or symptoms may act as a barrier to obtaining care (Grove, Marinucci, & Montagni, 2023). Furthermore, research in the United Kingdom revealed that young adults often refrained from seeking professional help due to feelings of being unwell and lacking available support. Common attitudes contributing to this avoidance included stigma and insufficient mental health literacy. Participants frequently expressed sentiments such as, *"I want to solve the problem on*

my own," and *"I thought the problem would get better by itself,"* highlighting dominant barriers to seeking help. In low- and middle-income countries, there was a common desire for individuals to take charge of managing their own symptoms. (Waumans, Muntingh, Draisma, Balkom & Batelaan, 2022, pp. 4–8).

According to Naslund and Deng (2022), barriers to care are often attitudinal or psychological in nature. However, it is essential to note that, although this may be true, the conclusion has its limitations, as research in lower-income countries is limited. Structural barriers are common globally (Grove et al., 2023). For example, the Netherlands reported alarmingly high rates of dissatisfaction with mental health services and financial constraints on accessing specialised care. In America, young adults with mental health conditions have indicated that financial limitations affect their access to mental health care (Waumans et al., 2022). A lack of awareness about the affordable or charitable mental health services available has led to young people in the UK experiencing an attitude barrier that is as significant as their belief that mental health care is costly (Waumans et al., 2022).

A South African study emphasised that stigma and limited literacy regarding mental health care are the main barriers that hinder young people from accessing care (Omotoso, Gbadegesin, Adewole, & Adesimi, 2021). Stigma has been identified as a significant factor in social exclusion, resulting from a combination of various elements, including limited knowledge, negative attitudes, and exclusionary behaviour (Omotoso et al., 2021). When stigma is present, it can affect both societal and individual levels, contributing to a person's self-stigma. For young individuals residing with relatives, revealing their mental health condition does not necessarily ensure they will receive emotional or financial assistance (Mokwena & Ndlovu, 2021). Relatives may possess stigmatising views about mental health issues, which negatively affect their responses (Omotoso et al., 2021). Moreover, the stigma and discrimination faced by individuals with mental health conditions play a key role in increasing self-harm and suicide attempts within this group. Studies show that people who feel isolated from social and workplace interactions due to their mental health challenges are at a higher risk of suicidal behaviour (Temane & Manamela, 2020). The repercussions of stigma and discrimination are not only felt by those with mental disorders; they also affect their families and caregivers. The stigma related to mental health issues and the resulting discriminatory practices are often associated with more severe consequences than the mental health conditions themselves or the obstacles to recovery (Bantjes, Saal, Lochner, Roos, Auerbach, Mortier, & Stein, 2020).

Access to mental health care is hampered in South Africa by the complex interplay of social, economic and institutional factors. Providing care is challenging due to a shortage of social workers, psychologists, psychiatrists and other mental health specialists (Bantjes et al., 2020). The shortage is exacerbated by the concentration of these specialists in cities, which limits the essential services that rural communities can access (Charumbira, Berner & Louw, 2022). Financial limitations are also significant because state services are usually overburdened and understaffed and many South Africans cannot afford private mental health therapies (Docrat, 2020). Similarly, cultural stigma and ignorance about mental health led to underreporting and a reluctance to seek care. Many people still view mental health concerns as a sign of weakness or through a superstitious lens, which further discourages people from obtaining therapy (Mokwena & Ndlovu, 2021). Effective communication and comprehensive care can be impeded in several ways, making it another key factor. For example, linguistic obstacles and the poor integration of mental health services in primary healthcare settings. Together, these barriers create a setting where mental health needs are frequently unmet, which perpetuates the cycle of untreated mental health issues and has broader social and economic ramifications, according to Mokwena and Ndlovu (2021). The elements that can affect mental health care are then discussed.

2.12 Facilitators for Seeking Mental Health Care

While many barriers discourage individuals from seeking mental health and psychosocial support, various facilitators can positively influence help-seeking behaviour. These facilitators serve as enablers or motivators, encouraging individuals to recognise their mental health issues and seek the appropriate help (Al Sabei, Labrague & Ross, 2022). Policymakers, educators and mental health practitioners who want to increase service uptake and close the treatment gap must have a thorough understanding of these issues. Seeking help is rarely an act that occurs on its own; rather, it is often the result of a convergence of environmental support, social influence and personal insight (Goetz, Mushquash & Maranzan, 2023). Research is scarce regarding the factors that promote help-seeking for mental health care worldwide (Barrow & Thomas, 2022). Supportive social networks are vital in encouraging individuals to seek help for mental health issues. Friends, peers, family members, teachers, and religious leaders can all significantly influence someone to pursue mental health care, particularly if they express concern, provide support, or share their own positive experiences (Al Sabei et al., 2022). Encouragement from a trustworthy person can be a decisive factor in whether someone receives

treatment, as in many cultures, the acceptance or direction of others has a significant impact on individual actions (Goetz et al., 2023).

Al Sabei et al. (2022) argue that peer support groups and mental health advocacy movements are also effective in establishing secure, accepting environments that acknowledge emotional difficulties and encourage healing through shared experiences. Close family members and existing relationships with caregivers are examples of social support for younger individuals, whereas friends and significant others are examples of peer support for older folks (Ferris-Day, Hoare, Wilson, Minton & Donaldson, 2021). It is essential to note, however, that parental views toward official help-seeking may influence adult children's decisions to seek care or not (Barrow & Thomas, 2022).

Social support is valued more than official care in other cultures or communities. According to a study, Filipinos preferred getting unofficial mental health support from friends or their communities rather than going to a doctor (Naslund & Deng, 2021). The severity and intricacy of mental health symptoms determine whether individuals pursue formal care. At the same time, sociodemographic factors do not affect the decision to seek formal or informal support. In a review of mental health in the Philippines, the perceived seriousness of mental health issues emerged as the most significant reason for individuals to seek professional assistance (Bemme & Kirmayer, 2020). To promote mental health care utilisation, it is essential to understand the factors that contribute to this behaviour (Martinez, Co, Lau, & Brown, 2020).

Seeking assistance is also made easier by the favourable opinions of mental health services. People are more inclined to seek therapy if they believe it will be efficient, courteous, and private (Goetz, Mushquash, & Maranzan, 2023). Accessible and affordable services, such as free counselling in schools, employee assistance programmes, or digital therapy platforms, lower logistical and financial barriers. Additionally, culturally competent care that respects language, traditions and identity help individuals feel understood and safe (Martinez, Co, Lau & Brown, 2020). When people trust the healthcare system and believe it can meet their specific needs, they are more likely to engage with it. Individuals want to be able to trust mental health service providers, their professional expertise and the confidentiality of their information (Randles & Finnegan, 2022). Individuals who have also had a positive experience with healthcare professionals are more likely to seek help if needed, whether personally or through observation in others, which is a strong motivator. Seeing someone improve following treatment or medication can encourage others to seek help as well (Naslund & Deng, 2021).

By openly discussing their mental health challenges, public figures, influencers, and celebrities help to normalise the conversation and reduce the stigma around seeking treatment. People are particularly empowered to take the initial step when mental health advertising emphasises hope, healing, and resilience rather than only disease (Bemme & Kirmayer, 2020). Ultimately, creating environments that promote awareness, support, access, and trust is essential in encouraging individuals to seek the help they need, as revealed by a study conducted in the United States (Lui, Sagar-Oriaghli & Brown, 2022). A study conducted in Türkiye revealed that individuals' confidence in the effectiveness of existing mental health services and heightened trust in professionals encourage them to pursue help. This can aid in reducing feelings of scepticism towards practitioners and overcoming cultural obstacles that hinder discussing personal issues beyond the family. Consequently, it is essential for practitioners to consistently maintain principles such as confidentiality and ensuring patient satisfaction (Cebi & Demir, 2020).

In primary healthcare environments, general practitioners need to identify the signs of mental health issues and accurately refer patients to the appropriate mental health care services. A quantitative study in Malawi showed that individuals experiencing common mental health conditions visited primary healthcare facilities more frequently. By enhancing training on recognising symptoms and making referrals, patient mental health outcomes could be improved. Moreover, building a solid therapeutic relationship with a general practitioner can lead to more effective referrals to mental health services (Jumbe, Nyali, Simbeye, Zakeyu, Motshewa & Pulapa, 2022).

Another facilitator is mental health literacy. People are more likely to seek help when they are aware of the warning signs and symptoms of mental illness, know where to get care and know that therapy is accessible (Hlongwa & Sibiya, 2019). Social media, public awareness campaigns, classroom instruction and firsthand experiences can all help to develop this literacy. People who understand the difference between temporary stress and clinical mental disorders are better prepared to take appropriate action (Jumbe, Nyali, Simbeye, Zakeyu, Motshewa & Pulapa, 2022). Enhancing mental health literacy also addresses misinformation and diminishes internalised stigma, allowing individuals to feel less ashamed of seeking help and more empowered to do so (Sampaio, Goncalves & Sequira, 2022). Advancing mental health literacy throughout sectors of society, including governmental initiatives, stakeholders, healthcare practitioners, academic program developers, and the media, could motivate more individuals to educate themselves about mental health (Eigenhuis et al., 2021).

Kutcher et al. (2019) explored the impact of mental health literacy programs for youth in Malawi and Tanzania, marking the first initiative of its nature in Southern Africa. These awareness and mental health literacy programs yielded positive outcomes for the youth involved. While more research is needed to understand the effects of these short-term interventions, implementing contextually relevant strategies is the most effective and non-invasive way to promote conversations about mental health and its care. In South Africa, healthcare providers are implementing mental health therapies to enhance access to primary healthcare, particularly in rural areas (Hlongwa & Sibiya, 2019). According to Hlongwa and Sibiya (2019), interventions involving the community, along with mental health literacy training for community health workers, are enhancing the accessibility and cultural sensitivity of mental health care. Telemedicine and mobile health technologies are expanding access to mental health services, enabling individuals in rural areas to receive ongoing support and consultations without long-distance travel (Charumbira, Berner, & Louw, 2022). Additionally, non-governmental organisations and community-based programs are vital in diminishing stigma, increasing awareness, and offering local support for mental health concerns (Docrat, Besada, Cleary, Daviaud, & Lund, 2019). Educational programs aimed at improving mental health literacy and understanding are motivating individuals to pursue treatment, thereby creating a more normalised and friendly environment for mental health care. Collectively, these factors help bridge the gap in accessing mental health services and improve mental health in South Africa's rural communities (Mokwena & Ndlovu, 2021).

2.13 Summary

This chapter discussed the broader context of mental health and the pursuit of help, starting with the global perspective, where mental health conditions significantly contribute to the overall burden of disease and are often under-identified and inadequately treated, particularly in areas with scarce resources. The review emphasised that low- and middle-income countries (LMICs) face a significant treatment gap due to limited infrastructure, a shortage of healthcare workers, and ongoing stigma. This issue is especially severe in the sub-Saharan African region, where mental health systems are still not fully developed and community-level support is irregular. While mental health research in Sub-Saharan Africa has expanded, much of the literature remains descriptive, with limited integration of cultural context and lived experience. Variability in methodologies and study populations further constrains the ability to explain help-seeking behaviours beyond prevalence estimates. This gap highlights the need for context-

specific, explanatory research that integrates quantitative patterns and qualitative meaning-making, which the current study seeks to address.

In South Africa, the existing literature indicates a dual burden. While the country has progressive mental health policies, implementation is uneven, with rural provinces experiencing the most significant inequities in access. Rural communities face numerous structural barriers, including long distances to facilities, inadequate staffing, cultural biases, and limited awareness. These challenges shape mental health-seeking behaviours and reinforce reliance on non-formal pathways. In the South African context, research consistently identifies mental health service gaps, particularly in rural areas; however, fewer studies examine how individual beliefs, attitudes, and intentions interact with structural barriers to shape help-seeking behaviour. As a result, existing evidence often documents inequalities without sufficiently explaining how they are experienced at the community level. This study responds by examining these psychosocial factors within a rural setting, thereby extending national-level findings into a locally grounded analysis.

The chapter further highlighted the growing use of telehealth and digital tools as innovative strategies to extend mental health services to rural areas. Evidence suggests that digital platforms can improve access, reduce travel costs, and offer anonymity, though connectivity, digital literacy, and acceptability remain barriers to widespread adoption.

Informal and traditional sources of care, including family, community elders, religious leaders, and traditional healers, emerged as central actors in rural mental health-seeking. These sources are often the first point of contact due to cultural legitimacy, accessibility, and trust, though they may sometimes delay engagement with formal services.

The literature also demonstrated that sociodemographic factors such as gender, age, and education influence how individuals perceive mental health and navigate available resources. Women are generally more likely to seek help than men, while younger and less-educated individuals may face greater stigma or lack awareness of mental health services. Across the reviewed studies, barriers to seeking care included stigma, cultural misconceptions, financial constraints, geographical distance, and limited-service availability. Conversely, facilitators included social support, mental health literacy, positive attitudes toward treatment, and trust in service providers.

CHAPTER 3

THEORETICAL FRAMEWORK

3.1 Introduction

This chapter presents the theoretical frameworks that underpin the study. The elucidation of the theoretical framework provides an in-depth understanding of this study. The study is grounded in several theoretical frameworks, beginning with the Health Belief Model (HBM) developed by Rosenstock, Hochbaum, and Kegels in 1950. This is followed by the Social Cognitive Theory (SCT), introduced by Bandura in 1986, and, finally, the Theory of Planned Behaviour (TPB), proposed by Ajzen in 1985. The Theory of Planned Behaviour and HBM are crucial models for comprehending how people in rural areas seek help. The HBM model examines perceptions of sickness severity, susceptibility, advantages and obstacles. The Theory of Planned Behaviour model examines intention as a predictor of behaviour. It focuses on individuals' attitudes, subjective norms, and perceived behavioural control. In rural settings, social norms and community influence individuals' intentions to seek mental health support. The Social Cognitive Theory model emphasises the importance of contextual influences, self-efficacy and observational learning in forming these behaviours. These three theories offer an in-depth insight into the complex factors influencing the mental health-seeking behaviours of rural communities.

3.2 The Health Belief Model

The Health Belief Model (HBM) was developed in the 1950s by social psychologists G. Hochbaum, I. Rosenstock, and R. Kegels. This model serves as a theoretical framework for understanding and predicting health-related behaviours (Alyafei & Easton-Carr, 2024). It explains the reasons why people choose to engage in or avoid health-promoting behaviours, such as seeking medical care (Mukhtar, 2020). Initially, the model was developed to address the failure of a free tuberculosis health screening programme. Hochbaum and colleagues wanted to understand the factors influencing people’s decisions to screen for tuberculosis and explore ways to increase participation rates (Rosenstock, 1974; Ahmed, Ibrahim & Younis, 2024). The Health Belief Model suggests that one’s health behaviours are shaped by their perceptions of susceptibility, severity, benefits, and obstacles associated with a specific health issue, including the recommended changes in behaviour (Ahmed et al., 2024).

The traditional theoretical paradigm for health behaviour research has been applied in various health belief models (Basile, Newton-John & Wootton, 2024). These models generally focus

on three main areas: (i) patient role behaviours, which are often studied in relation to adherence to healthcare protocols (Ahmed, et al., 2024); (ii) clinical aspects that examine patients' motivation to actively seek medical care (Beressa, Whiting & Belachew, 2024); and (iii) preventive healthcare behaviours, which include health-promoting and health-hazardous practices, as well as vaccinations and contraceptives (Bauer et al., 2024). Examples of research topics explored within the Health Belief Model include the human papillomavirus (HPV) vaccination, smoking cessation, self-care among diabetic patients, health screening behaviours, and voluntary premarital medical examinations (Ahmed et al., Jacob & Singh, 2024; Purwanti, Nursalam & Pandin, 2024). Historically, the Health Belief Model has primarily been used to explore individuals' perceptions of mental health conditions and their self-care practices. However, insufficient attention has been paid to understanding why individuals seek or do not seek mental health care (Alyafei & Easton-Carr, 2024).

The following section will present the three primary areas of the Health Belief Model.

3.2.1 Perceived Susceptibility and Severity

One key factor that encourages people to adopt better habits is perceived susceptibility to change. It refers to people's ideas about their own risk of illness; when perceived susceptibility is high, the likelihood of engaging in behaviours that lower susceptibility is higher (Taflinger & Sattler, 2024). In rural South Africa, perceived susceptibility to mental health issues is frequently low. Many individuals and community health workers lack the knowledge of mental conditions in forms such as depression, anxiety, or substance use disorders (Alyafei & Easton-Carr, 2024). Mental distress often manifests as physical complaints or is attributed to spiritual or moral causes rather than recognised as a mental health condition. Therefore, when a person does not perceive themselves to be at risk or when they internalise or misinterpret discomfort, they are less likely to seek help (Ahmed et al., 2024)

For example, a person must first believe that they are at risk of developing diabetes or malaria before they decide to get help and adhere to treatment. The likelihood that decisions about seeking healthcare are based on perceived susceptibility (Vasli, Shekarian-Asl, Zarmehrparirouy & Hosseini, 2024). Perceived susceptibility and severity speak about the perceptions the individual has of their likelihood to experience mental health issues and the severity of the potential consequences, which influences their motivation to seek help (Mohammadnabizadeh & Mohammadi, 2025). The HBM highlights the importance of perceived severity in rural South Africa. Understanding that several variables, including

cultural beliefs, ignorance and the prevalence of the severe consequences of untreated mental health conditions, influence this perception is important. According to Walrave and Waeterloos (2020), members of the community may underestimate the effects that mental health issues have on their overall well-being. A lack of knowledge and resources about the symptoms and long-term repercussions of untreated mental health conditions may also contribute to a decreased feeling of seriousness. Cultural beliefs and societal stigma can lead to a decreased perception of the seriousness of mental health issues, as people may attribute symptoms to spiritual or supernatural causes rather than recognising them as medical issues (Mohammadnabizadeh & Mohammadi, 2025). Understanding these perceptions is crucial for designing effective interventions and educational programs that address the specific needs and beliefs of these communities (Taflinger & Sattler, 2024).

The Health Belief Model also has a limited comprehension of perceived benefits. The advantages of seeking help are significantly diminished when formal mental health services are unavailable, overburdened, or culturally unsuitable (Mohammadnabizadeh & Mohammadi, 2025). Spending on mental health remains insufficient, accounting for only around 5% of the overall health budget and is disproportionately concentrated on tertiary urban care rather than primary rural access (Freeman, 2022). Because of this, people in rural areas usually believe that the advantages of formal care are outweighed by its complexity, inefficiency, or irrelevance.

Several perceived impediments exist in rural settings. There is a significant scarcity of qualified mental health specialists: primary healthcare providers in rural regions usually lack access to psychologists and psychiatrists, and they are undertrained and understaffed to deliver mental health treatments (Taflinger & Sattler, 2024). Structural limitations, such as long wait times, distance, and transportation costs, exacerbate access concerns. Economic hardship exacerbates the situation; private solutions are prohibitively expensive, medical aid coverage is insufficient for most, and governmental services may carry hidden costs (Jacob & Singh, 2024). Even when mental distress is identified, these practical barriers deter people from getting assistance.

Additionally, there are not many signs of action that could motivate people to get mental health care. Examples of these helpful triggers include community awareness campaigns, outreach initiatives and helplines. For instance, communication with helplines has increased, especially among young people, as outreach and anonymity reduce stigma and fear (Walrave & Waeterloos, 2020). Similarly, when appropriately targeted, trial digital treatments, such as the

DoBAt project, have shown promise in engaging adolescents. However, in rural areas, these attempts remain limited due to insufficient infrastructure and uneven availability (Vasli, Shekarian-Asl, Zarmehrparirouy, & Hosseini, 2024).

Although the Health Belief Model offers a helpful framework, rural South Africa needs to benefit from an expansion of its focus on the individual. It is necessary to include structural and cultural variables alongside intrapersonal ones. In rural locations, mental health costs and access patterns are influenced by poverty, long-term unemployment, exposure to violence and inadequate care delivery (Pengpid & Peltzer, 2025). Inequalities in service accessibility feed a vicious cycle; undertreatment results from limited access, which raises social and financial expenses. Potential help-seekers are further alienated by cultural disconnects, such as services that are not provided in local languages or that lack cultural congruence (Nguse & Wassenaar, 2021).

The fundamental principles of the Health Belief Model will be elaborated upon and incorporated into a larger, multi-level theoretical framework that addresses mental health-seeking in rural South Africa. This model acknowledges that individual motivations and thoughts will not result in effective behaviour change unless there is structural investment in rural mental health services, primary care provider training, mental health integration into primary care, task-sharing with community workers, mobile clinics and culturally appropriate digital tools (Vasli, Shekarian-Asl, Zarmehrparirouy & Hosseini, 2024). It also prioritises social determinants and cultural factors while addressing stigma through community-led education, faith leaders and culturally sensitive information (Taflinger & Sattler, 2024). Empowerment initiatives that strengthen self-efficacy, such as peer support models, group counselling, or income-support programmes, would further encourage help-seeking behaviour (Taflinger & Sattler, 2024). This means that rural-specific initiatives must be informed by policy and adequate funding, as implementation in rural regions is severely lacking (Mohammadnabizadeh & Mohammadi, 2025). By bridging these layers, the theory can be successfully translated into interventions that enable rural populations to recognise distress, believe in formal or adapted care, overcome obstacles, respond to cues, and act confidently to improve their mental health (Mohammadnabizadeh & Mohammadi, 2025).

3.3 The Social Cognitive Theory

The process of obtaining mental health treatment is complex and influenced by social, structural and individual factors. Although internal beliefs and perceptions can be explained by cognitive models such as the HBM, these models frequently overlook social dynamics and observational learning, which are especially important in rural, collectivist settings. In this context, Albert Bandura created the Social Cognitive Theory (SCT) in 1986. The Social Cognitive Theory provides an understanding of human behaviour by incorporating cognitive, social and environmental factors (Bandura, 1989; Sun & Li, 2025). Bandura developed the theory because of dissatisfaction with traditional behaviourist approaches, which focused solely on observable behaviour. He felt the traditional approaches did not adequately account for cognitive processes in learning and behaviour change (Ohta, Yakabe & Sano, 2024). The Social Cognitive Theory strongly emphasises the reciprocal interaction between personal factors, environmental influences, behaviour, and the consequences of actions.

The theory has significantly shaped the areas of psychology, health promotion, and education. It has offered valuable insights into various behaviours and serves as a basis for creating effective interventions and programs (Ohta et al., 2024). The influence of social cognitive theory goes beyond observable behaviour; it also encompasses self-efficacy (Scott, Cervone & Ebiringah, 2024). A crucial aspect of Social Cognitive Theory, self-efficacy, is particularly vital when addressing behaviours related to seeking mental health care. Self-efficacy pertains to an individual’s belief in their capabilities to effectively seek and utilise mental health treatments (Bandura, 1989). In rural areas, limited access to resources and support networks can impact an individual's self-efficacy (Sun & LI, 2025). According to Ohta et al. (2024), observational learning is a form of social influence, such as observing others' experiences with mental health care, which can shape individuals' attitudes and behaviours. Peer support networks, community leaders and healthcare providers are essential models for behaviour change. Additionally, outcome expectations, which refer to the anticipated outcomes of seeking mental health care, including social support, symptom relief and improved coping strategies, influence individuals' decision-making processes (Sun & Li, 2025).

Sun and Li (2025) emphasise that at the heart of Social Cognitive Theory is the idea that individuals learn not only through their own experiences but also by observing others. This perspective highlights the importance of modelling and imitation in the learning process, suggesting that behaviours, attitudes, and emotional responses can be acquired through observing others’ actions and the outcomes that follow. This theory underscores the significant

role of social contexts in shaping individual behaviour and learning. Observational learning is a crucial tactic for changing attitudes and actions in rural South Africa, where stigma around mental health is prevalent and knowledge about mental illness is limited (Scott, Cervone & Ebiringah, 2024). The treatment of people in psychological distress, whether they receive support or isolation, whether they improve after receiving assistance and the source of that assistance (e.g., traditional healers vs. modern mental health practitioners) are all factors that community members closely monitor (Sun & Li, 2025). These social indicators significantly predict help-seeking behaviour. Others are more inclined to use mental health therapies if friends or well-respected members of the community experience positive outcomes (Mahomed & Pretorius, 2023). Conversely, if individuals who seek help are labelled as "mad" or "possessed," or if they are known to receive poor treatment from health providers, this discourages similar behaviour in others (Atilola, 2021; Mahomed & Pretorius, 2023).

3.3.1 Self-efficacy

Self-efficacy is the belief in one's ability to perform a specific task. It is as important to the Social Cognitive Theory as observational learning. It is especially vital to determine whether those living in rural areas believe they can effectively navigate the healthcare system to access mental health care (Ohta et al., 2024). Self-efficacy can be influenced by systemic and environmental restrictions as well as individual agency. Extended travel to clinics, high transportation costs, ill-equipped medical facilities, and language barriers severely limit access in many rural South African communities (Kritzinger et al., 2022). Even if individuals wish to seek help, low self-efficacy, fuelled by structural inequality and prior negative experiences, can lead to resignation or fatalism. Moreover, health-seeking behaviour is often gendered. Men may experience lower self-efficacy when their suffering contradicts traditional masculine social standards and emotional stoicism (Mokoena & Mashaphu, 2023).

Self-efficacy is a key factor in determining whether people in remote areas believe they can obtain and use mental health services. Access to mental health care options has a substantial impact on self-efficacy. Individuals in rural areas often face financial limitations, a lack of mental health professionals, and restricted mobility. These impediments cause people to mistrust their ability to obtain the necessary aid, thereby lowering their sense of self-efficacy (Nickerson, 2024).

Community norms and social support are also significant. Strong social networks have been shown to either boost or undermine self-efficacy in rural regions. People may feel more

confident in seeking mental health care if they know their friends, family, or local authorities are behind them (Green, Murphy & Gryboski, 2020). In contrast, stigma associated with mental health issues and negative cultural standards can limit self-efficacy and decrease the likelihood of people seeking help. Positive interactions with medical services can enhance confidence and inspire future help-seeking behaviours, while negative experiences can erode trust and self-efficacy (Szota et al., 2024).

Cultural attitudes toward mental health and traditional medical practices also influence self-efficacy. Some rural populations prefer traditional healers or spiritual treatments over modern medical treatment. This cultural inclination may aid or hinder self-efficacy, depending on whether people believe they can access and trust traditional methods or manage current healthcare systems (Walrave & Waeterloos, 2020). It is crucial to comprehend the intricate relationships among resource availability, social support, prior experiences, and cultural beliefs that shape self-efficacy in rural settings (Nickerson, 2024). While low self-efficacy dramatically reduces access to mental health treatments, high self-efficacy allows people to overcome barriers and seek help. Understanding these factors and their intersectionality is critical for effectively encouraging community help-seeking behaviours (Green et al., 2020).

Another essential Social Cognitive Theory term is outcome expectancies, which characterise people's beliefs about the results of a specific action. The perceived consequences of seeking mental health therapy in rural locations are strongly tied to personal beliefs, prior exposure and cultural norms. For instance, if someone believes that visiting a clinic will expose them to stigma, lead to gossip, or result in ineffective treatment, they are unlikely to seek care. On the other hand, if someone expects counselling or psychiatric support to improve their condition and help them regain social or occupational functioning, the likelihood of seeking help increases (Sorsdahl et al., 2021). Unfortunately, due to persistent underinvestment in mental health services and an urban-centric distribution of care, many rural residents have low expectations regarding the effectiveness of formal services (Petersen, Selohilwe, Georgeu-Pepper, Zani, Petrus and Fairall, 2022). This limits not only help-seeking but also sustained engagement with care.

In the South African rural context, reinforcement mechanisms also shape behaviour. Positive reinforcements include community support and symptom treatment, while negative reinforcements include humiliation and prejudice (Oladimeji, Nyatela, Gumede, Dwarka & Lalla-Edward, 2023). Positive reinforcement, such as receiving support from family or

community leaders after getting mental health treatment, can inspire others to follow suit. Churches and traditional buildings frequently serve as reinforcement factors, both positive and negative (Booysen & Haine, 2025). In communities where pastors or traditional healers encourage clinic referrals or collaborate with mental health professionals, there is considerable social reinforcement for obtaining official care (Oladimeji et al., 2023). In contrast, in communities where spiritual explanations prevail and medical treatment is viewed as secondary or unsuitable, patients may be deliberately discouraged from seeking psychiatric care, instead being directed toward prayer, ritual cleansing, or isolation (Booysen & Haine, 2025).

The principle of reciprocal determinism in Social Cognitive Theory highlights the dynamic and mutual influence among individuals, their actions, and their surroundings, emphasising the significance of context (Booysen & Haine, 2025). In rural South Africa, behaviours related to seeking mental health cannot be comprehended without considering historical, structural, and socio-political factors (Oladimeji et al., 2023). High rates of substance abuse, violence, unemployment and poverty reduce access to supportive resources and create environmental stressors that exacerbate mental health issues (Abraham & Lund, 2022). Thus, the environment contributes to a cycle of pain and quiet by establishing mental health demands and constraining responses to those needs (Sorsdahl et al., 2021). Environmental realities (e.g., clinic closures, provider discrimination), behavioural variables (e.g., avoidance, self-medication), and personal factors (e.g., gender norms, beliefs) all interact to influence whether, when, and how people seek treatment (Sorsdahl et al., 2021).

Social Cognitive Theory also acknowledges the importance of social support networks in shaping behaviour, an especially critical dimension in tightly knit rural communities (Abraham & Lund, 2022). Family members, friends, church leaders and traditional healers often serve as gatekeepers to formal mental health services (Booysens & Haine, 2025). For example, in many cases, an individual will visit a clinic only after being urged to do so by a family member or after exhausting traditional options. Where these networks are informed, supportive and non-judgmental, they function as facilitators. They become obstacles, nevertheless, if they are ignorant, stigmatising, or contemptuous (Pretorius, 2023). Models that treat health-seeking as an individual activity are inadequate, considering the social embeddedness of decision-making.

Notably, the Social Cognitive Theory places value on behavioural capability, or the knowledge and skills needed to perform a behaviour (Zhang, Chen & Dong, 2022). This includes recognising indicators of mental distress, understanding how and where to seek help, being

aware of accessible services and effectively communicating with medical professionals (Booysens & Haine, 2025). According to research, these skills are often lacking in South Africa's rural communities. Many people struggle to distinguish between temporary emotional distress and clinical mental illness, especially when symptoms are somatised (for example, headaches, exhaustion) (Pretorius, 2023). Furthermore, when patients are uninformed or unaware of the available treatment alternatives, their chances of receiving it drop. Poor patient experiences discourage repeat visits because health providers commonly lack training in basic mental health screening and communication (Korhonen et al., 2022).

To enhance help-seeking behaviours, the Social Cognitive Theory emphasises the value of modelling positive behaviours through media, community influencers and peer support (Pretorius, 2023). In rural contexts, where direct access to mental health services is limited, interventions using local radio, community theatre, storytelling, or peer educators can serve as powerful tools to influence norms and increase mental health literacy (Sorsdahl et al., 2021). Studies have shown that local community members who have had mental health illnesses can function as role models and share their experiences to reduce stigma and encourage treatment (Petersen et al., 2022). These modelling strategies boost knowledge and self-efficacy, which can alter community views.

Digital tools also offer new opportunities for applying the Social Cognitive Theory in remote areas. Despite the limitations of data access and connectivity, mobile-based mental health support programs, such as the DoBAt study in the Eastern Cape, have shown that young adults and adolescents are willing to use technology when services are culturally appropriate and adequately supported by qualified lay counsellors (Sherr et al., 2023). These tools can improve behavioural ability, offer immediate reinforcement and model behaviour through interactive media.

Additionally, the Social Cognitive Theory emphasises that interventions designed to improve mental health should consider both the individual and the broader ecological system in which they reside (Sherr et al., 2023). Practical techniques in rural South Africa must include policy systems, healthcare practitioners, families and community leaders (Pretorius, 2023). Training programs for traditional healers and community health workers can help to increase observational learning and referral rates. By empowering peer supporters and building local champions, we can reduce stigma and model help-seeking behaviour (Sorsdahl et al., 2021). To create settings that encourage rather than discourage help-seeking behaviour, structural

adjustments are required. These reforms include ensuring culturally competent treatment, integrating mental health into primary care and improving transportation infrastructure (Sherr et al., 2023).

Lastly, sociocultural cognitive theory offers a valuable perspective for examining the complex interplay between structural, societal, and personal factors that influence how people in rural South Africa seek mental health treatment (Cervone, 2023). It is ideal for the collectivist and community-focused lifestyle of rural areas due to its emphasis on self-efficacy, modelling, social reinforcement and environmental determinants (Scott & Cervone, 2024). SCT must, however, be situated within the socioeconomic and cultural realities of rural South Africa, where historical marginalisation, poverty and inequality continue to influence health systems and practices (Hayden, 2022). A thorough implementation of the Social Cognitive Theory can guide the development of multi-level treatments that empower individuals and transform communities to achieve improved mental health outcomes, as well as inform the study of current behavioural trends (Hayden, 2022).

3.4 The Theory of Planned Behaviour

Icek Ajzen, a social psychologist, developed the Theory of Planned Behaviour (TPB) in 1985. Connor (2020) suggests that people's intentions to act are influenced by their attitudes, subjective norms, and sense of behavioural control. This theory highlights the interplay between individual beliefs and social influences in shaping intention and subsequent behaviour. Attitudes refer to individuals' feelings about an action, including their views on its potential outcomes and perceived value. Subjective norms represent people's perceptions of social expectations regarding how they should behave (Worthington, 2021). The Theory of Planned Behaviour is a crucial framework for understanding behaviours related to seeking mental health support, as it illuminates people's intentions and choices regarding accessing mental health services (Bosnjak, Ajzen, & Schmidt, 2020).

3.4.1 Attitudes

Attitudes refer to an individual’s overall beliefs about mental health, its effectiveness and its relevance. This influences their intention to seek help (Bosnjak et al., 2023). Hagger, Cheung, Ajzen and Hamilton (2022) argue that social variables, subjective experiences and cultural beliefs can all impact attitudes toward mental health-seeking behaviours in rural settings. They argue that these attitudes influence whether people with mental health problems seek care (Hagger et al., 2022). According to studies, mental health concerns are still widely misread in

rural communities, where symptoms of trauma, anxiety, or depression may be mistaken for signs of personal weakness, spiritual instability, or witchcraft (Van Rooyen et al., 2024). When traditional healing is perceived as more acceptable or approachable, it exacerbates negative views toward seeking official psychological or psychiatric help (Bosnjak et al., 2023). According to a study conducted in the Eastern Cape, many locals had a negative attitude toward clinic-based mental health services, often because they believed that "Western" therapies did not address the spiritual causes of illness (Gumede et al., 2023). When services are delivered in culturally inappropriate ways or when medical workers lack training and sensitivity, this distrust grows.

On the other hand, attitudes can shift positively when individuals or communities witness successful treatment outcomes (Hagger et al., 2022). Positive exposure to mental health interventions such as group counselling, school-based wellness programmes, or mobile mental health clinics can transform community perceptions and foster favourable attitudes. It has also been shown that well-crafted radio advertisements and digital platforms can influence public opinions of mental illness and its treatment (Sherr et al., 2023). These programmes increase the value people place on using official services by raising mental health awareness and normalising seeking assistance. As a result, altering attitudes remains an important approach for increasing intentions to seek mental health services (Worthington, 2020).

In rural communities, there may be widespread stigma and misconceptions about mental health. Mental health issues are sometimes misconstrued or dismissed as character flaws or failings rather than being recognised as medical diseases (Worthington, 2020). People may avoid seeking professional help because they fear rejection or judgment in their community. Furthermore, cultural beliefs can dramatically influence these attitudes (Adams, Gringart & Strobel, 2022). Traditional healing methods or spiritual therapies may be preferred in some rural places due to cultural predispositions; getting professional mental health care may be perceived as less successful or clashing with traditional beliefs, resulting in negative attitudes (Worthington, 2021). Firsthand experiences and positive encounters with mental health services, whether directly or through others, increase an individual's likelihood of developing a positive attitude towards seeking assistance. While unfavourable experiences cause distrust and aversion towards mental health services (Bosnjak et al., 2020).

Additionally, the degree of education and awareness around mental health care can influence one’s attitudes. A lack of understanding about mental health conditions and the benefits of

therapy may result in negative attitudes toward seeking help (Fan, Ezeudoka & Qalati, 2024). Cultural norms, direct experiences, awareness levels and stigma all have an impact on rural residents' perceptions of mental health-seeking activities. These perspectives have a critical role in determining whether someone will seek help. Negative perceptions can pose a considerable obstacle to obtaining essential mental health services, while supportive attitudes can encourage individuals to seek help. It is essential to understand and address these behavioural factors to improve mental health outcomes in rural areas (Bosnjak et al., 2020).

3.4.2 Subjective Norms

Subjective norms refer to the perceived social pressure to either participate in or avoid a specific behaviour (Fan, Ezeudoka, & Qalati, 2024). These norms encompass the beliefs and expectations that families, friends, and the community hold regarding mental health treatment, as well as how these beliefs influence individuals' decisions to seek assistance (Connor, 2020). The Theory of Planned Behaviour posits that subjective norms are linked to perceived social pressure surrounding a behaviour (Connor, 2020). In the context of pursuing mental health care in rural South African communities, subjective norms play a crucial role in influencing individuals' decisions to access mental health services. The beliefs and views of influential individuals, such as family members, friends, and community leaders, as well as broader societal expectations, shape these norms (Bosnjak et al., 2020).

In rural South Africa, subjective norms are particularly influential due to strong communal ties and the collectivist orientation of many rural communities. (Mbunge, Batani, Gaobotse & Muchemwa, 2022). According to Mbunge et al. (2022), family members, religious leaders, or traditional authorities are frequently consulted before making decisions on one's health. Even if a person has positive personal opinions, they are less likely to seek help from a psychologist or psychiatrist if they think prominent members of their community disapprove of seeking help (Mahomed & Pretorius, 2023).

Studies that demonstrate that perceived and actualised community stigma are substantial impediments to seeking help make this dynamic clear (Mbunge et al., 2022). For example, negative standards that associate mental suffering with weakness or moral failure are especially harmful to men and adolescents (Mokoena & Mashaphu, 2023). Even when people realise they need help in these situations, they could be afraid of being rejected or judged. Religious or cultural norms that prioritise prayer, spiritual purification, or herbal remedies over mental health treatment may also influence subjective norms (Silaule, Nkosi & Adams, 2024). Access

to care may be severely delayed or prevented if community gatekeepers, such as elders and spiritual leaders, encourage these norms (Silaule, Nkosi & Adams, 2024).

Subjective norms, however, are dynamic. Norm-changing initiatives, such as educating peer advocates, facilitating open discussions about mental health and involving community leaders in mental health education, can challenge and modify them (Morrison, Fourie & Adams, 2025). It has been demonstrated that when well-known community members speak favourably about mental health and set an example by seeking treatment, this can have a cascading impact, changing social norms and reducing stigma (Petersen et al., 2021).

In many rural areas of South Africa, there is a strong sense of community and shared values, and others' views can influence people's actions. People may be discouraged from seeking treatment if significant community members or influential personalities have negative views about mental health care or if stigma around mental health issues is pervasive (Fan et al., 2024). People may therefore choose social peace over their health needs out of fear of social rejection or condemnation if they choose to seek mental health care (Visser & Van Wyk, 2021).

Supportive subjective norms that normalise and promote mental health care increase the likelihood that people will seek help. People may feel more comfortable and supported in seeking care if prominent community leaders advocate for mental health awareness and treatment, or if mental health issues are more widely acknowledged as integral to overall health (Mbunge, 2020). It is possible to promote help-seeking behaviours and counteract the adverse effects of stigmatisation by constructive social reinforcement (Adams et al., 2022).

Therefore, in rural South Africa, the behaviours of individuals seeking mental health care are influenced by subjective norms. The general attitudes and views of the community can either facilitate or hinder the pursuit of mental health care, depending on whether there is a stigmatising or supportive environment. To develop treatments that help individuals access the mental health care they need and promote positive subjective outcomes, it is essential to understand these social aspects.

3.4.3 Perceived Behavioural Control

The third component of the Theory of Planned Behaviour is perceived behavioural control (PBC), which refers to an individual's belief in their capacity to perform the behaviour, taking into account the resources, opportunities, and limitations they encounter (Connor, 2020). While PBC is closely related to self-efficacy in Social Cognitive Theory, in the Theory of Planned

Behaviour it also includes control over external factors (Mbunge, 2020). In the rural South African setting, perceived behavioural control is often constrained by structural and systemic issues (Visser & Van Wyk, 2021).

Lack of availability and accessibility to mental health care is one of the biggest obstacles. In many areas, mental health experts are scarce, and rural clinics often face staff shortages (Mbunge, 2020). In many cases, services are located far from people's homes, making travel inconvenient or expensive (Kritzinger et al., 2022). These restrictions diminish people's perceived influence over the process, even when they strongly desire to seek help. Additionally, people might not know how to get mental health care, what services are appropriate, or if they qualify for care, all of which might impair behavioural control (Korhonen et al., 2022).

Significantly, Perceived Behaviour Control is influenced not only by real barriers but also by perceptions of difficulty. Even if a clinic is technically accessible, a person who has previously experienced judgment or indifference from a healthcare provider may perceive the process as emotionally and psychologically taxing (Adams et al., 2022). Internalised helplessness and a decreased likelihood of seeking help in the future might result from negative past experiences, such as being rejected, misinterpreted, or referred without explanation (Abraham & Lund, 2022). Therefore, increasing user confidence in the health system and improving treatment delivery are both necessary to increase perceived behavioural control.

Their attitudes influence a person's decision to seek mental health treatment, along with subjective norms and perceived behavioural control (Korhonen et al., 2022). Intention is the best immediate predictor of action, even though it does not always translate into conduct, especially in minimal situations (Abraham & Lund, 2022). Intention is intricately entwined with a complex web of material realities and social factors, and it is more than just a personal belief for South Africans living in rural areas (Kritzinger et al., 2022). The Theory of Planned Behaviour is therefore particularly well-suited to the South African context, where obstacles at the individual, interpersonal, institutional and cultural levels must be addressed.

Financial resources, transportation alternatives and access to culturally competent care all impact their intentions and behaviours (Wong & White, 2021). People's perceptions of their behavioural control are important in shaping their sense of capability when seeking mental health care (Wong & White, 2021). Several factors influence this view, including the accessibility of services, the availability of resources and the individual's confidence in overcoming potential difficulties. Several external influences can influence perceived

behavioural control in rural South Africa. Mbunge (2020) emphasises that when there are regularly insufficient mental health providers and facilities, this results in a lack of easily accessible services. People may struggle to access the care they require due to financial constraints, long travel times to medical facilities and limited transportation infrastructure (Mbunge, 2020). Furthermore, Wong and White (2020) emphasise that internal issues can erode people's confidence in receiving appropriate care, such as ignorance of available resources, concerns about the process of requesting assistance, or negative past experiences with the healthcare system.

Furthermore, how social and cultural standards are viewed can influence the perception of behavioural control. In some countries, people may doubt their ability to get and benefit from professional mental health services because customs and beliefs take precedence over modern medical approaches. Furthermore, Sun, Hu and Zhang (2024) point out that societal stigma and the fear of being criticised may discourage people from seeking help, as they perceive their social networks as not supportive. Thus, there is a complex relationship among societal influences, personal confidence, and external barriers. All these elements influence how behavioural control is perceived in South African rural communities. Morales and Barksdale (2020) also emphasise that, while low perceived behavioural control can function as a significant barrier, preventing people from receiving the treatments they require, high perceived behavioural control can enable people to overcome obstacles and seek the mental health care they need. Addressing these determinants is crucial for improving mental health outcomes and ensuring that individuals in these locations feel confident in seeking and receiving the care they need (Sun, Hu & Zhang, 2024).

One of the main advantages of the Theory of Planned Behaviour is its flexibility. To accurately represent the intricacies of decision-making in the real world, the theory allows for the addition of new variables (Wang & Tsai, 2022). Cultural beliefs, economic hardship, trauma and stigma can all be considered background factors that impact the three fundamental traits in rural South Africa (Wang & Tsai, 2022). For example, exposure to trauma (e.g. gender-based violence or loss due to HIV/AIDS) can shape negative attitudes toward seeking help. At the same time, traditional beliefs may bolster norms against psychiatric care (Sun, Hu & Zhang, 2024). Likewise, poverty and gender inequality can severely reduce perceived behavioural control, especially for women and young people. Recognising these intersections enables a more context-sensitive application of the Theory of Planned Behaviour (Mbunge, 2020).

The Theory of Planned Behaviour conducted a thorough analysis of the behaviour of persons seeking mental health care in rural South Africa, which is distinguished by close-knit communities, cultural diversity, healthcare system inequities and embedded stigma. By focusing on these determinants, stakeholders can develop diverse initiatives that empower people, change negative attitudes and reduce access barriers, ultimately improving mental health outcomes in remote communities.

To better understand the behaviours associated with seeking mental health treatment in a rural South African setting, this study employed the Health Belief Model (HBM), Social Cognitive Theory (SCT), and the Theory of Planned Behaviour (TPB). Although each theory described aspects of health-related behaviour on its own, their combined use enabled a more complex understanding of the interactions among societal pressures, structural limitations, and individual beliefs. The Health Belief Model was especially helpful in highlighting how people's decisions to seek professional mental health support are influenced by their perceptions of vulnerability, severity, benefits, and barriers (Alyafei & Easton-Carr, 2024). HBM emphasised in this study how accessibility, perceived stigma, and cost affected people's perceptions of mental health treatments' viability (Ahmed et al., 2024). This was strengthened by Social Cognitive Theory, which emphasised the importance of environmental influences, self-efficacy, and social learning. SCT is particularly relevant to understanding how community norms, observational learning, and the visibility of alternative coping mechanisms, such as dependence on family or traditional healers, influence help-seeking behaviour (Ohta et al., 2024). By taking into consideration behavioural intention through attitudes, subjective standards, and perceived behavioural control, the Theory of Planned Behaviour expanded on this approach. TPB is especially helpful in understanding the gap between the actual use of mental health services and favourable attitudes regarding them (Mbunge, 2020). As a result, the combination of these three frameworks offered an even greater analytical perspective than any one theory alone could. When taken together, they capture the cultural, social, and cognitive aspects of seeking mental health treatment, enabling a deeper evaluation of the qualitative and quantitative trends in this rural context.

3.5 Summary

This chapter examines the theoretical foundations of help-seeking behaviours related to mental health in rural South African communities. It uses three theories: the Health Belief Model, Social Cognitive Theory, and the Theory of Planned Behaviour, to explore factors influencing individuals' willingness to seek help. The Health Belief Model focuses on perceptions of vulnerability, the severity of the issue, the benefits of seeking help, and barriers to seeking help. Social Cognitive Theory examines social and environmental influences, emphasising how cultural and institutional factors can either enable or hinder help-seeking. The Theory of Planned Behaviour identifies elements such as attitudes towards mental health services, community norms, and perceived control over behaviour. The subsequent methodology section will outline the research design, data collection methods, and analytical procedures used to ensure the study’s validity and reliability within this theoretical framework.

CHAPTER 4

METHODOLOGY

4.1 Introduction

This chapter outlines the research design, methodology, and methods used to achieve the study's objectives. The study begins by describing its setting, followed by a discussion of the research design, philosophical approach, and methodology employed. Detailed information will be provided about the target population, sampling techniques, data sources, and the strategies used for data collection and analysis. Finally, the chapter will address ethical considerations related to the study and the measures taken to ensure data quality.

4.2 Description of the Setting of the Study

Context is crucial in social research, as it allows the researcher to understand the complexities of the social phenomena being studied (Wang, Hipp, Butts & Lakon, 2022). It influences how people interpret and give meaning to social phenomena, behaviours, and interactions, and can potentially affect the behaviours and outcomes of individuals and groups (Pervin & Mokhtar, 2022).

This study was conducted in Mkhuhlu Ward 03. It is a rural area within the Bushbuckridge Local Municipality, located in the Ehlanzeni Region (StatsSA, 2015). The area is characterised by its isolation from urban areas, limited access to advanced healthcare and employment opportunities and a lack of modern infrastructure. Hazyview, also known as Vakansiedorp, which translates to "vacation town," is the closest to Mkhuhlu. It is approximately 16km away, and the famous Kruger National Park (Phabeni Gate) is 8.8 km away from the area. The Municipality has a population of 750,821 as of the 2022 census (StatsSA, 2022). The area is primarily populated by Black Africans, with females accounting for 54.3% and males for 45.7%.

Bushbuckridge Mkhuhlu is the context of this study, which is culturally diverse and has significant historical value. The area is renowned for its rich diversity and history, which dates back to the indigenous groups of the Tsonga, Pedi and Ndebele. The Bushbuck, a native antelope in the region and the ridge where it is located are the sources of the name "Bushbuckridge" (Breetzke & Mthimunye, 2025). During apartheid, the region was supposed to be a component of the homelands, also referred to as Bantustans. Many people were forced to relocate due to the significant upheaval of traditional businesses and lifestyles during that

period. Following the end of apartheid in 1994, the region was incorporated into Mpumalanga province. In addition to its varied species and subtropical climate, this scenic area is well known for its rolling hills, valleys, and bushveld (Breetzke & Mthimunye, 2025).

Many individuals in the region engage in subsistence farming, making agriculture the main component of the local economy. Tourism significantly contributes to the economy, with initiatives focused on fostering small-business growth and generating overall employment opportunities (Wang et al., 2022). Despite substantial advancements, the region continues to face challenges such as poverty, unemployment, social disparities, inadequate access to clean water and sanitation services, and inconsistent energy supply (StatsSA, 2015).

The primary healthcare facility serving the community of Mkhuhlu is Matikwana Hospital. The hospital offers general medical care, maternal health services, emergency treatment and outpatient care (Mpumalanga Department of Health, 2015). The hospital serves the larger population of Mkhuhlu and the surrounding villages. Sadly, it continually faces challenges such as resource constraints, staff shortages and limited access to advanced medical equipment, all of which impact the quality of care. In addition to Matikwana Hospital, smaller clinics such as Mkhuhlu Clinic and Mobile Clinics provide basic healthcare services (Mpumalanga Department of Health,2009). In Mkhuhlu, traditional healers known as Sangomas and Abathandazi play a significant role in health-seeking behaviours. Several factors contribute to community members' challenges in accessing adequate healthcare, including geographic isolation, underdeveloped infrastructure and limited healthcare resources.

For this reason, conducting research on the Mkhuhlu community may be beneficial, given the socio-economic challenges it faces, including poverty, unemployment, and limited access to healthcare. Understanding these needs can help inform the design of culturally appropriate interventions.

It is essential to acknowledge that cultural diversity in Mkhuhlu can profoundly impact mental health (Morales, Barksdale, & Becker-Mitchener, 2020). Thus, research of this nature has the potential to reveal traditional customs and beliefs that may either obstruct or promote mental health, ultimately offering modern strategies tailored to the region. Additionally, the study could shed light on the stigma linked to mental health issues, which may deter community members from getting help. This research may also help inform policymakers, healthcare providers and community leaders in developing comprehensive and suitable mental health

programmes and awareness campaigns for rural communities. Next, the study's significance is presented in an overview.

Figure 1: Map of Mkhuhlu in the Bushbuckridge Municipality

4.3 Research Design

The research design encompasses the overarching plan and analytical techniques used to systematically integrate the different components of a study. This ensures a thorough investigation of the research problem (Kazdin, 2021). It serves as a guide for collecting, analysing, and interpreting data and information (Kazdin, 2021).

This research utilised a mixed-methods approach. Creswell (2024) described mixed-methods research design as a framework that encompasses all assumptions of a study, ranging from analytical techniques to the documentation of findings. As stated by Dawadi, Shresha, and Giri (2021), mixed-methods research integrates quantitative and qualitative methods within a single study to offer a broader understanding of the research issue. Employing mixed strategies involves collecting and analysing both qualitative and quantitative information, including narratives. Creswell (2024) highlighted that the advantage of mixed methods lies in their ability to harness the strengths of both quantitative and qualitative approaches.

When examining topics such as mental health-seeking behaviour, quantitative research offers the benefit of gathering and analysing numerical data from a sizable sample, providing an

overview of trends and patterns that might be overlooked with solely qualitative approaches (Trochim, 2020). On the other hand, the qualitative aspect of the research provided the investigator with an opportunity to explore participants' personal experiences and perspectives regarding behaviours related to seeking mental health care.

The study was grounded in the pragmatic paradigm, which emphasised practical problem-solving and flexibility in addressing complex research topics. It facilitated the integration of both qualitative and quantitative research methods. This paradigm highlights that no single approach can completely address the complexities of a research issue (Foster, 2024). It highlights the importance of research goals and unique contexts over rigid adherence to any one methodology (Johnson & Onwuegbuzie, 2004; Elgeddawy & Abouraia, 2024). The paradigm asserts that reality is not static but is influenced by individual human experiences and actions. It allows researchers to select the methods best suited to their inquiries. The pragmatic perspective promotes a holistic understanding of mental health-seeking behaviours in rural areas, enabling diverse data to yield meaningful insights while emphasising the outcomes and practical relevance of the research (Foster, 2024). The paradigm was chosen to address the complexities and variations in human behaviour because it emphasises the importance of multiple perspectives and diverse data sources in achieving meaningful findings (Elgeddawy & Abouraia, 2024). Takona (2024) states that mixed methods design encompasses more than simply merging qualitative and quantitative approaches. It introduces a novel "third way" epistemological paradigm that exists between positivism and interpretivism. Creswell (2014) and Takona (2024) emphasised that research using mixed methods is less about methodology and more about how a research problem is viewed. Consequently, it involves focusing on research problems that necessitate the following steps:

i. An analysis of multilevel perspectives, real-world contextual understandings and cultural influences

ii. a purposeful application of rigorous quantitative research evaluating the quantity and frequency of constructs and rigorous qualitative research delving into the meaning and comprehension of the constructs; and

iii. combining the best features of quantitative and qualitative data collection methods to create a comprehensive interpretive framework for formulating potential solutions or novel insights into the problem.

The above steps are integral to this study. The researcher was able to thoroughly investigate the prevalence of specific attitudes and behaviours, and the underlying motivations and experiences of individuals within the community, by combining quantitative questionnaires and qualitative interviews (Dawadi et al., 2021). The following section provides a detailed discussion of the research approach, encompassing both quantitative and qualitative components of the study.

4.4 Research Methods

The quantitative method part of the study was supported by a sequential explanatory approach. The initial phase consists of gathering and analysing quantitative data, while the second stage focuses on managing qualitative data (Toyon, 2021). While the weighting is more quantitative, the mixing process involves combining data from both approaches (Toyon, 2021). This method is employed when quantitative results inform qualitative data collection, utilising qualitative data as a follow-up to the initial quantitative results (Taherdoost, 2022).

A sequential explanatory approach was used to understand mental health-seeking behaviours in Mkhuhlu. The approach allowed for an in-depth analysis of the complex factors that influence these behaviours. During the quantitative phase, patterns and relationships, such as age, gender, education and cultural beliefs, that impact mental health attitudes were identified.

The phenomenological approach was employed to support the qualitative phase in this study. The qualitative phase was used to expand on the quantitative findings by providing deeper insights into demographic trends and barriers, such as stigma and manifestations in everyday life. The phenomenological approach studies phenomena as they appear in our lives, focusing on how they are experienced and their significance in our subjective experience (De Boer & Zeiler, 2024). The approach aims to identify various perspectives about mental health and help-seeking behaviours (Hossain, Alam & Ali, 2024).

The approach is well-suited to the study’s objectives because it allowed the researcher to look deeply into the participants' subjective experiences and meanings associated with mental health (De Boer & Zeiler, 2024). According to Williams (2021), the goal of phenomenology is to comprehend how individuals interpret and make sense of their experiences. When examining mental health attitudes and behaviours in rural settings, where cultural and environmental factors may affect perceptions and behaviours, this method becomes essential. (Williams, 2021). The researcher employed this approach because it enabled deeper engagement with participants. This method provided rich, descriptive data that highlighted the intricate

complexity of mental health-seeking behaviours (Hossain, Alam & Ali, 2024). Using the sequential exploratory approach and phenomenological approach in the study enhanced the depth and breadth of understanding of the data.

4.5 Population

Population is characterised by Hu (2024) as a collection of individuals who share similar attributes and specific traits relevant to the research question. For this study, the researcher selected the population based on the research objectives and the questions being asked. Berndt (2020) contended that a sample from a population can help identify an accessible population or the group that closely mirrors the sample. Participants were recruited from Mkhuhlu in the Bushbuckridge area of Mpumalanga Province, and the sample demonstrated diversity in terms of age, gender, socioeconomic status, and ethnic background.

4.5.1 Sampling

The initial sample size of around 300 was established using Israel's sample size determination table. This was the planned target for the research, based on a population of 70,000 and a margin of error of +/-5% (Israel, 1992). Of the desired sample, 200 individuals participated, yielding a response rate of 66%. Dehalwar and Sharma (2024) indicate that this response rate is deemed acceptable for a questionnaire.

4.5.2 The Socio-demographic Characteristics of Respondents

The surveyed individuals were community members from Bushbuckridge Mkhuhlu. The study involved 200 participants, aged 18 to 72 years, all of whom identified as African (Black), comprising 98 males and 96 females. The table below summarises their demographic details.

Table 1: Age Distribution of Respondents

Age Group	N	%
18-23	24	12
24-29	28	14
30-35	19	9,5
36-41	26	13
42-47	19	9,5
48-53	14	7
54-59	10	5
60-65	15	7,5
66-71	26	13
72 +	19	9,5
Total	200	100

Table 1 illustrates the distribution of the two hundred respondents across various age groups. Of the respondents, 28 (14%) were between the ages of 24 and 29, the largest group. The age ranges 36–41 and 66–71 have twenty-six respondents (13%) each. There were twenty-four respondents (12%) in the 18–23 age group. Nineteen respondents (9.5%) were in the 30-35 and 42-47 age groups, and 19 (9.5%) were in the 72+ group. Groups with fewer respondents were 48–53 (14 respondents, or 7% of the total), 60–65 (15 respondents, or 7.5%) and 54–59 (10 respondents, or 5% of the total). This distribution demonstrates a wide age range and equal participation in most age groups. The following table (Table 2) presents the gender distribution of respondents.

Table 2: Gender Distribution of Respondents

Gender	n	%
Female	96	48
Male	98	49
Missing response	3	1.5
Prefer not to say	3	1,5
Total	200	100

Table 2 indicates that the study included 200 individuals. Of them, ninety-six individuals (48%) self-identified as female and ninety-eight individuals (49%) as male. Furthermore, three respondents (1.5%) did not provide an answer, and three participants (1.5%) chose the "prefer not to say" option. There are very few non-disclosures and missing replies in this sample, and the distribution of respondents' genders is evenly split between male and female. This provides a significant representation of gender in the study. The following table (3) depicts the respondents' education levels.

Table 3: Educational level of Respondents

Education level	n	%
No Formal Schooling	11	5,5
Primary School	30	15
High School	84	42
Diploma	41	20,5
Degree	34	17
Total	200	100

Table 3 presents the educational background of the 200 respondents who participated in the study. Of the 200 respondents, 30 (15%) had a primary school education, 11 (5.5%) had never received any formal education, and 84 (42%) participants, which was the majority, reported having completed high school. Additionally, forty-one participants (20.5%) indicated they had

attained diplomas, and 34 (17%) had degrees. The distribution indicates that the sample consisted of diverse educational backgrounds.

The stratified sampling method was employed to ensure that key demographic groups, including gender, age, and educational levels, were adequately represented. This method is classified as a form of probability sampling. In this method, the population is divided into distinct subgroups, or strata, based on specific characteristics relevant to the research. After the strata are defined, participants are randomly chosen from each subgroup (Trochim, 2020).

Stratified sampling was employed in the research, as it enables examination of variations within subgroups that may influence the phenomenon under study (Dehalwar & Sharma, 2024). The study proposed that mental health-seeking behaviours would vary across demographic factors, including age, gender, and education. Consequently, segmenting the population into subgroups ensured that participants from each category were adequately included in the final sample of 200. This method improved the reliability of the results by facilitating comparisons between different groups, which could have been disproportionately represented if a simple random sampling technique had been employed (Creswell & Plano-Clark, 2023).

Ensuring that the sample accurately reflected the population's characteristics enabled the research to achieve external validity (Ahmad & Shabbir, 2024). This strategy aimed to reduce sampling bias and confirm that the findings could be generalised to a broader population (Dehalwar & Sharma, 2024). For the qualitative part of the study, purposive sampling was utilised to select eight individuals for the structured interviews. As Robinson (2024) highlights, purposive sampling is a technique that does not rely on probability. This research adopted purposive sampling to ensure the inclusion of participants with relevant knowledge and experience regarding mental health-seeking behaviours (Robinson, 2024). The group of participants consisted of four males and four females, aged 18 to 60, with diverse educational backgrounds. The diversity within the sample enabled exploration of different perspectives and experiences.

The phenomenological approach and purposive sampling technique complement each other well in the qualitative phase of the study. Purposeful sampling was beneficial because it focused on people who could offer deep, insightful perspectives on their lived experiences (Campbell, 2020). Qualitative data bolstered the quantitative findings.

4.5.3 Participants' Selection

A distress protocol developed by Draucker, Martsolf and Poole (2009) and further supported by Whitney and Evered (2022) was followed to ensure that participants were not affected or emotionally sensitive before the interview. A screening interview was employed in the study, which helped to mitigate harm.

Inclusion Criteria:

i. Participants must currently reside within Bushbuckridge Mkhuhlu in Mpumalanga

ii. Participants must be 18 years or older; at 18, one has the legal capacity to seek mental health care.

iii. Participants must be able to communicate in the language(s) used for data collection (English, Siswati, Xitsonga).

iv. People with various levels of mental health status, including those with and without diagnosed mental health conditions.

v. Participants from different demographic backgrounds, e.g., gender, race, age, education level and socioeconomic status.

Following the analysis of the quantitative survey data (n=200), eight participants were purposefully selected for in-depth qualitative interviews. This phase aimed to gain deeper insight into patterns observed in the quantitative results and to explore participants' experiences in detail. The number of interviews was guided by data saturation, as no new themes emerged after the eighth interview, indicating that the collected data were sufficient to address the research questions. Participants were selected to ensure diversity in key characteristics such as age, gender and education level, allowing for a range of perspectives to be represented. This sequential explanatory mixed-methods design prioritises depth and contextual understanding over breadth, with qualitative findings serving to elaborate and enrich the quantitative results rather than to generalise to the broader population

4.6 Validity and Reliability of the Instrument

Validity refers to the accuracy with which a data collection tool measures what it is intended to measure (Coleman, 2022). Ensuring validity and reliability are integral to the study. As such, the following steps were taken:

- Content Validity: A few well-known models, including TPB, SCT and HBM, that have been validated in behavioural research and healthcare settings served as the basis for the questionnaire modifications.
- Cronbach's Alpha Reliability: The reliability of the scales applied in the questionnaire was evaluated through the Cronbach's alpha coefficient. This analysis can be utilised to determine the degree to which the items of a particular scale or construct are compatible with one another. Additionally, Cronbach's Alpha measures the dependability of a tool. A high value of Cronbach's alpha (above 0.70) indicates strong internal consistency (Kennedy, 2022).
- Construct Validity: The questionnaire was tested with a small group of the target population (18) to evaluate the clarity, comprehensibility, and relevance of the items. Findings from the pilot study led to modifications in the questionnaire's wording and structure to improve construct validity. As noted by Kunselman (2024), conducting a pilot study is a vital initial step that enables researchers to assess their tools in a controlled setting before engaging in extensive data collection. This process is important because it allows the researcher to identify any unclear or misinterpreted questions that participants may encounter. It enables the researcher to make necessary adjustments to enhance clarity and relevance before distributing it to the actual sample (Sundram & Romli, 2023). The researcher identified ambiguous questions with improper wording through the responses from the pilot study. Framing inappropriate questions can lead to misunderstandings or confusion. Clarity and precision can be improved by refining the identified questions. This entails making sure that the construct intended to be measured is accurately represented in the questionnaire. According to Kunselman (2024), this improvement process during pilot research enhances the instrument's validity and reliability.

4.6.1 Trustworthiness

The reliability of the qualitative aspect of the research was maintained through rigorous data collection and analysis methods, supported by strategies discussed in existing literature. To enhance validity, Ahmed (2024) emphasised the importance of involving diverse groups in research. As a result, the study participants represented a diverse range of ages, genders, and educational backgrounds. The collected data were subjected to thematic analysis. Following the guidelines outlined by Braun and Clarke (2006), the research adhered to established

protocols for rigour in qualitative investigations to identify the main themes that surfaced from the interviews. To promote transparency in the procedure, the researcher kept a thorough audit trail, recording the steps taken in decision-making and analysis, which enhances the study's reliability (Lincoln & Guba, 1985; Enworo, 2023). Transferability was accomplished by providing detailed and contextual descriptions of the research setting, participant characteristics, and data collection methods (Ahmed, 2024). The comprehensive explanations and direct quotes from participants, as recommended by Shenton (2004) and Adler (2022), faithfully reflected the participants' viewpoints and were transcribed exactly. These approaches worked in unison to maintain the study's credibility, rigour, and trustworthiness.

4.7 Pilot Study

Before commencing this research, a pilot study was conducted. According to Sundram and Romli (2023), a pilot study is a preliminary, small-scale investigation undertaken before the primary research to evaluate its feasibility or improve the research design. Kunselman (2024) asserts that pilot studies are crucial for developing protocols and research methods. This process involves choosing a small set of participants to evaluate in the study. This aided researchers in pinpointing any ambiguities (i.e., uncommon items) and uncertainties in participant data (Teresi, Yu, Stewart & Hays, 2022).

The initial pilot study aimed to explore behaviours related to seeking mental health support, with a specific focus on understanding perspectives toward mental health and the accessibility of mental health services. The research examined various themes related to mental health-seeking behaviours. To assess the reliability of the scales used, Cronbach's alpha coefficient was employed. Unless otherwise noted, the internal consistency or reliability of the different items, measurements, or evaluations is measured by Cronbach's alpha coefficient (Kennedy, 2022). This coefficient evaluates the reliability of a subject's assessment of an instrument or the domain of a questionnaire (Cronbach, 1951). The first application of Cronbach's alpha was to assess the reliability of a psychometric tool. Higher values of Cronbach's alpha, which range from zero to one, indicate that the items are assessing the same construct. In contrast, a lower value suggests that some or all items may not be measuring the same construct (Cronbach, 1951; Forero, 2024).

4.7.1 Sample for Pilot Study

Table 4: Demographic Profile of Pilot Study Respondents

Variable	**Category**	**Frequency (n)**	**Percentage (%)**
Educational Level	No Formal Education	4	22.2%
	Primary Education	2	11.1%
	Secondary Education	5	27.8%
	Tertiary Education	7	38.9%
Total		*N=18*	*100%*
Gender	Male	9	50.0%
	Female	8	44.4%
	Other / Prefer not to say	1	5.6%
Total		*N=18*	*100%*
Age Group	18–24	2	11.1%
	25–34	4	22.2%
	35–44	4	22.2%
	45–54	3	16.7%
	55–64	3	16.7%
	65–74	2	11.1%
Total		*N=18*	*100%*

For this research, eighteen individuals participated in the initial phase of the quantitative study. The objective of the pilot study was to determine whether the developed questionnaire instrument was precise, reliable, and appropriate for the participants (Stensen & Lydersen, 2022). Those who took part in the pilot study were not eligible to join the main study. The questionnaire comprised 53 items, divided into six categories, each representing a distinct facet of mental health-seeking behaviour. The reliability of each category was evaluated using Cronbach's alpha coefficient. To ensure participants could understand the terminology, the pilot testing emphasised clarity. On average, it took twenty-five minutes to complete the

questionnaire. Furthermore, the participants' experiences and viewpoints regarding mental health were utilised to evaluate the relevance and clarity of the questions (Forero, 2024).

4.7.2 Pilot Study Data Collection

The pilot study included a total of eighteen participants. These people were specifically chosen from the Mkhuhlu area because the study population for the primary research was also based there. The volunteers represented a diverse range of age groups, genders, and educational backgrounds, reflecting the demographics expected in the main study. The data were collected firsthand by the researcher. Participants were approached directly in public and community settings near Mkhuhlu and invited to participate in the pilot study. Before administering the questionnaire, the researcher explained the purpose of the pilot project to each participant and obtained their verbal agreement.

During the in-person questionnaire administration, the researcher was available to assist participants with any questions or clarifications about the instrument's items. In addition to improving response accuracy, this approach enabled the detection of nonverbal indicators, such as hesitancy or perplexity, thereby facilitating the identification of questions that may be unclear or challenging to understand. Before the final questionnaire was used in the main study, it underwent several minor adjustments based on feedback and observations from the pilot project. To aid responders with lower literacy levels, certain sections were simplified, and several questions were rephrased for clarity.

Informed consent is essential in ethical research as it ensures that participants are aware of the study's risks, benefits, and procedures (Millum & Bromwich, 2021). Participants were informed of the study's objectives and made aware that their participation was voluntary. They were also told they could withdraw from the study at any time without penalty. All participants provided written informed consent. Additionally, participants were not required to share any information that could identify them, thereby preserving their anonymity. The data collected was kept secure, and access was restricted to the research team only (Millum & Bromwich, 2021).

4.7.3 Data Analysis for Pilot Study

The collected data were initially entered into an Excel spreadsheet and later transferred to SPSS. To summarise the participants' demographics and responses to each item, the researcher employed descriptive statistics. Subsequently, the researcher used Cronbach's alpha coefficient to evaluate the internal consistency of each theme.

4.7.4 Reliability Analysis

To assess the reliability of the instruments used, the study utilised Cronbach's alpha coefficient for each theme. The results are as follows:

Table 5: Cronbach's Alpha Coefficient of Knowledge and Awareness of Mental Health

Item-Total Statistics					
S/N	Items	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
1.	I know about conditions such as depression	35.00	15.647	0.710	0.692
2.	I know about anxiety	34.94	15.114	0.645	0.687
3.	I know about bipolar disorder	35.44	13.908	0.486	0.699
4.	Access to mental health services can help individuals cope with their mental health concerns.	34.61	16.487	0.438	0.715
5.	Lack of access to mental health services can hinder seeking mental health support.	34.78	16.889	0.231	0.735

6.	I know where to go should I need mental health services.	35.50	14.853	0.335	0.729
7.	I know about the mental health resources or support networks available in my community	36.72	12.448	0.505	0.702
8.	The available mental health care resources are effective in addressing mental health needs in the community.	36.56	16.026	0.196	0.752
9.	Mental health education programmes in my community would help reduce stigma and encourage people to seek help	35.17	16.382	0.366	0.720
10.	Mental health problems can	34.78	16.065	0.513	0.707

	have serious consequences if left untreated				

This theme showed acceptable reliability, indicating consistent responses among the items with a Cronbach's Alpha of 0.735.

Table 6: Cronbach's Alpha Coefficient of Sociocultural and Attitudinal Influence on Help-seeking Behaviours

	Item-Total Statistics				
S/N	Items	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
11.	Cultural beliefs in my community discourage seeking professional mental health services.	18.17	12.265	0.660	0.609
12.	There is a stigma associated with seeking mental health services in my community.	18.22	12.065	0.591	0.626
13.	Culture impacts attitudes towards	18.28	15.271	0.406	0.684

	mental health in my community.				
14.	I would be comfortable with discussing mental health openly in my cultural context	18.78	14.654	0.289	0.712
15.	It is best to avoid anyone who has mental health problems	20.22	16.183	0.255	0.711
16.	People in my community look down on those who seek mental health services.	18.50	12.618	0.574	0.633
17.	Traditional healing methods are more effective than modern mental health services	19.50	15.559	0.200	0.731

Cronbach's Alpha of 0.710 indicates that the theme demonstrates acceptable reliability, suggesting consistent responses across items.

Table 7: Cronbach's Alpha Coefficient of Perception of Stigma and Attitudes Towards Mental Health Treatment

	Item-Total Statistics				
S/N	Items	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
18.	People with mental health conditions should not be treated like outcasts in society.	41.33	17.647	0.498	0.693
19.	A person showing signs of mental disturbance should seek mental health care from a hospital.	41.28	21.507	0.424	0.702
20.	I am knowledgeable about mental health issues.	41.72	21.271	0.434	0.701
21.	Changes are needed in mental health services in rural communities.	41.06	22.761	0.389	0.710
22.	The community needs to prioritise	40.89	22.810	0.516	0.704

	mental health awareness and support.				
23	Mental health issues are common and not something to be ashamed of	40.94	21.820	0.572	0.692
24	I would be comfortable discussing mental health concerns with family members.	42.28	20.801	0.327	0.720
25	One may find it difficult to manage their mental health, given the resources available in the community.	41.50	20.853	0.360	0.713
26	My community provides enough support for those seeking mental health services.	41.33	22.471	0.350	0.713

27.	If I had mental health issues, I would go to a traditional healer (Sangoma)	42.00	23.176	0.159	0.740
28.	I would be able to identify when I need to seek help for my mental health	41.22	22.418	0.392	0.708

Cronbach's Alpha of 0.728 indicates acceptable reliability, suggesting consistent responses across the items.

Table 8: Cronbach's Alpha Coefficient of Culture, Coping and Community View on Mental Health

	Item-Total Statistics				
S/N	Items	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
29.	Pressure from family members may push one to seek mental health care	19.56	16.614	0.467	0.668
30.	I would be able to access mental health services if I needed them.	19.61	17.193	0.538	0.664

31.	One can manage mental health effectively without professional help.	20.78	17.242	0.245	0.721
32.	I have a positive attitude towards seeking professional help for mental health conditions.	20.17	11.559	0.549	0.653
33.	Seeking mental health support is a sign of strength.	19.11	18.575	0.375	0.694
34.	Mental health services are an important resource for maintaining overall health and well-being.	20.72	14.095	0.506	0.652
35.	Mental health problems are serious and can affect anyone.	20.72	17.154	0.503	0.667

Cronbach's Alpha 0.709. This theme has demonstrated acceptable reliability. Indicating consistent responses among the items.

Table 9: Cronbach's Alpha Coefficient of Perceptions of Mental Health Barriers

	Item-Total Statistics				
S/N	Items	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
36.	You often see people in the community seeking mental health support.	16.72	11.389	0.189	0.775
37.	One may feel pressure from the community to seek mental health support.	16.89	11.163	0.308	0.738
38.	I cope well with stress.	16.83	8.853	0.520	0.684
39.	I have effective stress coping strategies.	16.44	8.732	0.660	0.637
40.	I have felt overwhelmed in	15.94	8.526	0.659	0.635

	the past few months.				
41	Overall, I would say I have good mental health.	15.22	10.771	0.603	0.683

- Cronbach's Alpha: 0.735. This theme has demonstrated acceptable reliability. Indicating consistent responses among the items.

Table 10: Cronbach's Alpha Coefficient of Mental Health Interventions

	Item-Total Statistics				
S/N	Statements	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Cronbach's Alpha if Item Deleted
42.	Mental health services are expensive.	9.17	0.735	0.558	0.604
43.	Discussing mental health issues with family and friends can be helpful.	8.33	1.647	0.487	0.603
44.	Early intervention can	8.39	1.546	0.565	0.524

	prevent mental health issues from becoming more serious				

Theme 6 has a Cronbach's Alpha of 0.668, which is below the acceptable reliability threshold. This indicates inconsistent responses across the items. According to DeVellis (2016), a Cronbach's Alpha score of 0.668 is appropriate for a questionnaire or measurement tool in social science research. Strong reliability is often 0.70 or higher; however, values lower than this can be acceptable, particularly in exploratory research or complex social environments. DeVellis (2016) says that alpha levels ranging from 0.65 to 0.70 are acceptable, depending on the context and nature of the constructs being evaluated. According to Dong, Jong and King (2020), a Cronbach's alpha value of 0.60 or above is still appropriate for concluding. Thus, in a study examining mental health-seeking behaviours in a culturally specific setting, minor fluctuations in answers should be expected, resulting in slightly lower consistency, but not invalidating the findings. Dong, Jong, and King (2020) emphasise that if qualitative insights enhance the study, a Cronbach's Alpha of 0.668 is adequate to proceed with the conclusions.

The questionnaire instrument showed overall reliability and feasibility for evaluating behaviours related to obtaining mental health care, according to the pilot study.

The questionnaire instrument was improved by reducing the number of items. Four of the original fifty-three items were eliminated from the questionnaire. Because they were redundant, irrelevant and contributed little to the scales' overall reliability, these items were eliminated. Their removal streamlined the questionnaire, focusing on the most pertinent aspects of mental health-seeking behaviours. Additionally, the researcher reclassified some of the items. During the pilot study, the researcher identified five items that did not fit cohesively into any of the existing themes. These items did not exhibit compatibility with the conceptual framework of the established themes. As a result, these items were set aside and excluded from the main questionnaire. Their exclusion is intended to maintain thematic integrity and ensure that each theme is well-defined and dependable.

4.8 Data Collection

Data collection refers to the process of gathering information from various sources to address research questions (Bryman, 2021). The quantitative data for this research were collected through standardised questionnaires, whereas the qualitative data were gathered via structured interviews. The combination of these two methodologies enriched the data and allowed for a more comprehensive understanding of the research issue (Creswell & Plano-Clark, 2023).

4.8.1 Data Collection Tool: Quantitative Phase

The Questionnaire for the quantitative phase was created using validated scales and constructs derived from the Health Belief Model (HBM), the Social Cognitive Theory (SCT), and the Theory of Planned Behaviour (TPB). The purpose of the questionnaire was to evaluate the participants' attitudes, beliefs, perceived norms, self-efficacy, and intentions regarding mental health-seeking behaviours. It was designed as a 5-point Likert scale, with options ranging from "agree" to "strongly disagree" (see Appendix A).

Data Collection

A structured questionnaire was distributed to 200 participants as part of the data collection process. The researcher was present in person throughout this procedure, as the questionnaires were distributed and filled out directly. This presence served several key functions, including enabling the researcher to engage with participants, providing immediate clarification on any confusing questions, and ensuring that each respondent completed the questionnaire correctly and consistently. This approach enhanced the overall validity and reliability of the data collected by minimising response errors and misunderstandings. Participants were not asked to provide any information that could identify them. This was done to maintain confidentiality and anonymity, although true anonymity could not be entirely guaranteed due to the researcher’s presence.

After completing the physical questionnaires, all responses were uploaded to an online questionnaire platform (Google Forms) to digitise the data. This stage aimed to improve the efficiency of data management and analysis. The researcher improved data entry accuracy, made variable organisation and categorisation easier and efficiently prepared the information for statistical analysis by gathering responses in digital format. The use of an online questionnaire tool enabled automated processes, such as data cleaning, coding, and exporting to statistical software, which significantly enhanced the overall effectiveness and quality of the data analysis stage.

4.8.2 Data Collection Tool: Qualitative Phase

Semi-structured interviews were utilised for the qualitative phase. The interview questions were crafted to facilitate exploration of participants' experiences, such as "What are the primary reasons individuals refrain from seeking help for mental health issues?" and "In what ways do your family and cultural beliefs influence your perspectives on mental health?" These questions were posed to participants to gain a deeper insight into their experiences (see Appendix B). Theoretical frameworks guided the development of the interview questions. Eight participants were interviewed in person. The interviews were recorded and transcribed with the assistance of Otter AI, an AI transcription application that automatically converts audio into text.

4.9 Data Analysis

Data analysis entails utilising statistical and logical methods to assess and interpret the gathered data (Braun & Clarke, 2019). Techniques such as ANOVA, the Kruskal-Wallis test, and the Shapiro-Wilk test are employed in quantitative research to detect significant differences among groups (Pallant, 2020). Thematic analysis is a widely used method for uncovering patterns and themes within qualitative data (Braun & Clarke, 2019). Merging these two approaches provides a thorough understanding of the research issue (Creswell & Creswell, 2023).

4.9.1 Quantitative Data Analysis

The questionnaire data was initially recorded in Google Forms, making it easy to export to an Excel file. The Excel spreadsheet cleaned the dataset by assigning numerical values to the 5-point Likert scale responses, ranging from 1 to 5. This standardisation ensured the data were suitable for analysis. The Excel spreadsheet was imported into SPSS for statistical analysis. Howitt and Cramer (2020) emphasise that this methodical approach enables a comprehensive examination of questionnaire responses. It ensures the precision and trustworthiness of the outcomes. During the quantitative phase of the investigation, descriptive statistics and frequency analyses were utilised to collect and analyse data. Descriptive statistics, including means and standard deviations, were employed to provide an overview of the questionnaire results and participant demographics (Yan & Fan, 2021). The ability to discover central tendencies and variability within the sample makes this method extremely useful for interpreting patterns and trends in datasets (Yan & Fan, 2021). Specifically, categorical characteristics such as gender, education level and attitudes toward mental health were studied using frequencies. The frequencies provided the percentage of participants who held a specific opinion or demonstrated a specific behaviour, providing insight into the distribution of

responses across various categories (Abu-Bader, 2021). In quantitative research, descriptive statistics and frequencies are crucial because they facilitate the clear and concise summarisation of large volumes of data, laying the groundwork for subsequent inferential analysis (Abu-Bader, 2021).

In this research, various statistical methods were employed to assess differences in the dependent variables across groups and to examine relationships among variables. Initially, histograms were utilised to inspect the data distribution visually. To validate this assessment, the Shapiro-Wilk test was performed to analyse normality (Abu-Bader, 2021). Since the data did not follow a normal distribution, the Kruskal-Wallis test was conducted to identify statistically significant differences among the dependent variables across groups. Additionally, the relationships between non-parametric variables were analysed using Spearman's rank correlation.

4.9.2 Qualitative Data

In qualitative research, data analysis is viewed as an ongoing, informal process that often occurs before the formal stage (Kiger & Varpio, 2020). In this study, data analysis began with transcribing the voice recording and practising active listening. Following Salmona and Kaczynski (2024), the researcher concluded that verbatim transcriptions are the most reliable and impartial. Nonetheless, several lines were trimmed and rewritten to focus solely on the information the study was interested in (Bihu, 2024). According to Özden (2024), qualitative researchers categorise data based on themes, concepts, or related features. Thematic analysis was used in this study because it takes one step further by analysing the numerous aspects of the research problem and organising and describing trends throughout the dataset in detail (Majumdar, 2020). According to Braun and Clarke (2024), conducting a thematic analysis requires the researcher to actively participate in a rigorous process of familiarising oneself with the data, coding it and constructing a topic. The researcher classified the data into conceptual categories to identify themes and concepts that could be used to analyse the gathered information. The researcher analysed data using Braun and Clarke's (2013) six-step technique, with the participants suggesting the intervention strategy.

By reading the interview transcripts multiple times, the researcher was able to immerse themselves, which formed part of the first step of thematic analysis. This process of familiarisation allowed the researcher to understand the data. The research made initial observations and noted any potential themes that could serve as a guide in the later stages of

analysis. Thereafter, the researcher systematically reviewed the data and generated codes. This step involved identifying any points participants made regarding the research questions and assigning concise labels. The explicit and underlying meanings of the participants' information were considered, ensuring a detailed, rich coding process. Many codes were created to reflect the complexity of the participants' responses. In the third step, the researcher grouped the codes that related to each other. This phase involved identifying the patterns to formulate themes. Initially, the codes were clustered into preliminary themes and subthemes to highlight the significant ideas from the collected data. In the fourth step, the initial themes were reviewed to ensure they accurately reflected the coded data. After revisiting the themes, the researcher adjusted them as necessary to ensure coherence and alignment with the research questions. When the themes were finalised, the process of defining and naming them began. In this step, the researcher ensured that each theme was clearly articulated and explained how it relates to the research questions. Lastly, in the reporting phase, the researcher combined the themes into a cohesive narrative. Every theme was well discussed and supported by relevant excerpts from the interview data. This allowed the researcher to present a coherent, well-structured and persuasive analysis that demonstrated the breadth of the findings and how they answered the study's goals.

4.9.3 Integration of Data

In this stage of the study, the findings from both quantitative and qualitative research were integrated to provide an overall understanding of the attitudes, factors, and facilitators that influence mental health-seeking behaviours in rural communities. The quantitative results from the study contextualised the qualitative results and vice versa. Integration of the two data sets aligned with the sequential explanatory design (Toyon, 2021). The data from the questionnaires provided a broad overview of the attitudes, perceptions and behavioural patterns prevalent within the community. Furthermore, the interview data provided context and a deeper understanding of the quantitative results by emphasising individual experiences. The combination of quantitative and qualitative data provided an in-depth understanding of the factors that influence mental health-seeking in rural communities like Mkhuhlu.

Triangulation of the data was particularly important in this research study, as quantitative data informed the areas of focus in the qualitative phase, and qualitative data served as a validation tool for the statistical trends (Kimmons, 2022). Meydan and Akkaş (2024) emphasised that integrating data in this way enhances the validity of findings by serving as a cross-verification method, allowing the researcher to identify discrepancies between datasets.

Takona (2024) highlighted that the importance of mixed methods lies in their ability to address the complexity of human behaviour and social phenomena more effectively. The integration of quantitative and qualitative data in this study not only enriched the findings but also provided a complete multi-dimensional overview of the factors influencing mental health-seeking behaviours within the community (Mertens, 2024).

4.10 Ethical Considerations

Prior to initiating data collection, the proposal was submitted to the Faculty of Social Sciences Postgraduate Committee for assessment, before being sent to the University Research Ethics Committee for a thorough evaluation to confirm its feasibility and address any ethical considerations. Approval to conduct the study in the Bushbuckridge Mkhuhlu area was also secured from the Traditional tribal authorities (Hosi Nkuna) of the Nkuna Tribal Council, which oversees the Bushbuckridge Mkhuhlu region. Informed consent was obtained from all participants, and measures were taken to ensure confidentiality, anonymity, and voluntary participation throughout the research (Millum & Bromwich, 2021).

In this study, the researcher focused on reducing harm and ensuring participant safety throughout the research process. To reduce risks, the survey and interview questions were crafted to avoid asking participants to elaborate on or share distressing or subjective experiences (Hwang, 2023). The researcher also provided participants with a comprehensive explanation of the interview's nature and how the data would be utilised.

Participants were screened prior to the interviews using the adapted "Screening Interview and Distress Protocol" developed by Draucker and Martsolf (2009, pp. 347). They were provided with written informed consent forms, and the researcher ensured that participants understood the study's purpose, their role in it, and the potential benefits and risks (Nair, 2022). After this, participants were asked to sign the consent form and verbally affirm their understanding and acceptance. They were guaranteed complete confidentiality and privacy throughout the process. Furthermore, the researcher shared contact details for any questions or concerns that might arise (Pietrzykowski & Smilowska, 2021).

The study excluded deception of respondents, as complete awareness of the study's nature and goals would not compromise the data. The questions are directly related to the participants' experiences and perceptions regarding the research topic. By properly informing participants about the study's scope, their understanding of its full purposes, and their involvement, their

understanding was affirmed, leading to the successful collection of relevant data (Dougherty, 2021).

Confidentiality is the understanding between the researcher and the participant that ensures sensitive information is treated with care and discretion. The student served as the only researcher, responsible for collecting and managing the data while guaranteeing that no information was disclosed outside the research framework (Hoft, 2021). To further protect their identities, participants were given pseudonyms. Additionally, no information from the interviews, including demographic details or topics discussed, was shared with anyone (Dougherty, 2021).

Privacy is a person's entitlement to limit others' access to various aspects of themselves, including thoughts, personal identifiers, and even information contained in bodily tissues and fluids (Hoft, 2021). Throughout the research process, the confidentiality of participants and their stories was maintained. No identifiable participant information was revealed outside of the research context.

Anonymity is often confused with confidentiality. Willies et al. (2008) clarify that anonymity refers to the separation of participants from the information shared about them. The researcher maintained participants' anonymity throughout the study. At no time were participants required to provide their personal details. Furthermore, the researcher used pseudonyms when necessary to ensure that responses remained confidential and identities were safeguarded. Hwang (2023) noted that this approach fosters trust between participants and the researcher, encouraging open and honest responses.

The researcher had an ethical obligation to demonstrate competence. According to Hwang (2023), researchers must show awareness and skill in the research process, particularly in human research. The researcher demonstrated competence by ensuring that participants were adequately informed and reassured that their data would be handled confidentially and that their identities would remain anonymous and untraceable. In this study, the researcher did not conduct any interviews or distribute questionnaires without obtaining informed consent from the subjects.

Although formal ethical approval was obtained and informed consent procedures were followed, conducting research with participants in rural communities raises additional ethical considerations. Cultural sensitivity was prioritised by allowing participants to express experiences using locally meaningful terms and by acknowledging the legitimacy of traditional

belief systems. Given the potential for emotional distress during discussions of mental health, participants were reminded of their right to pause or withdraw from interviews at any point. Power imbalances were mitigated by emphasising the voluntary nature of participation and by adopting a non-hierarchical interview approach that positioned participants as experts of their own experiences.

4.11 Summary

This section provides an overview of the research framework, sampling techniques, data collection methods, data analysis approaches, and the study's research methodology. To maintain the study's credibility and dependability, ethical considerations were taken into account. The methodological selections outlined in this section were designed to achieve the study's goals while ensuring the validity and reliability of the findings. The outcomes and conclusions derived from the data collection will be presented in the following chapter, after the research methodology has been thoroughly established. Chapter 5 will include a complete analysis and interpretation of the data, reflecting on the study's research questions.

CHAPTER 5

RESULTS AND DISCUSSION

5.1 Introduction

This chapter presents data analysis, findings and discussion. The quantitative data are first analysed and presented, starting with the Shapiro-Wilk normality test results. The study employed a normality test, which was deemed the appropriate analytical approach for the dataset. To provide a clear understanding of the nature and distribution of the data, the chapter then presents the descriptive analysis. The chapter then compares the mean scores across several groups using both parametric and non-parametric statistical tests. However, when the data do not meet the normality assumptions, the nonparametric Kruskal-Wallis test is used. A correlational analysis examining the relationships among the variables under investigation is also presented in this chapter. The findings provide further insight into the interactions and influences between these variables.

In addition, the chapter presents the study's findings, including interpretations and comments based on the research hypotheses, as well as linkages to current literature on mental health-seeking behaviours. The chapter will also connect the statistical and qualitative results, providing meaning and context to the statistical findings using quantitative data. The chapter will also look at whether the results support or contradict previous research and theoretical frameworks. Meaningful inferences about the study's relevance for enhancing mental health-seeking behaviour in rural communities will also be drawn.

5.2 Determining Statistical Approach Through Test of Normality

A crucial step in determining the appropriate statistical method for data analysis is the Shapiro-Wilk test. This study employed this test to determine whether the data followed a normal distribution (Shapiro & Wilk, 1965). Nicholas and Edlund (2023) argue that if the data are normally distributed, parametric tests such as ANOVA can be used. This method is used to compare group means; however, if the data do not follow a normal distribution, non-parametric tests, such as the Kruskal-Wallis test, are more suitable. Pallant (2020) emphasised the importance of using the results from normality tests as a guide when selecting statistical analysis. Doing this will ensure reliable and robust findings (Habibzadeh, 2024).

Determining whether the data met the assumption required for a parametric or non-parametric test was an important step in the data analysis phase of this study. The decision was based on

examining data distribution using histograms. It is essential to note that the data type guides decisions and determines whether the data follow the established statistical assumptions.

Evans (2024) defines parametric tests as statistical procedures that assume normality of the data. The key assumptions first hinged on normality; essentially, this means that the data should mimic a bell-shaped distribution. Secondly, the groups being compared should have similar variances. Finally, parametric tests require data measured on an interval or ratio scale (Pallant, 2020); examples include the t-test, ANOVA, and Pearson's correlation. These tests are excellent as they use all the information in the dataset and are said to have greater statistical power when assumptions are met (Nichols & Edlund, 2023). However, if any crucial assumptions, such as normality, are violated, the findings of parametric tests may become unreliable, leading to incorrect interpretations and conclusions. This case highlights the importance of verifying data distribution before analysis. In contrast, non-parametric tests are statistical methods that do not assume normality of the data (Habibzadeh, 2024). These tests are also known as distribution-free tests. They are suitable for data sets that do not follow the standard distributional assumption, when the sample size is small, and when the data uses ranking or an ordinal scale. The Kruskal-Wallis test, the Mann-Whitney U test, and Spearman's rank correlation are examples of nonparametric tests. Although flexible, these tests can handle any deviation from the assumption (Luna, Moya, Luna & Ventura, 2024). They are less powerful than parametric tests when the data distribution is normal.

5.2.1. Histograms as Means for Determining Test Choice

The role of histograms in the study was to visually assess the distribution of each variable. The histograms allowed visual detection of skewness, outliers, and deviations from normality. We should employ nonparametric tests if the histograms indicate nonnormality and parametric tests if they indicate normality. The use of histograms is important in this study, as it aligns with best statistical analysis practices to ensure the correct method is used (Demir, 2022). The use of histograms when determining which statistical method to use is a form of methodological rigour. It could help to maintain the integrity of the statistical analysis and ensure that results are valid and reliable. The following are the five variables assessed:

i. Perceptions of stigma and attitudes towards mental health treatment

ii. Culture, coping and community views on mental health

iii. Perception of mental health barriers

iv. Sociocultural and attitudinal influence on help-seeking behaviours

v. Knowledge of mental health

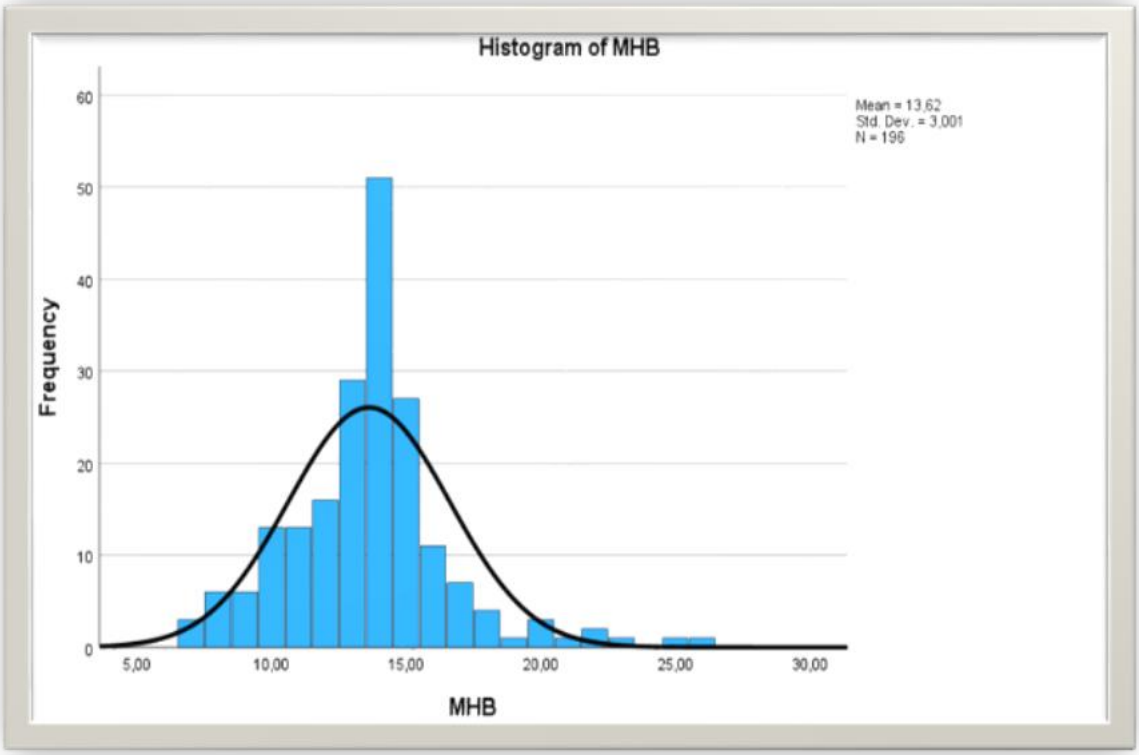


Figure 2: Histogram of Perceptions of Stigma and Attitudes Towards Mental Health Treatment

In Figure 2, the histograms of perceptions of stigma and attitudes towards mental health treatment show a slightly positively skewed distribution. The Figure shows apparent deviations from complete normality, despite the data having a bell-shaped distribution, with most values clustered around the mean of 13.62 and tapering off towards the tails. The few data points that exceed the 25-point range indicate the presence of outliers, which may skew the data's normal distribution. The Shapiro-Wilk test results for gender groups 1 and 2 were significant ($p < 0.001$), indicating that the null hypothesis of normality was rejected for these groups. The Kolmogorov-Smirnov (KS) test also yielded significant p-values. According to Dudley (2023), when the p-value in normality tests is less than 0.05, the data significantly deviate from normality.

Skewness is the asymmetry of a probability distribution and plays a crucial role in determining whether a distribution is normal (Nichols & Edlund, 2023). In a perfectly normal distribution,

skewness is expected to approach zero (Nichols & Edlund, 2023). This means that even the slightest positive skewness, as shown in the Figure above, indicates that some values are higher than the mean, resulting in a longer right tail. According to Tabachnick and Fidell (2019), kurtosis measures the peakedness of the distribution, which can differ from the normal value of 3, as indicated by the histogram, which shows a small peak around the mean.

The findings of the statistical tests and the visual inspection indicate that the MHB variable does not meet the normality assumptions. Therefore, we recommend non-parametric alternatives that are more robust to violations of normality. The following Figure (Figure 3) presents a histogram of views on culture, coping and community related to mental health.

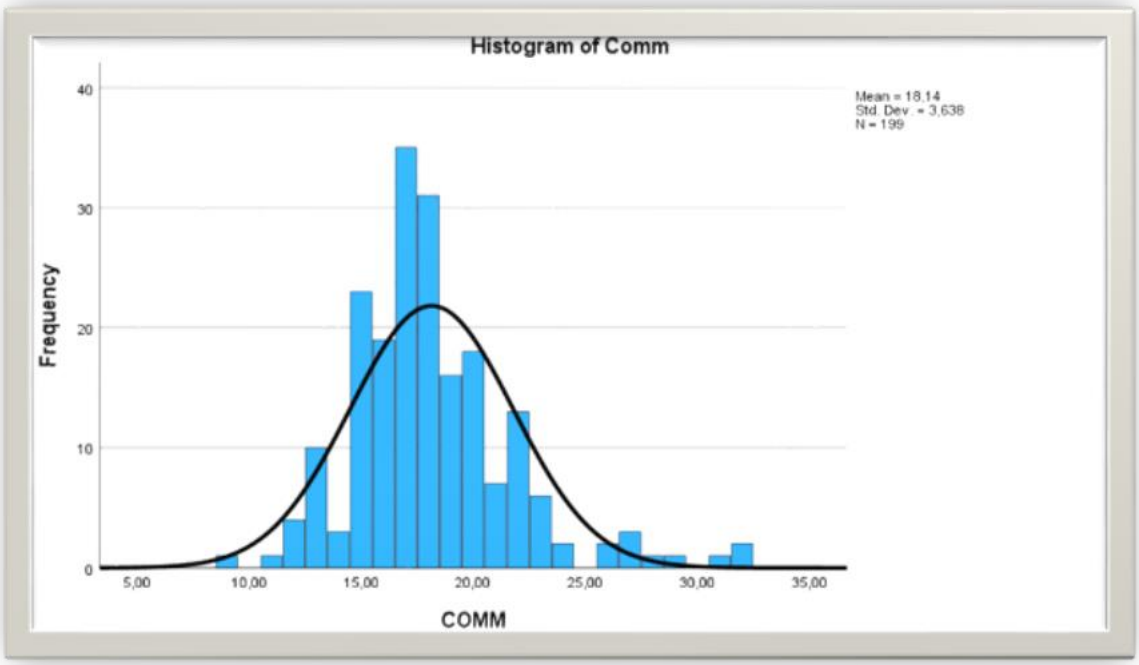


Figure 3: Histogram of Culture, Coping, and Community Views on Mental Health

Figure 3 shows that the culture, coping, and community views of mental health (COMM) exhibit a bell-shaped distribution. However, a slight positive skewness is observed. The mean value is 18.14, and the standard deviation is 3.638; these values indicate a moderate spread around the central tendency, with most of the data clustered between 15 and 22, exhibiting a visible tapering towards the right tail. The positive skewness indicates that a small proportion of participants reported values above the mean, extending to 25 and approaching 35. The

presence of outliers and skewness challenges the assumption of perfect normality, despite the histogram resembling a normal distribution.

Additionally, the significant p-value ($p < 0.05$) would reject the null hypothesis of normality, as supported by the visual evidence provided in Figure 3. The deviations observed from the statistical and visual approaches will likely impact the parametric statistical tests. The use of non-parametric methods would be more appropriate in this case because the histogram for COMM shows a general tendency toward a bell shape; the visual presence of skewness and outliers indicates significant deviations from normality (Dudley, 2023). Next, Figure 4 presents a histogram of perceptions of mental health barriers.

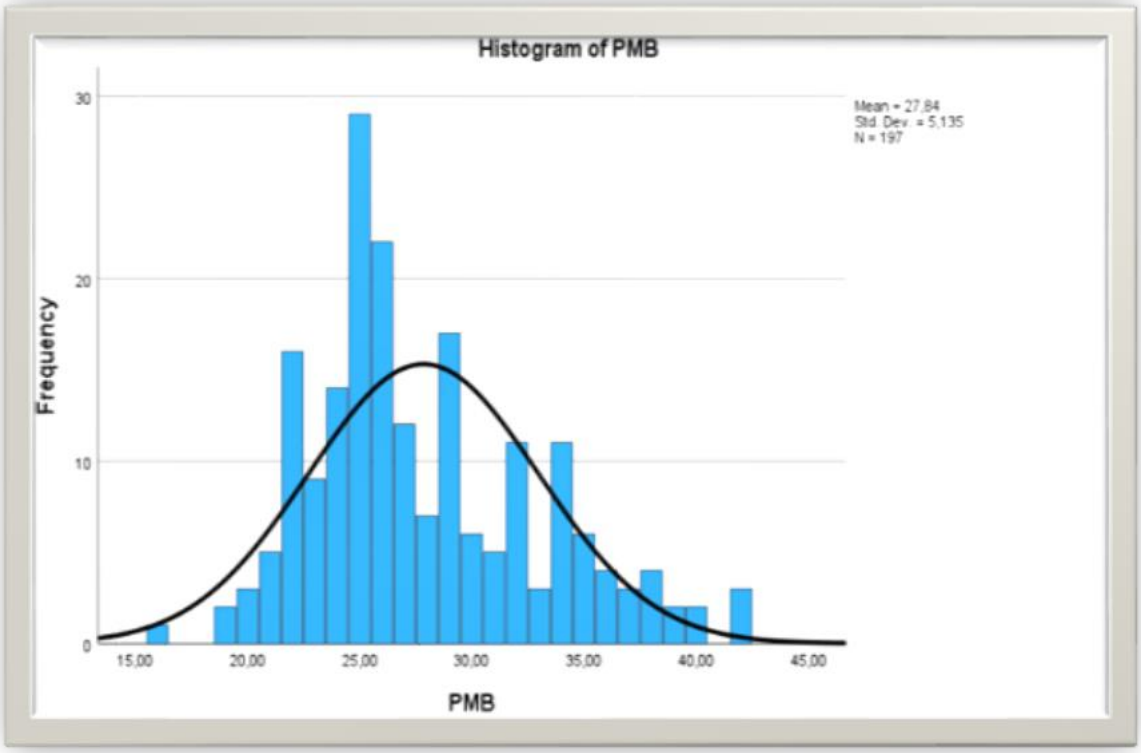


Figure 4: Histogram of Perceptions of Mental Health Barriers

Figure 4 illustrates perceptions of mental health barriers, with a significant positive skew. It shows that the mean is 27.84, the standard deviation is 5.135, and the data are tightly clustered between 22 and 30. The tail clearly extends to the higher end between 35 and 45, indicating that a sizable proportion of participants reported moderate levels of perceived mental health barriers, with a small proportion reporting much higher scores. This trend results in a prolonged tail, and the positive skewness indicates an irregular distribution of data. Khatun (2021)

describes the data as asymmetrically distributed, with a leftward skew. Skewed data distribution is a common phenomenon in psychology and social science research, as answers are often influenced by individual and community-level factors that vary across individuals.

Figure 4 indicates potential outliers within the higher range. Such findings may negatively influence statistical analyses that assume normality. Pallant (2020) argues that the validity of parametric tests may be compromised when data depart from normality, particularly in terms of skewness and kurtosis.

The Shapiro-Wilk tests would likely yield significant results ($p < 0.05$), providing supporting evidence for the visual evidence of positive skewness illustrated in Figure 4. Such results would lead to the rejection of the null hypothesis of normality. Thus, the use of non-parametric tests would be appropriate.

The skewness observed in this variable may reflect real-world perceptions of mental health barriers, especially in rural communities (Khatun, 2021). According to Corrigan (2014), people in rural and underserved communities often experience a wide range of barriers when it comes to accessing mental health care or care in general. The following Figure 5 presents a histogram of sociocultural and attitudinal influences on help-seeking behaviours.

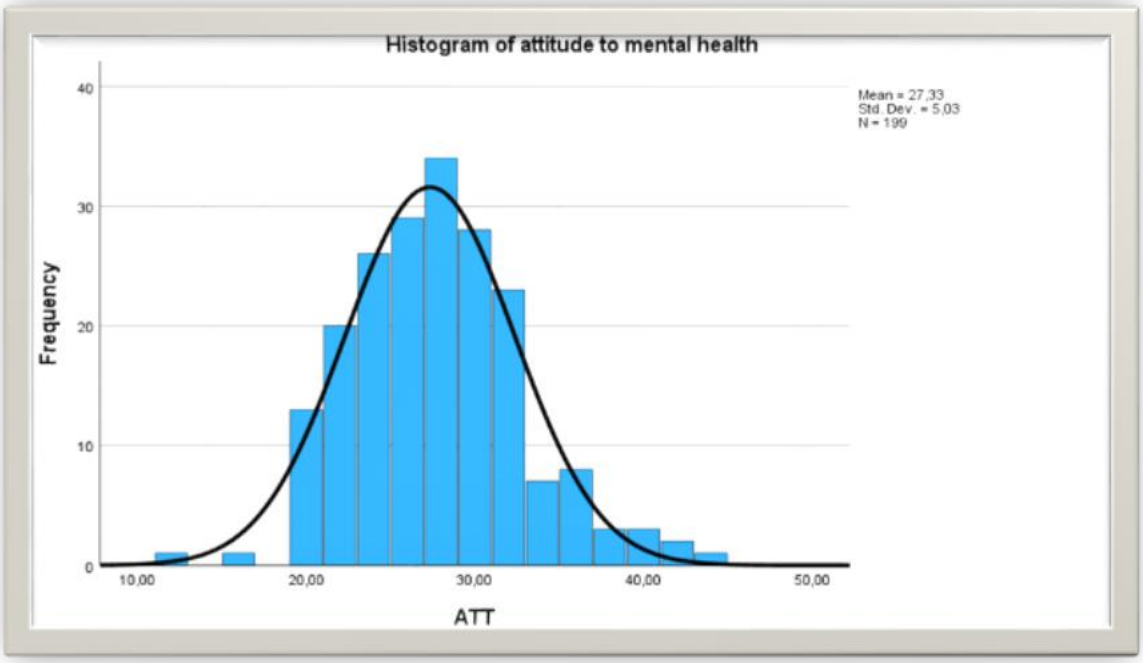


Figure 5: Histogram of Socio-cultural and Attitudinal Influence on Help-seeking Behaviours

The histogram of social-cultural and attitudinal influences on help-seeking behaviour (ATT) displays a normal distribution, as evidenced by its bell-shaped curve. The data demonstrates a moderate spread, with a mean of 27.33 and a standard deviation of 5.03. Frequencies begin to increase between 25 and 30, indicating that most answers fall within a narrow range around the mean. The data may be normally distributed, as evidenced by the symmetrical distribution of values around the mean. In a typical distribution, most data points cluster around the mean, and as you move away from the centre, you will see fewer observations (Dudley, 2023).

The shape of the histogram is consistent with the Central Limit Theorem. The theorem states that, for sufficiently large sample sizes ($n > 30$), the sampling distribution of the mean tends to be normal regardless of the population distribution. In Figure 4, although the data came from a single population, it is plausible to assume normality given the large sample size of 200 participants.

The symmetrical distribution suggests that parametric tests, such as ANOVA or t-tests, would be appropriate for analysing this data. These tests offer practical approaches for comparing group means, assuming the distributions of the variables are normal (Pallant, 2020). The Shapiro-Wilk or Kolmogorov-Smirnov tests for normality would produce p-values of 0.05, indicating no significant deviation from normalcy. Statistical approaches based on parametric assumptions are valid since the histogram appears normal. To compare group averages, independent t-tests or ANOVA are used, followed by Pearson's correlation to assess associations (Demir, 2022). When data display signs of a normal distribution, researchers typically use these tests, which yield more accurate and robust results than nonparametric tests. Although the ATT variable shows normality, non-parametric methods would ensure methodological consistency across all variables and eliminate the risk of falsely assuming normality. Figure 6 illustrates the histogram of knowledge regarding mental health.

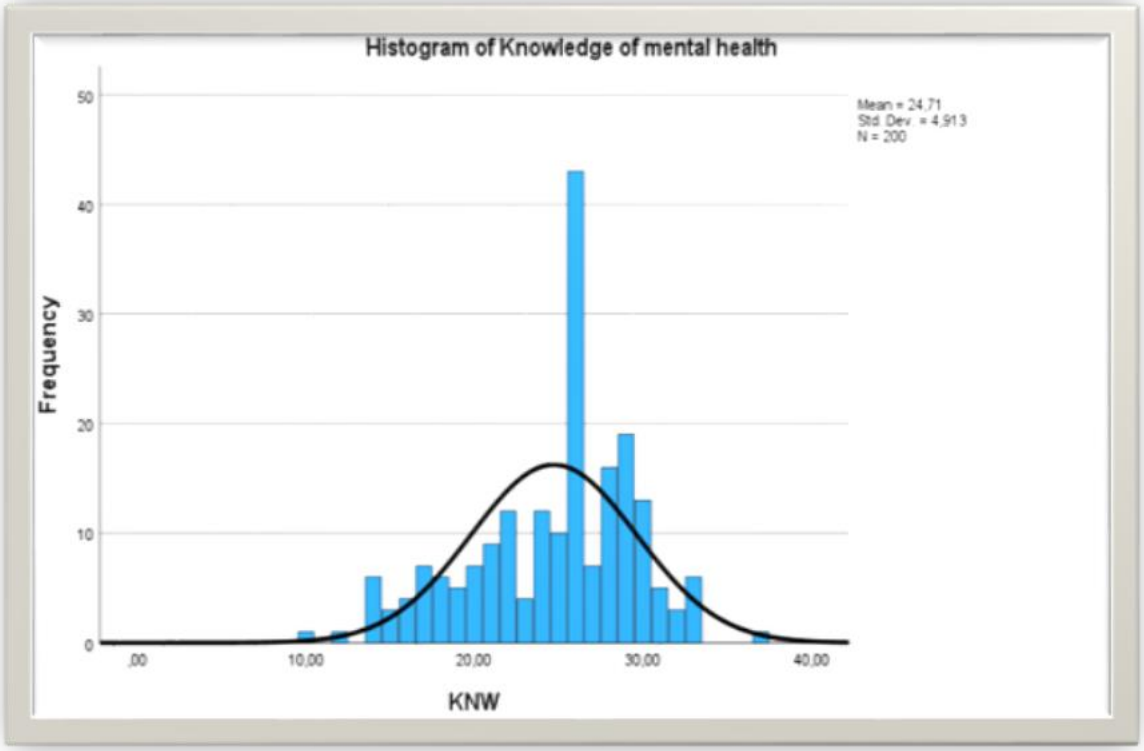


Figure 6: Histogram of Knowledge and Awareness of Mental Health

The histogram illustrates the knowledge scores related to mental health (KNW), which helps determine the appropriate statistical approach: parametric or nonparametric. The dataset shows a standard deviation of 4.913 and a mean of 24.71. These two figures show a moderate spread in scores. The distribution exhibits positive skewness and a tail that extends to higher values, exceeding 30. This signal suggests that the distribution is not normal. According to Akhatu (2021), even minor deviations from normality can affect the reliability of parametric testing. The observed positive skewness and the presence of outliers in the tails highlight the suitability of non-parametric methods. According to Dudley (2023), non-parametric tests are suitable for skewed data with outliers, as outliers have a more negligible influence than in parametric alternatives. Although the large sample size (n=200) allowed parametric testing under the Central Limit Theorem, the noticeable skewness and potential outliers underscored the importance of checking for normality and considering nonparametric methods. When normality tests revealed substantial disparities, nonparametric procedures such as the Kruskal-Wallis test provided a more robust means of ensuring the analysis was correct and reliable. When normality tests revealed significant deviations, non-parametric methods, such as the Kruskal-Wallis test, provided a more robust approach, ensuring the analysis was valid and accurate.

5.3 Data Analysis and Findings of the Study

Starting with the questionnaire responses, this section analyses and discusses the results, focusing on key factors that influence mental health in rural communities. Following this, the themes extracted from the qualitative data will be addressed, and a final integration analysis of both the quantitative and qualitative data will be conducted.

5.3.1 Measured Variables

The study measured the following variables: sociocultural and attitudinal influence on help seeking (ATT), perception of mental health barriers (PMB), cultural influence, coping mechanisms and community perceptions of mental health support (COMM), perception of stigma and attitudes towards mental health treatment (MHB) and knowledge of mental health (KNW). The tables below illustrate how the 200 participants responded to the questionnaire.

5.3.1.1 Knowledge and Awareness of Mental Health

This variable explores participants' general understanding and awareness of mental health concepts, including symptoms, causes and the importance of mental well-being.

Table 11: Knowledge and Awareness of Mental Health

Knowledge of mental health	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Median
I know about conditions such as depression	24.6%	32.2%	8%	30.2%	5%	2.3
I know about anxiety	28.5%	43.5%	7%	17.5%	3.5%	2.0
I know about bipolar disorder	31.5%	44.5%	7.5%	13.5%	3%	1.9
Access to mental health services can help individuals	1%	4.5%	3%	78.5%	13%	4

cope with their mental health concerns						
Lack of access to mental health services can hinder seeking mental health support	1%	6.5%	3.5%	75%	14%	4
I know where to go should I need mental health services	11.6%	55.5%	1%	27.1%	4.5%	2
I know about the mental health resources or support networks available in my community.	37%	48.5%	3.5%	10%	1%	2
The available mental health care resources are effective in addressing mental health needs in the community	34.7%	40.2%	11.1%	12.1%	2%	2

Mental health education programs in my community would help reduce stigma and encourage people to seek help	2%	3.5%	2%	63.3%	29.1%	4
Mental health problems can have serious consequences if left untreated	1.5%	3%	3.5%	79%	13%	4

The analysis of responses regarding knowledge of mental health (KNW) highlights important patterns in the community's understanding of mental health conditions, the perceived importance of services, and awareness of local resources. Overall, the findings suggest a community that is conceptually aware of mental health as a legitimate concern but lacks detailed knowledge and practical information to support effective help-seeking behaviours. The median scores across the items showed an overall tendency towards agreement, suggesting that most respondents demonstrated a moderate level of awareness of mental health concepts. However, variations in responses imply that understanding of specific conditions remains uneven among community members.

Responses regarding knowledge of specific mental health conditions revealed a generally low level of awareness among participants. Only 35.2% of those surveyed reported being aware of depression, while even fewer acknowledged awareness of bipolar disorder (16.5%) or anxiety (21%). Additionally, 44.5% of respondents indicated a lack of knowledge about conditions related to bipolar disorder, and the majority expressed disagreement or strong disagreement with the idea of learning more about these mental health issues. These results suggest a deficiency in diagnostic understanding within the general population, which may hinder

individuals from accurately diagnosing or distinguishing between different mental health disorders. This outcome aligns with earlier studies conducted in rural areas of South Africa, where mental health issues are often misunderstood or viewed through spiritual or cultural perspectives rather than scientific terms (Masemola, Moodley & Shirinde, 2022; Petersen et al., 2020).

Respondents demonstrated a strong awareness of the necessity for access to mental health services, despite lacking specific information about conditions. 91.5% of respondents agreed or strongly agreed that access to services helps them manage their circumstances, while 89% believed that the absence of such access discourages individuals from seeking assistance. In the same vein, 92% of participants perceived untreated mental illness as a threat. Even among those who might not fully grasp the academic terminology, these responses reflect an increasing acknowledgement of mental health as a genuine and significant issue. Even in low-income and rural areas, mental health is gaining more recognition, as shown by this conceptual understanding and broader advancements in public perceptions.

Despite this optimistic view, a significant gap remains between practical awareness and perceived relevance. Only 11% of people agreed or strongly agreed that they were aware of local mental health support networks or resources, while more than half (55.5%) disagreed that they knew where to get mental health care. 74.9% of respondents strongly disagreed or disagreed with the effectiveness of local services in addressing mental health difficulties. Despite admitting the seriousness of mental health issues, these findings highlight a critical knowledge gap that may prevent community members from acting.

Notably, there was broad agreement on the potential benefits of mental health education. A total of 92.4% of respondents believed that community education programmes would help reduce stigma and encourage help-seeking. Even among individuals with little prior knowledge, this answer demonstrates a strong willingness to learn and lays the groundwork for future activities that improve mental health.

To summarise, there are significant gaps in specific knowledge and understanding of local options, despite the community's overall good attitude toward mental health and recognition of its importance. A recurring theme in rural mental health literature is the gap between broad awareness and practical application, emphasising the need for more freely accessible, contextually relevant information to enable rapid help-seeking and well-informed decision-making.

5.3.1.2. Sociocultural and Attitudinal Influence on Help-Seeking Behaviours

This variable captures how cultural beliefs, family expectations and personal attitudes shape individuals' willingness or reluctance to seek help for mental health concerns.

Table 12: Sociocultural and Attitudinal Influences on Help-Seeking Behaviours

Sociocultural and Attitudinal Influences on Help-Seeking Behaviours	Strongly Disagree	Disagree	Neutral	Agree	Strongly agree	Median
Cultural beliefs in my community discourage seeking professional mental health services.	1.5%	9.5%	1.5%	71.4%	16.1%	4
There is a stigma associated with seeking mental health services in my community.	2%	7%	4%	65%	22%	4

Culture impacts attitudes towards mental health in my community.	0.5%	5.5%	4.5%	73.9%	15.6%	4
I would be comfortable with discussing mental health openly in my cultural context	5.5%	42%	4.5%	43.5%	4.5%	3
It is best to avoid anyone who has mental health problems	19.6%	42.7%	10.6%	23.6%	3.5%	2
People in my community look down on those who seek mental health services.	3.5%	23.6%	10.5%	42.7%	19.6%	4

Traditional healing methods are more effective than modern mental health services	14.5%	31%	13.5%	34%	7%	3

The results regarding the variable Sociocultural and Attitudinal Influence on Help-Seeking Behaviours highlight a complicated relationship among cultural beliefs, social stigma, and the willingness to engage with mental health issues in the examined community. While most participants acknowledged that stigma and culture play a crucial role in shaping mental health behaviours, there were notable differences in their comfort levels when it came to talking about mental health and their perspectives on individuals with mental health conditions.

The median scores generally clustered around “Agree” (4). This score reflects a positive attitude towards mental health services and recognises their importance. However, slightly lower median accessibility values suggest that perceived barriers to service remain dominant.

A large majority of respondents acknowledged the impact of cultural beliefs and community attitudes on the willingness to seek help. In particular, 87.5% either agreed or strongly agreed that cultural beliefs in their community discourage individuals from pursuing professional mental health services. In comparison, 89.5% agreed that culture influences perspectives on mental health. These results align with earlier studies conducted in rural South Africa, where traditional belief systems often perceive mental illness as a spiritual issue or the outcome of ancestral grievances, prompting people to turn to traditional healers or spiritual leaders instead of medical practitioners (Petersen et al., 2020; Van der Walt & Mabaso, 2021). Such cultural environments may unintentionally prevent individuals from accessing formal mental health services. Additionally, perceived stigma appeared as a crucial social factor; 62.3% of respondents felt that individuals in their community look down on those who seek mental health assistance, and 87% agreed or strongly agreed that there is stigma associated with receiving such care. This corresponds with recent studies showing that mental illness continues

to be a taboo topic in numerous rural African communities, often resulting in individuals suffering from it being ostracised, shunned, or isolated (Kola et al., 2021). The persistence of stigma, even among those who acknowledge its harmful effects, suggests that deeply rooted societal norms persist in shaping attitudes and behaviours related to mental health.

When asked if individuals felt safe discussing mental health in their cultural setting, responses varied. There was considerable ambivalence, with only 48% agreeing or strongly agreeing and 47.5% objecting or strongly disagreeing. This exemplifies the conflict between growing awareness and persistent anxiety, in which people may intellectually recognise the importance of mental health but feel bound by societal norms, fear of being judged, or a lack of community support for candid conversations. Other studies have observed ambivalence in rural areas, where mental health remains a "silent struggle" due to fears of being misconstrued or branded (Campbell-Hall et al., 2019).

Responses to the statement further highlight this tension: "It is best to avoid anyone who has mental health problems." 10.6% were neutral, 27.1% agreed with the stigmatising perspective and 62.3% disagreed with it. This implies that a large proportion of the population still has avoidant or fear-based attitudes toward people with mental illnesses, which may be influenced by cultural narratives portraying them as dangerous, unpredictable, or spiritually damaged.

Finally, opinions on the effectiveness of traditional healing methods compared to modern services were divided. Forty-one per cent of participants agreed that traditional healing is more effective, 45.5% disagreed, and 13.5% were neutral. This division reflects the coexistence of biomedical and traditional understandings of mental health in many rural African settings. Some community members may choose and trust modern treatments due to cultural familiarity, accessibility, or spiritual alignment, while others remain rooted in traditional healing methods (Gqaleni & Mkhize, 2023). Importantly, this does not imply that professional services are being rejected; rather, it illustrates that traditional healing remains a recognised and culturally supported type of support.

Overall, the study's findings on sociocultural and attitude influences on help-seeking behaviours indicate a community that is becoming more aware of mental health issues and the role that stigma and culture play, but is still grappling with internal tensions between conventional wisdom, social norms and contemporary mental health discourse. Many participants expressed discomfort with open communication and remained distrustful of professional services, despite acknowledging the detrimental effects of stigma and cultural

norms on their lives. These findings underscore the importance of addressing both cultural beliefs and community-level attitudes to promote mental health awareness and increase help-seeking behaviour. They reflect broader rural mental health dynamics in South Africa.

5.3.1.3 Culture, Coping and Community Views on Mental Health

The variable culture, coping and community view on mental health examined how cultural background and community perspectives influence coping strategies and beliefs about mental health and its treatment.

Table 13: Culture, Coping and Community Views on Mental Health

Culture, Coping and Community Views on Mental Health	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Median
Pressure from family members may push one to seek mental health care	0.5%	10.1%	5%	72.4%	12.1%	4
I would be able to access mental health services if I needed them.	9.5%	43.7%	2.5%	40.2%	4%	2
One can manage mental health effectively without	29%	33%	2.5%	32.5%	3%	2

professional help.						
I have a positive attitude towards seeking professional help for mental health conditions.	7%	21%	17%	49%	6%	4
Seeking mental health support is a sign of strength.	13%	27.5%	11%	39.5%	9%	3
Mental health services are an important resource for maintaining overall health and well-being.	7%	22.5%	7%	42.5%	21%	4
Mental health problems are serious and can affect anyone.	9.5%	14%	3%	65%	11.5%	4

The analysis of the responses related to Culture, Coping and Community Views on Mental Health reveals a community that generally acknowledges the seriousness of mental illness and the value of professional support. There are, however, conflicting views on accessibility, self-sufficiency and whether asking for help is regarded positively. These opposing responses highlight the complex interplay in rural mental health settings between personal beliefs, social constraints and cultural norms. Most participants (84.5%) agreed or strongly agreed that family pressure could lead to persons seeking mental health care. This highlights how familial and societal institutions shape the actions of those seeking assistance, particularly in rural areas where decisions are often made collectively. Van der Watt et al. (2020) argue that family members in many South African communities play a significant role in either supporting or discouraging treatment-seeking, based on existing cultural narratives, which, they argue, contributes to these findings.

Perceived service availability remains a barrier. In response to the statement "I would be able to access mental health services if I needed them," only 44.2% agreed or strongly agreed, while 53.2% disagreed or strongly disagreed. This negative perception of accessibility can be attributed to infrastructure issues in rural South Africa, including transportation problems, lengthy journeys to clinics, and a shortage of mental health specialists (Abraham & Lund, 2022). Even people who are willing to seek help may find it difficult due to structural hurdles.

Coping belief answers were split. Notably, 35.5% agreed or strongly agreed with the statement "one can manage mental health effectively without professional help," while 62% disagreed. This means that even while many individuals recognise the importance of professional care, independence and unofficial coping mechanisms, such as family support, spiritual healing, or customary practices, may still be valued or tolerated. These findings are consistent with previous research in rural South Africa, which has emphasised the role of traditional belief systems, community-based support and internal coping in managing emotional distress (Petersen et al., 2021; Gqaleni & Mkhize, 2023).

Individual sentiments were largely positive. Only 28% of people disagreed, while 55% expressed a positive attitude toward seeking professional help. Similarly, 40.5% of respondents disagreed with the statement "seeking mental health support is a sign of strength," while 50.5% agreed or strongly agreed. Even if negative sentiments persist, these findings indicate a growing

shift in attitudes, with more people recognising the value and relevance of professional mental health care.

Additionally, 76.5% of respondents believed that mental health problems are serious and can impact anyone, and 63.5% agreed that mental health services are a valuable resource for preserving general well-being. These answers challenge more conventional beliefs that link mental disease to weakness, insanity, or spiritual retribution by demonstrating a general understanding of the significance and universality of mental health issues. Even in rural areas, the recognition of the importance of mental health across all demographics indicates that public awareness is growing. The median scores in the “agree” range indicate that respondents acknowledge the influence of culture and stigma on mental health attitudes. A few lower median scores indicate that there is a lingering cultural reservation about openly discussing mental health.

The findings in "Culture, Coping, and Community Views on Mental Health" depict a changing rural community. Although many people understand the severity of mental illness and are open to obtaining professional help, there are still challenges with stigma, accessibility and self-management attitudes. Importantly, family influence was found to be a significant potential motivator for seeking help. This suggests that, in addition to focusing on individuals, rural mental health outreach and education should also involve families and communities. Overall, these findings are consistent with larger rural South African trends, in which traditional values and contemporary ideas of mental health coexist and influence behavioural decisions.

5.3.1.4 Perceptions of Mental Health Barriers

This variable focused on perceived challenges that prevent individuals from accessing mental health care, such as cost, availability, or fear of discrimination.

Table 14: Perceptions of Mental Health Barriers

Perceptions of Mental Health Barriers	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Median
You often see people in the community seeking mental health support.	13%	62.5%	4%	17.5%	3%	2
One may feel pressure from the community to seek mental health support.	7%	23%	6.5%	60%	3.5%	4
I cope well with stress.	11%	15.5%	13%	60%	0.5%	4
I have effective stress coping strategies.	16.5%	19.5%	13.5%	47.5%	3%	4
I have felt overwhelmed in the past few months.	4.5%	28.5%	8%	56.5%	2.5%	4
Overall, I would say I have good mental health.	7.5%	4.5%	20.5%	62.5%	5%	4

The data under the "Perceptions of Mental Health Barriers" variable paints a complicated picture of how members of the community see and understand mental health in their daily interactions. Even if many people report managing their lives and maintaining good mental

health, their attitudes toward seeking mental health support in the larger community indicate a gap between personal experiences and public awareness of mental health involvement. The median scores averaged around 3.7, indicating that respondents generally perceived themselves as coping well and maintaining good mental health; however, the lower median scores for visible community help-seeking suggest that there is still some reluctance to seek support publicly.

The fact that a considerable majority of respondents (75.5%) disagreed or strongly disagreed with the statement, "You often see people in the community seeking mental health support," is one of the most surprising findings. This implies that seeking mental health treatment is either unusual or not prevalent in the general population. This is consistent with research from low-resource settings, such as rural South Africa, where stigma, a lack of services, or cultural norms that prohibit openly acknowledging mental health issues frequently impede treatment utilisation (Abraham & Lund, 2022; Petersen et al., 2021). The low visibility of aid-seeking behaviour may prolong a cycle in which people avoid seeking help due to fear of being criticised or detected.

Interestingly, 63.5% of participants agreed or strongly agreed that "one may feel pressure from the community to seek mental health support" despite the absence of visibility. This could be due to family or community expectations to "do something" about emotional suffering, which may cause people to avoid established mental health care in favour of unofficial support networks such as churches, elders, or traditional healers. Furthermore, it can signal that community understanding is growing, even if that awareness has not yet translated into actual service use.

Nearly half (50.5%) of respondents reported effective stress-coping skills, while the majority (60%) indicated that they deal well with stress. According to these self-evaluations, most people believe they are resilient and capable of dealing with emotional stress. This contrasts with 56.5% who reported feeling overloaded in the past few months, indicating a potential disparity between emotional experience and perceived coping capacity. This could indicate either an overestimation of personal resilience or an underreporting of suffering due to stigma, both of which are common in situations where mental health issues are dismissed or viewed as a sign of weakness. Although 60% of participants reported coping well with stress, 56.5% also indicated feeling overwhelmed in the recent past. This apparent contradiction may reflect social desirability bias or a limited vocabulary for expressing psychological distress. Importantly, this

interpretation is supported by the qualitative findings (Theme 2), where participants described distress indirectly and often normalised emotional strain rather than framing it as a mental health concern.

Despite these obstacles, most participants had a positive impression of their current mental health: "Overall, I would say I have good mental health" was a statement with which 67.5% of respondents agreed or strongly agreed. This conclusion is positive, but it should be viewed with caution. The true well-being of many participants may be reflected in it. However, it could also be due to cultural reluctance to self-identify as unwell or a lack of mental health literacy (Van der Watt et al., 2020). People may be hesitant to admit their own grief in communities where mental illness is regarded as a sign of weakness or shame.

These findings suggest that, while a significant proportion of people in the community report having good mental health and coping skills, emotional challenges such as feeling overburdened persist, and mental health help-seeking remains mostly unknown. Individual experiences and societal traditions appear to be at odds, with mental health difficulties acknowledged in private but not manifested through public or collective action. To bridge the gap between awareness and actual help-seeking behaviour, it is necessary to reduce stigma, increase service visibility and improve mental health literacy in rural communities.

5.3.1.5 Perceptions of Stigma and Attitudes Towards Mental Health Treatment

The perceptions of stigma and attitudes towards mental health treatment were explored in participants' views on how stigma and societal attitudes may affect one's decision to seek mental health treatment.

Table 15: Perceptions of Stigma and Attitudes Towards Mental Health Treatment

Perceptions of Stigma and Attitudes Towards Mental Health Treatment	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree	Median
People with mental health conditions must not be treated like outcasts in society.	1%	2.5%	4%	62.8%	29.6%	4
A person showing signs of mental disturbance should seek mental health care from a hospital.	0%	10%	2%	52.8%	33.7%	4
I am knowledgeable about mental health issues.	5%	59%	6%	29%	1%	2
Changes are needed in mental health services in rural communities.	1%	1%	1%	56%	41%	4

The community needs to prioritise mental health awareness and support.	0%	0.5%	1%	38.7%	59.8%	5
Mental health issues are common and not something to be ashamed of	12%	23%	7%	37%	21%	4
I would be comfortable discussing mental health concerns with family members.	5.5%	42%	4.5%	43.5%	4.5%	4
One may find it difficult to manage their mental health, given the resources available in the community.	2%	27%	4%	45%	22%	4
My community provides enough support for those seeking mental health services.	51%	29%	1.5%	15.5%	3%	2
If I had mental health issues, I would go to a traditional healer (Sangoma)	15%	25%	7.5%	46.5%	6%	4

I would be able to identify when I need to seek help for my mental health	3%	39.2%	9%	45.7%	3%	4
Mental health services are expensive.	4%	23%	7.5%	60%	7%	4
Discussing mental health issues with family and friends can be helpful.	11%	28%	5.5%	47.5%	8%	4
Early intervention can prevent mental health issues from becoming more serious	9.5%	19.5%	4.5%	53.5%	13%	4

The findings for the variables Perceptions of Stigma and Attitudes Towards Mental Health Treatment indicate that the rural population under investigation has a complex but evolving view of mental health. Responses also show that there are still gaps in mental health literacy, disclosure comfort and confidence in local mental health infrastructure. There are encouraging indications of decreased stigma and an increased acknowledgement of the necessity for mental health services.

The median scores ranged from 2 to 5, with an overall average of 4.07. This indicates strong agreement with statements promoting mental health awareness and destigmatisation of mental health conditions. The lower median for knowledge and community support indicates that a gap still exists in education and the available resources within these communities.

The explicit rejection of discriminatory attitudes is demonstrated by most respondents (92.4%) who agreed or strongly agreed that "People with mental health conditions must not be treated like outcasts." In a similar vein, 86.5% of respondents agreed that those who exhibit symptoms

of mental illness ought to get hospital-based mental health treatment. These results point to a positive change in perceptions, with mental health being viewed increasingly as a social and medical problem that requires attention and understanding. This is consistent with new research from South Africa's rural areas, where community discussions and public health initiatives have begun to have a favourable impact on attitudes (Petersen et al., 2021).

This more acceptable attitude of mental health conditions, however, contrasts with the scarcity of self-reported information. Notably, 64% of respondents disagreed with the statement "I am knowledgeable about mental health issues." This demonstrates an apparent lack of mental health literacy. Only 30% of those polled agreed or strongly agreed that they would recognise when they need assistance. This lack of confidence in recognising mental health disorders is similar to prior research in low-income and rural areas, where there is still a lack of understanding about symptoms, diagnosis and treatment options (Abraham & Lund, 2022; Van der Watt et al., 2020). This disparity impedes timely help-seeking, even when opinions toward therapy are favourable.

The findings were mixed, but overall negative regarding perceived adequacy and health service infrastructure. Only 18.5% of respondents said their town provided adequate assistance to those in need, while 97% agreed that "changes must be made in mental health services in rural communities." Despite a willingness to participate, a lack of trust in the system may deter people from seeking assistance, according to the overwhelming consensus on the need for improved services. A significant 67% of participants agreed that "mental health services are expensive," highlighting the notion of financial constraints as a barrier, which is a chronic issue in rural Sub-Saharan Africa (Kola et al., 2021).

Although stigma in the community appears to be disappearing, internalised discomfort persists. Even though 74.7% of respondents agreed that "mental health issues are not something to be ashamed of," 35.5% disagreed or were undecided, showing ambivalence or continued societal shame. Similarly, 39% of participants disagreed or were unsure, even though the majority said, "talking about mental health issues with family and friends can be helpful." This shows that, while openness is typically acceptable, many people may be uncomfortable having such conversations with themselves. This statistic is corroborated by prior responses, which found that 47.5% of respondents would feel uncomfortable discussing mental health with family members.

Surprisingly, 52.5% of respondents said they would seek therapy from a traditional healer (Sangoma) for mental health issues, demonstrating that traditional and biomedical belief systems coexist. This finding is consistent with a previous study that highlights the critical role traditional healers play in many rural South African communities, where they are frequently more approachable, dependable, and culturally compatible than official medical experts (Gqaleni & Mkhize, 2023). This suggests that treatment pathways are often influenced by cultural familiarity and access, rather than clinical urgency or symptom severity, although this does not always imply resistance to professional care (Kola et al., 2021).

The need for early intervention and prevention is generally recognised. "Early intervention can prevent mental health issues from becoming more serious," said more than 66% of those who agreed or strongly agreed. This perspective provides a suitable starting point for community education and screening campaigns, particularly for individuals who are not currently attending clinics but are receptive to proactive involvement (Mboweni et al., 2024).

Overall, the findings indicate that the community is rejecting overt stigma and becoming more open to the concept of professional mental health treatment. However, it still struggles with internalised discomfort, information gaps and service accessibility. Traditional healing is important, despite perceived financial and infrastructure challenges. (Morar et al., 2024) Although evidence of ongoing cultural change exists, statistics emphasise the need to enhance mental health awareness and service capacity, especially in rural areas where social norms, limited access and cultural beliefs all influence how mental health is perceived and treated. (Mokwena & Ndlovu, 2021).

5.4 Independent Samples Kruskal-Wallis Tests

This section presents the findings of the Kruskal-Wallis tests, which were conducted to assess whether there are disparities in mental health scores across groups defined by gender, age, and educational level. This test was used since the data did not follow a normal distribution and it is effective when comparing more than two groups. It is helpful to determine whether groups have higher or lower levels of mental health behaviours than others. The findings of this study contribute to previous findings by demonstrating how these demographic characteristics may influence mental health-seeking behaviours in diverse ways

Table 16: Gender as a Factor across Variables

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig. [a.b]	Decision
1	The distribution of (ATT) is the same across categories of GNDR.	Independent-Samples Kruskal-Wallis Test	0.003	Reject the null hypothesis.
2	The distribution of (PMB) is the same across categories of GNDR.	Independent-Samples Kruskal-Wallis Test	0.015	Reject the null hypothesis.
3	The distribution of (COMM) is the same across categories of GNDR.	Independent-Samples Kruskal-Wallis Test	0.420	Retain the null hypothesis.
4	The distribution of (MHB) is the same across categories of GNDR.	Independent-Samples Kruskal-Wallis Test	0.374	Retain the null hypothesis.
5	The distribution of (KNW) is the same across categories of GNDR.	Independent-Samples Kruskal-Wallis Test	0.002	Reject the null hypothesis.

Table 16 shows a detailed Interpretation of the results for each variable. The Kruskal-Wallis test results for each variable across gender (GNDR) categories are interpreted as follows:

i. The Attitudes Towards Mental Health Treatment

- Sig.: 0.003
- Decision: The null hypothesis is rejected.

The statistics show a considerable disparity in views regarding mental health care across gender groupings. Groups 1 (females) and 2 (males) differed significantly. The findings indicate that females are more likely than males to have good views toward getting help. Several factors contribute to this conclusion, including societal standards, emotional openness and gender-specific expectations about vulnerability. It is also critical that the therapies used address the unfavourable attitudes about treatment reported within specific gender groupings, notably males who may perceive help-seeking as a sign of weakness.

ii. The Perceptions of Mental Health Barriers

- Sig.: 0.015
- Decision: The null hypothesis is rejected

Gender groupings hold diverse perspectives on mental health barriers. While men struggled to express their emotional or mental health needs and were susceptible, women reported feeling more burdened due to social stigma. As a result, gender-specific challenges should be the primary focus of focused interventions. Campaigns that mainstream men ask for aid or reduce the cost and privacy concerns for women, for example, may be effective.

iii. Culture, Coping and Community Views on Mental Health

- Sig.: 0.420
- Decision: The null hypothesis is retained

There are no significant differences identified in how gender groups perceive community mental health resources. Both genders reported similar views on the effectiveness, availability, and adequacy of mental health services and community support systems. This indicates that gender is not a factor when it comes to shaping perceptions of community mental health resources. Since there is no difference across all groups, improving community mental health resources can be designed inclusively.

iv. Perceptions of Stigma and Attitudes Towards Mental Health Treatment

- Sig.: 0.374
- Decision: The null hypothesis is retained.

The result indicates that both genders have similar perceptions regarding stigma and beliefs about mental health treatment. Therefore, there is no significant difference in mental health beliefs and stigma across the two gender groups. This highlights that the stigma is not a gender specific problem within the community. Therefore, efforts should be made to create awareness and challenge the negative beliefs surrounding mental health.

v. Knowledge of Mental Health

- Sig.: 0.002
- Decision: The null hypothesis is rejected.

With regards to mental health problems, general symptoms and where to seek help, the results show that females and males have different awareness levels. Therefore, there is a significant difference in mental health knowledge across the gender groups. The findings indicate that women have higher levels of knowledge because they are more likely to seek information and participate in discussions regarding mental health. Men, on the other hand, demonstrated lower levels of knowledge, which could be due to societal norms that discourage men from being interested in mental health concerns. Gender inequities must be addressed in educational initiatives aimed at improving mental health literacy. Our findings highlight the need for gender-sensitive mental health initiatives for improving attitudes, lowering barriers and raising mental health awareness.

Table 17: Age as a Factor Across Variables

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig. [a.b]	Decision
1	The distribution of (ATT) is the same across categories of AGR.	Independent-Samples Kruskal-Wallis Test	0.006	Reject the null hypothesis.
2	The distribution of (PMB) is the same across categories of AGR.	Independent-Samples Kruskal-Wallis Test	0.000	Reject the null hypothesis.
3	The distribution of (COMM) is the same across categories of AGR.	Independent-Samples Kruskal-Wallis Test	0.003	Reject the null hypothesis.
4	The distribution of (MHB) is the same across categories of AGR.	Independent-Samples Kruskal-Wallis Test	0.000	Reject the null hypothesis.
5	The distribution of (KNW) is the same across categories of AGR.	Independent-Samples Kruskal-Wallis Test	0.000	Reject the null hypothesis.

a. The significance level is .050.
b. Asymptotic significance is displayed.

Table 17 presents a detailed interpretation of the results for each variable across the age categories (AGR). The Kruskal-Wallis test results for the variables across age as a factor (AGR) are interpreted as follows:

i. Sociocultural and Attitudinal Influence on Help-Seeking Behaviours

- Sig.: 0.006
- Decision: The null hypothesis is rejected

The results indicate that age has a role in attitudes towards mental health care. The results indicate a significant difference in attitudes toward mental health care. Furthermore, it has been identified that younger individuals tend to have more positive attitudes and are more open to it, while older individuals have fewer positive attitudes; this can be attributed to their traditional views, cultural, and generational norms. Thus, to combat this, mental health awareness campaigns must adopt more age-sensitive approaches.

ii. Perceptions of Mental Health Barriers

- Sig.: 0.000
- Decision: The null hypothesis is rejected.

The data demonstrate that the perceptions of various age groups on mental health barriers differed significantly. One could claim that the elderly are more likely to face barriers such as stigma, cost and lack of availability due to the changing social norms and increased openness to discussions about mental health; younger people are either less likely to face these challenges or may encounter fewer of them. When overcoming these challenges, it is necessary to consider one's age.

iii. Culture, Coping and Community Views on Mental Health

- Sig.: 0.003
- Decision: The null hypothesis is rejected.

According to the results, there is a significant difference across age groups when it comes to the perception of community mental health resources. This suggests that younger individuals may view community resources more positively, as they are better able to navigate modern approaches and services. At the same time, their older counterparts may perceive the resources as inadequate and ineffective, either because of past experiences or a lack of awareness. The needs and expectations of different age groups must be addressed, thereby improving the community's mental health resources.

iv. Perceptions of Stigma and Attitudes Towards Mental Health Treatment

- Sig.: 0.000
- Decision: The null hypothesis is rejected.

With regards to mental health beliefs and the stigma surrounding it, the results indicate that there is a significant variation across age groups. Older individuals are more likely to hold beliefs that are stigmatising, as they might see mental health struggles as a sign of weakness or something supernatural, influenced by cultural beliefs. Younger people are more likely to embrace mental health as part of a person’s overall well-being.

v. Knowledge of Mental Health

- Sig.: 0.000
- Decision: The null hypothesis is rejected

The results indicate that there is a significant difference across age groups when it comes to knowledge about mental health. The older respondents may have lower levels of knowledge, attributed to limited access to information and traditional and cultural beliefs. Contrastingly, younger people may have higher levels of knowledge, which could be attributed to factors such as exposure to mental health education, digital information, and social media trends. It is therefore essential to ensure that programmes aimed at addressing mental health literacy are aware of the various factors that can contribute to lower levels of knowledge among older people and align their programmes with these factors. For example, for older people, the focus should be on raising awareness of the different types of conditions, symptoms, and available

treatment options. For younger people, the focus should be on building upon existing knowledge and finding innovative ways to create awareness.

Table 18: Educational Levels as a Factor Across Variables

Hypothesis Test Summary				
	Null Hypothesis	Test	Sig.[a.b]	Decision
1	The distribution of (ATT) is the same across categories of EDU.	Independent-Samples Kruskal-Wallis Test	0.000	Reject the null hypothesis.
2	The distribution of (PMB) is the same across categories of EDU.	Independent-Samples Kruskal-Wallis Test	0.024	Reject the null hypothesis.
3	The distribution of (COMM) is the same across categories of EDU.	Independent-Samples Kruskal-Wallis Test	0.202	Retain the null hypothesis.
4	The distribution of (MHB) is the same across categories of EDU.	Independent-Samples Kruskal-Wallis Test	0.452	Retain the null hypothesis.
5	The distribution of (KNW) is the same across	Independent-Samples	0.000	Reject the null hypothesis.

	categories of EDU.	Kruskal-Wallis Test		
a. The significance level is .050.				

Table 18 presents a detailed interpretation of the results for each variable across education levels (EDU). The Kruskal-Wallis test results for each variable across education levels (EDU) are interpreted as follows:

(i) Sociocultural and Attitudinal Influence on Help-Seeking Behaviours

- Sig.: 0.000
- Decision: The null hypothesis is rejected.

The results indicate a significant difference in attitudes toward mental health care. The results suggest that participants with higher levels of education tend to have more positive attitudes towards seeking help, which can be attributed to greater awareness and exposure to mental health education. Individuals with lower levels of education may exhibit negative or indifferent attitudes towards the topic.

(ii) Perceptions of Mental Health Barriers

- Sig.: 0.024
- Decision: The null hypothesis is rejected

The results indicate that across educational levels, perceptions of mental health barriers exist. This is to say that there is a significant difference between the perceptions of mental health barriers and education levels. Individuals with lower levels of education may face additional barriers, including financial costs, stigma, and a lack of resources. Conversely, those with higher levels of education may experience fewer barriers, which may be attributed to greater awareness and access to resources.

(iii). Culture, Coping and Community Views on Mental Health

- Sig.: 0.202

- Decision: The null hypothesis is retained.

Regarding community mental health resources, the results indicate no significant difference across educational levels. This suggests that there are similar views regarding the availability, effectiveness and adequacy of community health resources across various educational levels.

(iv). Perceptions of Stigma and Attitudes Towards Mental Health Treatment

- Sig.: 0.452
- Decision: The null hypothesis is retained.

With regards to mental health beliefs and stigma, the results indicate that there is no significant difference across education levels. This reveals that stigmatising beliefs or negative attitudes towards mental health care are not limited to specific educational levels but are widespread within the community. This can be attributed to societal and cultural factors. Therefore, more effort should be put into addressing cultural stereotypes and dispelling myths.

(v). Knowledge of Mental Health

- Sig.: 0.000
- Decision: The null hypothesis is rejected.

Regarding knowledge, this result reveals a significant difference across education levels. Respondents with higher education levels may have greater knowledge of mental health issues, the available resources and treatment options. Conversely, those with lower levels of education may lack general awareness. It is therefore important to ensure that mental health literacy is made available through community-based programs.

Overall, the results highlight the important role that education plays in shaping attitudes, perceptions and knowledge of mental health.

5.5 Discussion

This section presents the study's findings by examining the relationships between gender, age, educational attainment and key mental health traits. To demonstrate trends and relationships between demographic variables and mental health outcomes, the quantitative findings from the Kruskal-Wallis tests and Spearman's correlation are examined. The qualitative findings are then analysed to shed more light on the participants' perspectives and life experiences. Ultimately, combining quantitative and qualitative data offers a comprehensive understanding of how demographic features impact mental health, contextualising statistical findings with real-world anecdotes.

Gender on Mental Health Variables

(i) Sociocultural and Attitudinal Influence on Help-Seeking Behaviours Across Gender

The Kruskal-Wallis test ($p = 0.003$) revealed a significant gender difference in attitudes towards mental health (ATT), with females showing more positive attitudes. This finding aligns with recent research conducted by Campbell, Bann and Patalay (2021). The research found that women are less stigmatised and more open to speaking and seeking assistance where mental health is concerned than men. According to Patel (2023), this is due to socialisation patterns and enhanced emotional expression, which contribute to women's positive attitudes and improve their inclination to seek help when needed. Furthermore, Campbell et al (2021) revealed that women are more likely than men to seek mental health treatment, implying that gender norms have a significant impact on mental health behaviour. Previous research has repeatedly found that men and women have different attitudes regarding help-seeking, with women being more open and eager to seek professional psychiatric support than men (Petersen et al., 2022). This distinction may be due to a combination of cultural standards, societal expectations and internalised attitudes regarding gender roles.

Traditional masculinity-based social ideals, such as emotional stoicism, independence and a fear of exposing vulnerability, make it difficult for many men to seek help (Pietrzykowski et al., 2024). Men commonly minimise or hide mental health difficulties in society because they are afraid of being perceived as weak due to gendered expectations. Women, on the other hand, are more likely to be conditioned to express their feelings and to believe that asking for help is acceptable, if not encouraged, in their social circles (Temane et al., 2022). Women may be able to obtain mental health resources more easily because of fewer barriers, such as stigma and a fear of being criticised.

Societal factors, including peer norms, familial expectations and stigma, heavily influence this dynamic. Mental health is still stigmatised in many cultural contexts, particularly in African countries such as Ghana and Lesotho and especially among men (Vasli et al.,2024). Males are usually discouraged from acknowledging they have mental health concerns in these settings, and seeking treatment can be viewed as a huge societal expense. On the other side, women may face less social stigma for expressing sadness and receive greater emotional support from their networks. This mismatch is likely to affect the gender differences identified in this investigation (Wang et al., 2022).

Additionally, mental health literacy may be beneficial. Women are often better educated about mental health symptoms and potential treatments because they utilise health services more regularly or are more open to discussions about emotional well-being (Tamres et al., 2022). This increased awareness may lead to more positive attitudes toward seeking aid. Low mental health literacy and a lack of exposure to effective help-seeking models may exacerbate existing societal barriers for men (Wijeratne et al., 2021).

This outcome is consistent with both regional and worldwide research. According to national epidemiological surveys undertaken in Australia (Jorm et al., 2021), women are significantly more likely than men to seek treatment for affective and anxiety disorders. Similarly, qualitative research undertaken in Southern Africa has shown that men's reluctance to seek care is heavily impacted by cultural scripts about masculinity and community standards (BMC Psychiatry, 2025). These findings support the idea that seeking charity is influenced by a complex interplay of internalised beliefs and gendered social norms, rather than being merely a matter of personal desire.

(ii) Perceptions of Mental Health Barriers Across Gender

Perceptions of mental health barriers (PMB) differed considerably between genders ($p = 0.015$), with men expressing more hurdles to obtaining help. According to Kondirolli and Sunder (2022), men face additional barriers to receiving mental health care due to societal norms around masculinity. According to Patafio et al. (2020), men's reluctance to seek mental health treatment is linked to gendered perceptions of barriers, since they typically consider mental health illnesses as a sign of weakness. This study found that men and women experience and interpret barriers to mental health care very differently (Williams, 2021). These distinctions are well documented in the literature, which identifies gender as a crucial component in recognising, interpreting and overcoming barriers to mental health care. Men and women see

and internalise barriers differently, which is often reinforced by stigma and established gender standards, although women are more likely to notice emotional suffering and seek help (Vogel et al., 2021).

Men's opinions of mental health challenges are frequently influenced by cultural standards associated with masculinity (Mojtabia & Olfson, 2020). Many cultures respect values such as emotional control, independence and self-reliance and seeking psychological help may be perceived as a violation of these beliefs. Men are thus more likely to perceive that the primary barriers to receiving care are societal disapproval, fear of judgment and stigma (Yousaf et al., 2025). Even if they understand they require assistance, this internalised shame may prevent them from seeking it. Women, on the other hand, usually report fewer stigma-related barriers and may face more structural or practical challenges such as time constraints, caring responsibilities, or confidentiality concerns (Thompson et al., 2024).

Understanding gendered perspectives on mental health barriers is also largely dependent on the sociocultural milieu. Mental illness is still associated with moral weakness, spiritual sorrow, or personal failure in many African countries, including South Africa and Ghana (Palomin et al.,2023). Due to cultural standards surrounding strength and resilience, these relationships are typically applied more strictly to men (BMC Psychiatry, 2025; Adjorlolo & Azongo, 2019). Women, on the other hand, are more likely to be integrated into social support networks that validate emotional expression and psychological help-seeking, and they may feel more socially acceptable expressing vulnerability. In contrast to men, who tend to internalise perceived obstacles, women may perceive limits as external (e.g., cost or access) rather than internal (e.g., shame or fear) (Omotoso et al., 2021).

Furthermore, gender differences in mental health literacy can help to explain the variance in perceived barriers. Women's psychological reluctance to seek care is reduced as they become more knowledgeable about their symptoms, available therapies and the benefits of professional help (Tamres et al., 2022). Men may perceive asking for help as weird, hazardous, or unnecessary because they are less exposed to or unwilling to participate in mental health education. These disparities in knowledge and belief systems shape perceptions of barriers, which in turn influence service consumption habits (Omotoso et al., 2021).

These findings are consistent with worldwide investigations. According to a study conducted by Addis and Mahalik (2023), women are more concerned with practical challenges. In contrast, men are more likely to support barriers related to perceived social norms and self-

reliance. According to an extensive survey conducted across Europe (OECD, 2021), women reported fewer attitudinal barriers and were more likely to overcome logistical ones when seeking assistance. A South African study found that men in rural areas were more concerned about secrecy, other people's opinions and being perceived as "weak" (Sorsdahl et al., 2021), which exacerbated the gender gap in perceived barriers.

(iii). Culture, Coping and Community Views on Mental Health Across Gender

Perceptions of community mental health resources (COMM) did not differ significantly by gender ($p = 0.420$). This data implies that men and women see community mental health resources similarly. Recent research, such as that of Proto and Quintana (2022), supports the idea that perceptions of community services are influenced more by quality and accessibility than by gender. This highlights the fact that men and women may face similar challenges in terms of accessibility and availability.

The absence of a significant difference in Culture, Coping and Community Views on Mental Health across gender suggests that men and women in the rural community studied may share similar cultural frameworks and communal perceptions of mental health. This convergence is likely due to the significant impact of shared social, cultural, and environmental factors in rural areas, which shape gender-neutral collective beliefs and coping methods. Deeply ingrained cultural values in South African rural communities, such as a sense of collective duty and reliance on traditional healing and spiritual coping mechanisms, are passed down through family and religious institutions, frequently transcending gender lines (Gqaleni & Mkhize, 2023). As a result, even if men and women experience discomfort differently or adhere to different rules for emotional expression, they may internalise similar views about mental health.

Previous research supports this finding. According to Van der Watt et al. (2020), underlying cultural attitudes toward mental health, such as viewing it through spiritual or moral lenses, are consistent among male and female respondents in rural and peri-urban South African contexts, even though gender can influence willingness to seek help. Furthermore, both genders typically employ coping techniques in these situations, such as avoidance, seeking family support, or relying on prayer (Abraham & Lund, 2022). The findings are also consistent with research from other Sub-Saharan African countries, which found that, after controlling for other social factors such as educational access and community norms, gender differences in mental health literacy or cultural interpretation of mental illness were negligible (Nair, 2022).

Thus, the lack of a significant gender difference may indicate that, in rural contexts like the one analysed, collective lived experience has a greater influence on mental health-related cultural beliefs and community perspectives than gender-specific roles. This emphasises the importance of addressing community-wide ideas and norms in mental health awareness or intervention programs, rather than presuming gender differences in cultural attitudes and coping behaviours (Morar et al., 2024).

(iv). Perceptions of Stigma and Attitudes Towards Mental Health Treatment Across Gender

The gender differences in mental health barriers (MHB) were not statistically significant ($p = 0.374$). This suggests that challenges related to managing mental health are comparable for both males and females. Yoon, Eisenstadt, Lereya and Deighton (2023) contend that factors such as stigma, social support, and cultural attitudes have comparable effects on both genders across situations, even when there are gender disparities in help-seeking behaviours. This is to say that societal expectations and stigma around mental health are significant obstacles for both genders, even if men are less likely to seek help.

The absence of a statistically significant difference across gender in perceptions of stigma and attitudes toward mental health treatment suggests that, in the study context, men and women hold broadly similar views about whether stigma exists around mental health conditions and how acceptable treatment is (Dhanpat, Makhubele & De Braine, 2025). Recent research in South Africa and internationally shows that both male and female service users experience mental health stigma, with caregivers often withholding diagnoses due to broader communal misunderstanding and low mental health literacy (Masemola et al., 2022). In a study of fourth-year medical students at the University of the Witwatersrand, there was generally a low prevalence of negative or stigmatising attitudes, with no strong gender effect reported in attitudes toward psychiatry and mental illness. These findings suggest that in more educated or healthcare-aware subpopulations, both genders may internalise similar norms around stigma and treatment (Ochse & Lowton, 2023).

Perceptions and Attitudes of Black Men in a Rural District of South Africa towards Depression and Its Treatment (Masemola et al., 2022) is another South African study that focuses primarily on men. However, it found that many attitudes considered barriers (such as fear of stigma, concerns about expressing feelings and gender norms) are generally acknowledged in local discourse, indicating a communal awareness of stigma that likely transcends gender. Additionally, reviews of workplace mental health after COVID in South Africa show that

stigma and attitudinal barriers are frequently reported by employees of all genders (Dhanpat et al., 2025), indicating that these experiences are shared rather than strongly gendered.

(v). Knowledge of Mental Health Across Gender

There was a significant difference in knowledge of mental health (KNW) across gender ($p = 0.002$); in this instance, females displayed greater knowledge. This is in accordance with research conducted by Proto and Qintana (2021) and Kondirolli and Sunder (2022). Their research indicated that women had higher levels of mental health literacy compared to men. Women had greater access to health education and awareness efforts, which explains this. Furthermore, these studies found that women's higher educational attainment and participation in mental health discourse led to a better understanding and knowledge of mental health issues (Kondirolli & Sunder, 2022). This is similar to prior research undertaken in rural South Africa, where gender differences in socialisation, education and access to health care usually cause discrepancies in mental health literacy. Masemola et al. (2022) found that rural men in Limpopo had a poor understanding of psychological disorders and associated sadness with stress or spiritual weakness. Women, on the other hand, were more likely to freely express and identify discomfort as a mental health illness because they are more likely to participate in caregiving obligations and community health programmes where such knowledge is more routinely shared.

In rural areas, structural and cultural factors frequently increase gender inequities. Women are more likely to seek family or child health services at clinics, where nurses or other community health workers may provide them with mental health education indirectly. Furthermore, rural women are more likely to attend community events, church groups and social support networks, which can serve as informal forums for exchanging health-related information. Men may be barred from such environments due to traditional gender roles that emphasise emotional control, stoicism and avoiding perceived vulnerability. Because of these roles, men are less likely to seek out information on mental health or engage in open discussions about it, lowering their baseline level of awareness.

This trend is supported by research undertaken in other rural South African communities. According to Makhubela's (2020) research on young people in Limpopo, females were significantly more likely than males to correctly recognise indicators of common mental disorders and voice favourable judgments about the efficacy of psychological treatment. Furthermore, community-based participatory research in the rural Eastern Cape found that,

even when men reported experiencing stress or emotional challenges, they framed them as social or economic hardship rather than mental health (Ndlovu & Sodi, 2021). This suggests that rural men's weaker mental health literacy stems from culturally mediated concepts of distress rather than a lack of emotional experience.

Age and Mental Health Variables

(i) Sociocultural And Attitudinal Influence on Help-Seeking Behaviours Across Age

A significant difference was found between ATT and the different age groups. The Kruskal-Wallis test ($p = 0.006$) revealed that younger individuals had more positive attitudes. This finding is like that of Buchholz et al. (2021), who revealed that younger people tend to exhibit less stigma and have progressive attitudes towards mental health as opposed to their older counterparts. Kuehner (2022) suggests that the increasing social acceptability amongst younger people influences more open views towards obtaining mental health treatment.

The significant difference observed in sociocultural and attitudinal influences on help-seeking behaviours across age groups suggests that individuals at different life stages perceive and respond to mental health concerns in distinct ways. This variation is especially relevant in rural settings, where generational gaps in education, access to information and cultural exposure are more pronounced (Makhubela, 2020). Younger individuals in rural areas are being exposed to more current narratives about mental health through education, social media and NGO-led awareness initiatives, which often encourage open discussion and the pursuit of professional support (Bila & Carbonatto, 2022). Older people, on the other hand, have more conventional attitudes about mental illness that are based on cultural, spiritual, or community factors; they frequently prefer religious interventions or traditional healers over clinical services (Tshitangano & Tosin, 2022).

According to research conducted in rural South Africa, community elders may stigmatise mental health issues more strongly and have fewer positive opinions about biological treatment options because they believe mental health issues are linked to witchcraft, ancestral disapproval, or moral weakness (Gqaleni & Mkhize, 2023). Because older people are more likely to reject the reality of mental health concerns or to interpret symptoms via non-medical lenses, the age gap can make a difference in how people seek treatment. Younger adults, particularly those who have completed secondary or tertiary education, tend to have more positive attitudes toward psychological services and are more likely to utilise official support

networks, especially when those services are confidential or youth-friendly (Mokgothu & Nduna, 2023).

Furthermore, age-related differences in help-seeking are also influenced by perceived autonomy and decision-making power. Older adults, particularly in patriarchal rural structures, often serve as gatekeepers for health-related decisions within families, meaning their attitudes can affect the help-seeking behaviours of younger family members as well. Conversely, youth who experience more individual agency, especially in educational settings or peer networks, may independently choose to seek help despite prevailing community norms (Mojapelo-Batka & Sodi, 2021). This change is noteworthy because it points to a gradual generational shift in attitudes, with younger rural residents playing a vital role in normalising mental health.

(ii) Perceptions of Mental Health Barriers Across Age

A significant difference has been identified in perceptions of mental health barriers (PMB) across age groups ($p=0.000$). The results reveal that younger people perceive fewer barriers to mental health care. Studies conducted by Mojtabai et al. (2021) and Pescosolido et al. (2021) highlighted that younger people tend to view mental health care more positively and experience fewer obstacles when accessing services. This is because they have better education in mental health care. Contrastingly, older people tend to hold onto the cultural and traditional views about mental health, which results in them having problems with access and views that are stigmatising.

The significant difference in perceptions of mental health barriers across age groups suggests that individuals at different life stages encounter and interpret obstacles to accessing mental health care in distinct ways. In rural communities, such differences are often shaped by generational exposure to healthcare systems, cultural norms and levels of mental health literacy. While older people often regard mental health care as less necessary or culturally incompatible, younger people may perceive barriers in terms of service availability, cost and confidentiality concerns. Mokwena and Madiga's (2023) studies indicate this age disparity. They discovered that older individuals were more concerned with social stigma and scepticism of Western treatment procedures. In contrast, younger participants were more likely to complain about practical difficulties such as long commutes to clinics and a lack of youth-friendly facilities.

Age-related differences also reflect varying levels of internalised stigma and emotional expression. Traditional beliefs that associate mental health conditions with weakness,

witchcraft, or moral failing may make older people in rural regions less likely to acknowledge they are experiencing psychological distress. Younger persons, who have had more exposure to mental health education and public campaigns promoting emotional well-being, may be less affected by these significant internal barriers to treatment (Mojapelo-Batka & Sodi, 2021). As a result, psychological and cultural barriers are more prevalent among the elderly, even though structural obstructions may affect people of all ages.

Furthermore, younger generations are increasingly using the internet and social media platforms to address mental health issues freely. This is helping to shift mindsets and reduce the stigma associated with seeking help (Boakye et al., 2024). On the other hand, older persons may not have the same access to or may not want to study these more contemporary, destigmatising methods, especially if they have limited formal education or have not been exposed to mental health messaging (Tshitangano & Tosin, 2022). These variances produce varying degrees of perceived barriers, necessitating targeted treatments that address both cultural and informational difficulties.

(iii) Culture, Coping and Community Views on Mental Health Across Age

When it comes to community mental health resources (CMHR), a significant difference has been identified across age groups ($p = 0.003$). The findings reveal that older individuals were less likely to report inadequate mental health resources in the community. According to Mojtabai et al. (2021), older individuals often face challenges such as a lack of availability, accessibility, and adequacy of services, particularly in rural areas, which may explain why older participants in this study perceived community resources less favourably than younger participants (Mojtabai et al., 2021).

Generational factors may significantly influence how people view mental health, their coping strategies, and the impact of community assistance, according to the findings of a considerable difference in culture, coping and community views on mental health across age groups. An increased dependence on unofficial support networks or traditional healers may result from older individuals' more conventional perspectives on mental illness, which frequently link it to spiritual origins or moral weakness (Gqaleni & Mkhize, 2023). On the other hand, younger people might be more receptive to professional treatment alternatives and scientific explanations, especially if they have had more recent exposure to media and mental health education (Petersen, Kemp, Rao, Wagenaar, Sherr, Grant, Bachman, Barnabas, Mntambo, Gigaba, et al., 2021). The results of other rural South African studies, which indicate that

younger populations typically report higher levels of mental health awareness, reduced stigma and a greater willingness to engage with mental health services, align with this generational shift in attitudes (Van der Watt et al., 2020).

Age disparities could also be explained by differences in life experiences and exposure to formal mental health promotion. While younger people rely more on peer networks, social media and school-based information, older adults in rural areas may have had limited access to mental health education and continue to rely heavily on collective coping mechanisms such as prayer, family support, or local leaders (Abraham & Lund, 2022). These findings show how cultural beliefs and community dynamics surrounding mental health evolve, influenced by greater social and informational transformations. The findings emphasise the importance of tailoring mental health therapies to different age groups while accounting for the varied cultural, informational and experiential contexts that influence their coping strategies and mental health perspectives.

(iv) Perceptions of Stigma and Attitudes Towards Mental Health Treatment Across Age

With regards to mental health barriers (MHB), a significant difference was identified across the different age groups ($p=0.000$). These results reveal that older people perceive more barriers to accessing care, which greatly reflects the generational differences regarding mental health stigma and access to resources. According to research by Pescosolido et al. (2020), several variables, including social stigma, unfamiliarity with contemporary mental health care and financial limitations, may contribute to the larger obstacles older persons encounter. On the other hand, it has been demonstrated that younger people feel more at ease asking for expert assistance.

The significant age-related differences in attitudes toward mental health treatment and stigma perceptions discovered in this study suggest that cultural conditioning and generational experiences play an important role in determining how people perceive mental illness and whether it is acceptable to seek help (Breetzke & Mthimunye, 2025). Older people in rural places may have grown up in environments where mental health was heavily stigmatised, viewed via moral or spiritual lenses and rarely discussed publicly. As a result, they may still hold more negative or sceptical attitudes toward formal treatment and are more likely to associate mental illness with personal weakness, shame, or family dishonour. Gqaleni & Mkhize (2023) noted that elder residents of rural communities frequently prefer traditional healing methods because they have a long-standing distrust of biomedical procedures and

believe that seeking professional assistance equates to admitting failure or inviting societal criticism, which supports this view.

Younger people, on the other hand, are more likely to have progressive views, particularly those who have received mental health education from the media, schools, or non-governmental groups. They are less concerned about societal criticism and are more likely to regard mental health difficulties as legitimate medical disorders (Brower, 2021). Rural youth who use internet platforms, where peer-driven content and mental health awareness campaigns have normalised discussions about treatment, depression and anxiety, are most affected by this generational shift. South African teenagers displayed a strong desire to discuss mental health and challenge conventional stigmas, according to a recent youth-focused study by Mokgothu and Nduna (2023). This openness was especially evident when peer networks or school-based mental health programs were in existence.

Furthermore, older adults often internalise stigma as a fixed and deeply embedded communal norm, whereas younger people may view stigma as more situational or peer-related (Burger &Strassman, 2024). Younger people are more impacted by changing national and international narratives surrounding mental health, whereas older folks frequently rely on traditional community values and religious teachings. This difference reflects various social reference points. Age differences also impact trust: younger generations are more likely to view therapy as beneficial or even necessary, whereas older generations may doubt the intentions or cultural significance of mental health providers (Campbell et al.,2021).

vi. Knowledge of Mental Health Across Age

With knowledge (KNW) varying across age groups ($p = 0.000$), this indicates a significant difference in mental health knowledge across age groups. Younger participants showed greater knowledge compared to older participants. Sartorius (2020) and Sankoh (2021) argued that due to integrated education programs and greater emphasis on mental health awareness in new educational curricula, younger people have a significantly higher level of mental health literacy.

The significant difference in mental health knowledge across age groups in this rural community echoes findings from prior research, reinforcing the notion that generational disparities in education, exposure and cultural framing influence mental health literacy. This study found that older people are less knowledgeable about mental health conditions than younger people, which is consistent with Van der Walt and Mabaso's (2021) findings that older

rural South Africans had a limited grasp of mental health difficulties. This disparity is commonly attributed to historical educational gaps and prevalent traditional belief systems that see mental illness through moral or spiritual lenses rather than biological frameworks. The higher levels of knowledge demonstrated by younger participants in this study are also consistent with Craig et al (2022) results, which show that rural adolescents exposed to a school-based mental health curriculum demonstrated a superior ability to detect and characterise symptoms of prevalent mental disorders.

The role of evolving educational opportunities is critical in explaining these differences. Younger generations are increasingly exposed to mental health awareness programs embedded in school curricula or delivered through digital platforms, which, as shown in several South African studies, have been shown to improve mental health literacy (Mokgothu & Nduna, 2023; Tshitangano & Tosin, 2022). According to Mokgothu and Nduna (2023), rural teenagers are increasingly adopting social media and mobile devices to access mental health information and increase their literacy skills. Masemola et al. (2022) found that older individuals' reliance on traditional healers and cultural explanations limits their access to accurate biomedical knowledge, perpetuating misconceptions and a lack of awareness.

Education Level and Mental Health Variables

(i) Sociocultural And Attitudinal Influence on Help-Seeking Behaviours Across Education Level

There is substantial variation in attitudes toward mental health across educational levels, as indicated by the Kruskal-Wallis test ($p = 0.000$). More positive perceptions of mental health were associated with higher levels of education (Strassmann & Burger, 2024). According to Evans-Lacko, Gilabert and Knapp (2024), individuals with higher levels of education are likely to hold more favourable opinions. This can be attributed to their increased exposure to mental health education and services, as well as heightened awareness of societal mental health challenges (Evans-Lacko et al., 2024).

The significant differences in sociocultural and attitudinal influences on help-seeking behaviours across educational levels underscore the critical role education plays in shaping perceptions and responses to mental health challenges. Higher educational attainment has been repeatedly linked to greater mental health literacy, which, in turn, promotes more positive attitudes toward seeking professional treatment (Makhubela, 2020; Tshitangano & Tosin, 2022). Reluctance or avoidance of formal mental health services can be attributed to the

prevalence of traditional belief systems that interpret mental illness through spiritual or supernatural frameworks among people with limited education in rural South Africa (Masemola et al., 2022). This is supported by research showing that people with less education frequently saw mental health issues as the product of moral flaws or witchcraft rather than curable illnesses.

Higher-educated individuals, on the other hand, are more likely to question established cultural norms and be open to psychological and biological explanations. According to Dlamini and Mchunu (2023), education provides people with access to a variety of knowledge sources, thereby improving their ability to question stigmatising views within their communities. This reduces the influence of social barriers and fosters more positive attitudes regarding asking for assistance. These findings underscore the importance of education as a variable in rural mental health dynamics, demonstrating that it plays a substantial role in increasing knowledge and shaping cultural attitudes that influence mental health practices.

(ii) Perceptions of Mental Health Barriers Across Education

The quantitative results also revealed a significant difference in perceptions of mental health barriers across different education levels ($p = 0.024$). The findings align with a study by Mojtabai and Olfson (2020), which found that people with higher levels of education experienced fewer barriers to care. This could be because they have a greater understanding of the resources available and hold fewer stigmatising beliefs about seeking help. This finding suggests that higher levels of education are associated with greater mental health literacy (Mojtabai & Olfson, 2020).

The significant disparity in how people perceive mental health barriers across educational levels reflects the greater influence that educational attainment has on people's ability to identify and comprehend hurdles to accessing mental health care. According to Masemola et al. (2022), lower-educated people in rural South Africa typically interpret mental illness via cultural and spiritual lenses, such as witchcraft or ancestral disapproval, which heightens stigma and inhibits people from seeking official mental health care. This pattern aligns with findings from other low-income countries and Sub-Saharan Africa, where limited education correlates with stronger adherence to traditional beliefs and misconceptions about mental illness, which act as substantial barriers to help-seeking (Kola et al., 2021; Petersen et al., 2021).

Conversely, individuals with higher levels of education are generally more aware of structural and systemic challenges, including transportation difficulties, financial costs, and inadequate service provision, rather than cultural or attitudinal barriers (Makhubela, 2020; Tshitangano & Tosin, 2022). In Sub-Saharan Africa, education enhances mental health literacy, which has been shown to reduce stigma and facilitate more effective navigation of healthcare systems in various contexts (Dlamini & Mchunu, 2023; Abbo et al., 2020). This variation in how barriers are perceived highlights the intricate interactions between cultural, educational and health system elements that influence people's decision to seek mental health treatment. It also emphasises the importance of education as a social driver in changing rural communities' perceptions and experiences of barriers.

(iii) Culture, Coping and Community Views on Mental Health Across Education

The Kruskal-Wallis test revealed no significant differences in the perception of community support across educational levels ($p = 0.202$). The implication here is that while education can change attitudes and perceptions about impediments to mental seeking behaviours, it can also impact how individuals perceive the sufficiency or accessibility of local resources. According to Mojtabai and Olfson (2020), personal educational credentials have less influence on how people view communal resources than local surroundings, such as community infrastructure.

In this rural area, shared cultural norms and community-based coping methods may be broadly stable, regardless of people's educational level, as evidenced by the lack of significant differences in Culture, Coping, and Community Views of Mental Health across educational levels. This conclusion implies that formal education alone may not have a significant impact on people's notions of mental health, techniques for dealing with psychological pain and beliefs about the role of community in promoting well-being. Similar trends have been observed in rural South African communities, where culturally based understandings of mental health and communal beliefs often transcend educational and socioeconomic boundaries (Petersen et al., 2021). Coping mechanisms, such as spiritual practices, reliance on family support, and the use of traditional healers, are commonly practised across all educational levels in these communities, demonstrating the importance of cultural continuity over formal knowledge acquisition (Gqaleni & Mkhize, 2023).

Moreover, recent studies have shown that mental health literacy, while generally associated with education, does not always lead to changes in attitudes or behaviours in contexts where stigma or cultural explanations of mental illness are dominant (Van der Watt et al., 2020). Even

among educated individuals, beliefs about supernatural causes or moral interpretations of distress can influence coping strategies and help-seeking patterns, especially in tightly knit rural settings. This is consistent with research indicating that without community-based, culturally sensitive mental health promotion, educational attainment alone is not enough to change deeply ingrained attitudes regarding mental illness (Abraham & Lund, 2022). Thus, in rural South Africa, shared cultural frameworks are likely to have a greater influence on mental health attitudes than individual educational experiences, as evidenced by the lack of notable variation in cultural and community views on mental health across educational levels.

(iv) Perceptions of Stigma and Attitudes Towards Mental Health Treatment Across Education

The Kruskal-Wallis test revealed no significant difference in perceptions of mental health barriers across educational levels ($p = 0.452$). According to a study by Ring and Lawn (2025), stigma is a problem at all educational levels. Furthermore, the stigma linked with mental health sometimes crosses educational boundaries. This shows that more structural improvements are needed to reduce barriers such as stigma surrounding mental health care.

The finding that attitudes toward mental health treatment and stigma perceptions did not alter much across educational levels suggests that stigma around mental illness is ubiquitous and firmly embedded in rural communities at all levels of education. This finding is consistent with research conducted in Sub-Saharan Africa, which reveals that stigma is a pervasive social phenomenon influenced by societal norms and deeply ingrained cultural beliefs that extend beyond formal schooling (Petersen et al., 2022; Kola et al., 2021). For example, stigma is heavily influenced by community and cultural context, as seen by the prevalence of negative perceptions and worries about social exclusion linked with mental illness, even among more educated people.

While education can increase understanding and help-seeking behaviours, it does not always result in less stigma or more favourable views about treatment, according to studies conducted in low-income and rural areas, including South Africa (Campbell-Hall et al., 2019; Petersen, 2021). This could be because, rather than being solely based on personal knowledge, stigma is frequently upheld by social punishments and collective community perceptions. Moreover, stigma around mental health is often linked to morality, religion and social identity, all of which are difficult to alter by education alone (Chibanda et al., 2020). Therefore, more thorough community-level, culturally aware strategies beyond formal education may be necessary to reduce stigma and effectively change attitudes.

(v) Knowledge of Mental Health Across Education

Regarding knowledge of mental health across education levels, the Kruskal-Wallis test revealed a significant difference ($p = 0.000$). Higher knowledge levels are directly linked to higher educational levels. Previous studies have emphasised a positive relationship between education and mental health literacy (Ring & Lawn, 2025). Research indicates that people with higher education levels are more likely to have access to information and mental health education tools, which helps them comprehend and be more conscious of mental health difficulties. The Kruskal-Wallis test's finding of considerable variation in mental health knowledge across educational levels supports the body of research showing that education is a key factor in determining mental health literacy, especially in rural and low-resource environments. Higher-educated participants demonstrated a better understanding of mental health issues, likely due to their increased exposure to formal information sources, health education and broader perspectives.

Studies in South Africa and throughout Sub-Saharan Africa have demonstrated that people with secondary or tertiary education are more likely to acknowledge mental health conditions as a medical condition rather than attributing them to supernatural or moral causes. This finding aligns with those of Masemola et al. (2022) and Petersen et al. (2021).

People with lower levels of education, particularly those living in rural regions, frequently do not have access to reliable mental health information and are more likely to be swayed by informal or traditional beliefs that fuel misconceptions or anxiety about mental illness (Van der Walt & Mabaso, 2021). This discrepancy was also noted in a multi-country review by Kola et al. (2021), which discovered that less educated individuals in low-income and Sub-Saharan African nations consistently had inferior mental health understanding, which results in poor symptom assessment and delayed treatment-seeking. Higher education, on the other hand, gives people the mental tools and resources they need to acquire, understand and use mental health information, which leads to more accurate impressions and more receptivity to mental health conversations.

This knowledge gap across educational levels is especially significant in rural South African communities, where systemic and historical injustices have left educational attainment gaps glaring. Education appears to provide an understanding of mental health, which may serve as a buffer against stigma and misinformation, even if it does not directly alter cultural norms. These results are consistent with the broader body of research that views education as a social

predictor of health, influencing socioeconomic outcomes and the ability to engage meaningfully and intelligently with mental health information.

The results of the Kruskal-Wallis tests demonstrated that demographic characteristics, such as age, gender and educational attainment, have a huge impact on how individuals think, feel and understand mental health. The results showed that younger individuals, females, and those better educated had greater knowledge of mental health and more positive opinions about it. The significance of targeted treatments is underscored by variations across demographic factors.

The following section uses Spearman's correlation to examine the relationships among the identified variables and the demographic factors that influence intentions to seek help.

5.6 Determining the Relationship Between and Among Factors Using Spearman's Correlations

A Spearman's correlation was conducted to explore relationships among all variables.

Table 19: Spearman's Correlation

Correlations										
	GNDR	AGR	EDU	KNW	ATT	COMM	MHB	PMB		
Spearman's rho	GNDR	Correlation Coeffic ient	1.000	0.241	-0.230	0.248	0.263	0.085	0.098	-0.180
		Sig. (2-tailed)	.	<0.001	0.001	<0.001	<0.001	0.232	0.172	0.011
		N	200	200	200	200	200	200	200	200
	AGR	Correlation Coeffic ient	0.241	1.000	-0.465	0.451	0.250	0.008	0.145	-0.355
		Sig. (2-tailed)	<0.001	.	<0.001	<0.001	<0.001	0.908	0.043	<0.001
		N	200	200	200	200	200	200	200	200
	EDU	Correlation Coeffic ient	-0.230	-0.465	1.000	-0.607	-0.251	-0.119	-0.127	0.213
		Sig. (2-tailed)	0.001	<0.001	.	<0.001	<.001	0.095	0.076	0.003
		N	200	200	200	200	200	200	200	200

	KNW	Correlation Coefficient	0.248	0.451	-0.607	1.000	0.516	0.265	0.446	-0.365
		Sig. (2-tailed)	<0.001	<0.001	<0.001	.	<0.001	<0.001	<0.001	<0.001
		N	200	200	200	200	200	200	200	200
	ATT	Correlation Coefficient	0.263	0.250	-0.251	0.516	1.000	0.159	0.295	-0.261
		Sig. (2-tailed)	<.001	<.001	<.001	<.001	.	.025	<.001	<.001
		N	200	200	200	200	200	200	200	200
	COMM	Correlation Coefficient	0.085	0.008	-0.119	0.265	0.159	1.000	0.615	-0.300
		Sig. (2-tailed)	0.232	0.908	0.095	<0.001	0.025	.	<0.001	<0.001
		N	200	200	200	200	200	200	200	200
	MHB	Correlation Coefficient	0.098	0.145	-0.127	0.446	0.295	0.615	1.000	-0.454
		Sig. (2-tailed)	0.172	0.043	0.076	<0.001	<0.001	<0.001	.	<0.001

		N	200	200	200	200	200	200	200	193
	PMB	Correlation Coeffic ient	-0.180	-0.355	0.213	-0.365	-0.261	-0.300	-0.454	1.000
		Sig. (2-tailed)	0.011	<0.001	0.003	<0.001	<0.001	<0.001	<0.001	.
		N	200	200	200	200	200	200	193	200

Correlation is significant at the 0.01 level (2-tailed).

For gender (GNDR). Significant positive correlations were observed with knowledge (KNW) ($r = 0.248$, $p < 0.001$) and attitudes (ATT) ($r = 0.263$, $p < 0.001$). This tells us that gender influences mental health knowledge and attitudes. Certain gender groups show higher levels of awareness and more favourable attitudes toward mental health than others. There was no significant relationship between gender and perceptions of community resources (COMM) ($r = 0.085$, $p = 0.232$). A strong, significant negative correlation was identified between perceived barriers (PMB) and gender ($r = -0.180$, $p = 0.011$). This indicates that specific gender groups perceive fewer obstacles in accessing mental health services. Lastly, gender showed a weak positive correlation with mental health behaviours (MHB) ($r = 0.098$, $p = 0.172$). This relationship was not statistically significant.

Regarding education (EDU), a strong negative correlation was identified with knowledge (KNW) ($r = -0.607$, $p < 0.001$) and attitudes (ATT) ($r = -0.251$, $p < 0.001$). The results highlight a direct relationship between education level, knowledge and positive attitudes. This means that higher levels of education can be associated with greater mental health knowledge and more positive attitudes towards mental health care and help-seeking. The results also reveal a positive correlation between perceived barriers (PMB) and education ($r = 0.213$, $p = 0.003$). This means that those with higher levels of education perceive fewer barriers to accessing mental health services. Furthermore, no significant relationship was found between education and perceptions of community mental health resources (COMM) ($r = 0.051$, $p = 0.492$). There

was also no significant relationship between education and mental health beliefs (MHB) ($r = 0.089$, $p = 0.203$). This suggests that most individuals in the community share similar views regarding the resources available and mental health beliefs.

Spearman's correlation results for age (AGR) highlight important findings. A strong positive correlation exists between age (AGR) and knowledge (KNW) ($r = 0.451$, $p < 0.001$), indicating that age is a significant factor in mental health knowledge. As expected, age (AGR) and attitudes (ATT) were highly correlated ($r = 1.000$, $p < 0.001$) regarding age and perceptions of community resources. A positive significant relationship was also identified (COMM) ($r = 0.159$, $p = 0.025$). This means that the individuals who thought the resources made available to the community were sufficient and effective were younger and had experience using the services. Contrastingly. There was a significant negative correlation between age and the perceived mental health barriers (PMB) ($r = -0.355$, $p < 0.001$). This highlighted that age affected the perceived barriers to seeking help. Additionally, it was revealed that age had a positive correlation with mental health barriers. (MHB) ($r = 0.295$. $p < 0.001$). This result indicates that there is a significant role that is played by age in mental health beliefs and barriers. In summary, Spearman's correlation analysis revealed significant roles for gender, education, and age in shaping mental health outcomes and help-seeking behaviours.

5.7 Qualitative Findings

Qualitative data were implemented to explore the factors influencing mental health-seeking behaviours in Bushbuckridge Mkhuhlu. Interviews were conducted to uncover personal and community-level insights into factors influencing mental health-seeking behaviours. The use of qualitative data in this study is summarised in Table 5.11, which presents the overall findings, the objective guiding this phase of the study, and the themes that emerged. This table is provided for clarity and alignment with the research focus.

Table 20: Objectives And Themes

Objective	Theme	Interview Questions
1. Identify the factors influencing mental health-seeking behaviours.	(i) Stigma surrounding mental health and cultural barriers	1. What are the most common reasons why people do not seek help for mental health problems?
	(v) Service Cost and Accessibility as perceived barriers to help seeking.	1. What are the most common reasons why people do not seek help for mental health problems? 3. Do you believe mental health services in the community are effective?
2. Explore variations in attitudes toward mental health care.	(ii) Lack of Mental health literacy	4. Do people in your community believe that mental health issues are under your personal control?
3. Examine differences in intentions to seek help.	(iii) The Function of Social Support and Community	8. How would you personally feel about seeking professional help for mental health issues? 6. What roles do your peers or friends play in influencing your beliefs about mental health?
	(iv) Preference for Traditional Health Care	9. How do you think your family and cultural beliefs affect your own views on mental health?

4. Investigate how perceptions of susceptibility, severity, benefits and barriers influence help-seeking intentions.	(vi) The need for increased mental health awareness and resources	5. What makes someone in your community take mental health seriously?
5. Understand how factors and facilitators intersect with cultural norms and social networks.	(iii) The role of Social Support and Community	7. What roles do you think your community, social circles and the media play in shaping beliefs about mental health?

These objectives ensured that the qualitative phase addressed broader socio-cultural and individual factors. Providing context-specific insights that could inform policy and intervention strategies aimed at improving mental health care access and acceptance in rural communities.

Based on the participants' responses. The researcher employed thematic analysis to identify key themes, providing insight into the societal, cultural, and personal factors that influence mental health attitudes and behaviours in rural communities. These findings contributed to a better understanding of the barriers, facilitators and perceptions associated with mental health care, complementing the quantitative data. The participants' contributions highlighted the experiences of individuals in the community, providing a deeper understanding and context for mental health challenges. This enabled statistical data to be contextualised.

5.7.1 Thematic Analysis

In this study. The researcher used thematic analysis to identify recurring themes and patterns. The researcher identified six themes through thematic analysis.

(i). Stigma surrounding mental health and cultural barriers.

(ii) Mental health literacy

(iii) The role of social and community support.

(iv). Preference for traditional care

(v). Service Cost and Accessibility as perceived barriers to help seeking.

(vi) The need for increased mental health awareness and resources

Theme 1: Stigma Surrounding Mental Health and Cultural Barriers.

The emergence of this theme came from participants highlighting how cultural preconceptions fuel stigma and discourage people from getting treatment. This aligns with the perceived barriers construct of the HBM, which suggests that people hesitate to act because of the fear of being judged.

Participant (P002) said:

"Having Mental health problems is often associated with being crazy."

"There is a fear of being seen as weak".

Participant (P007) said:

"In my culture, men, especially, are told to be strong. Going to a psychologist might make people think I can't handle life, and the notion that you are crazy. Alternatively, it is related to being something spiritual."

Participant (P005) said:

"People don't talk about mental health here because once others know, they start treating you differently. They think you are unstable or dangerous, so it is better to keep quiet."

These responses are consistent with the quantitative results of Perceptions of Mental Health Barriers (PMB), which found that individuals avoided mental health services out of fear of being judged and regarding the potential role of cultural influence as a treatment obstacle. The quantitative results on perceptions of mental health barriers are closely tied to the qualitative theme of stigma surrounding mental health and cultural barriers, which emphasises the widespread impact of stigma and cultural beliefs on behaviours related to seeking mental health help in the rural community being studied. These accounts illustrate how stigma, cultural beliefs, and gender expectations intersect to discourage open discussion of mental health challenges and formal help-seeking within the community. According to both data streams, mental illness is still stigmatised and is usually seen as a cause of social exclusion or shame, which prevents people from getting professional assistance.

This is in line with recent research conducted in South Africa and other Sub-Saharan countries, where stigma continues to be a significant obstacle to the use of mental health services,

especially in rural areas where cultural interpretations frequently attribute mental health issues to moral failings or supernatural causes (Gqaleni & Mkhize, 2023; Van Rensburg et al., 2021). By offering detailed explanations of how stigma appears through family pressures, fear of social rejection and reliance on conventional healing, the qualitative insights enhance the quantitative findings and highlight the complexity of mental health barriers that go beyond simple awareness or knowledge.

According to Abraham and Lund (2022), this congruence supports the notion that reducing stigma requires culturally relevant community engagement that considers both societal perceptions and personal concerns. Additionally, this aligns with the literature, which emphasises the importance of a mixed-methods approach to capture the lived experiences that influence mental health perceptions and stresses that cultural barriers are deeply ingrained and cannot be fully understood using quantitative measures alone (Petersen et al., 2021). Both the qualitative and quantitative results highlight the urgent need for interventions that actively address stigma within cultural contexts and extend beyond the dissemination of knowledge.

Theme 2: Lack of Mental Health Literacy

Another issue participants raised was a lack of mental health literacy among community members. The theme reveals a lack of understanding. When it comes to mental health issues and the resources available, it impacts people's ability to assess the seriousness of their conditions and seek assistance. This topic aligns with the HBM's perceived severity and susceptibility constructs, which describe how perceptions of seriousness and vulnerability influence decision-making. This theme helps explain the apparent contradiction in the quantitative findings: a majority of participants reported coping well with stress while also reporting recent feelings of being overwhelmed.

Participants had to say:

"A lot of us in the community do not know what depression is or anxiety, because we do not have those words in our vocabulary, so it is hard to seek help for something that you do not know or cannot explain. If I do not know what I am feeling and don't have the words to describe it, it will be difficult to seek help. So, lack of knowledge." (P003)

"Many people don't know where to go or what kind of services are available in the community" (P004)

Participant (P001) said:

"I don't think we even have a doctor for mental health conditions here; seeing a general doctor is already a struggle, so what more a specialist doctor?"

The Knowledge (KNW) variable from the quantitative data indicated that many respondents were unsure where to seek treatment for mental health difficulties, a finding supported by the following interview comments.

As indicated by the knowledge of mental health (KNW) variable, the quantitative findings on respondents' hesitancy to seek mental health care are closely aligned with the topic of Lack of Mental Health Literacy that emerged from the qualitative data. This interaction draws attention to a severe lack of knowledge about mental health, which has an immediate effect on behaviours related to seeking help. Theoretically, this finding aligns with the Health Belief Model's (HBM) perceived severity and susceptibility constructs, which posit that an individual's awareness of the gravity of a health condition and their susceptibility to it are important factors in their decision to seek treatment (Rosenstock, 2020). People who lack mental health literacy are less likely to recognise the seriousness of mental health issues or know where to find the right kind of care, which can delay or even prevent them from seeking help.

Recent research has clearly demonstrated this association in rural South African contexts, where structural constraints and cultural beliefs often intersect with low mental health literacy, further complicating access to care (Mendenhall et al., 2021; Petersen et al., 2022). The qualitative interviews reinforce the quantitative findings that many community members are unaware of treatment alternatives, illuminating how a lack of information manifests as uncertainty about available treatments and mistrust of formal health systems. These results underscore the importance of targeted mental health education programs that enhance understanding of mental health conditions and the available services, thereby reducing perceptions of vulnerability and severity and promoting prompt assistance-seeking (Abraham & Lund, 2022).

Theme 3: The Role of Social and Community Support

The participants highlighted the importance of social and community support. They mentioned that having a supportive social network makes it easier to access and seek help. This also aligns with the social influence construct in SCT, which posits that decision-making is significantly influenced by others' actions in a person's social environment.

"Having a supportive family or supportive people around you in my family, we don't talk about mental health openly, but we do support each other when someone is struggling, or we can see that someone is not their usual self, we encourage and try to make sure that the person knows that they can rely on us to support them" (P005)

Participant (P006) said*:*

"I think it is easier to seek help if you don't feel like you're alone, or that the people close to you will judge you"

Another added :

" People don't seek help because they are afraid that people in the community or even their own families might start to treat them differently or see them as having some sort of contagious disease" (P002)

Participant (P008) shared:

"When you have people who check on you and listen, it makes a big difference. Even if they don't understand mental health fully, knowing that someone cares helps you cope better."

Participant (P004) explained:

"Support from family can help, but it depends on how they think. Some families are supportive, while others make you feel ashamed, so people choose carefully who they talk to."

As seen in the quantitative COMM variable, where community attitudes regarding mental health strongly affected willingness to seek help, this subject emphasises the importance of social influence on health practices.

The qualitative theme "The Role of Social and Community Support" strongly aligns with the quantitative findings under the Culture, Coping and Community Views on Mental Health variable, reinforcing the central role of social environments in shaping mental health behaviours. Participants consistently described how having supportive relationships with family, friends, or broader community members made it easier to acknowledge distress and seek appropriate help. This observation aligns with the social influence construct within Social Cognitive Theory (SCT), which posits that individuals' decision-making is significantly influenced by the behaviours, expectations and norms of those around them (Bandura, 2001). Social norms have a powerful impact on obtaining mental health care in rural areas, where dependency and collective identity are essential.

This result aligns with previous research from South Africa, which emphasises the value of utilising social networks to enhance the accessibility of mental health services. According to Van Rensburg et al. (2021), people in rural areas who reported having close community ties were less likely to internalise stigma and more likely to seek support. Similarly, Gureje et al. (2020) stress that social cohesiveness and community involvement might serve as protective factors in low-resource environments, promoting resilience and healthy coping mechanisms. The qualitative findings of the study not only support these findings but also suggest that, in situations with limited access to official services, the perceived moral and emotional support of one's intimate social network may operate as a buffer in the management of mental health disorders. When taken together, the qualitative and quantitative data demonstrate that social and community support networks are significant in influencing mental health outcomes rather than being incidental. Building these networks may be as crucial in rural places as increasing access to professional services, especially if those treatments are still scarce or stigmatised.

Theme 4: Preference For Traditional Health Care

The participants interviewed mentioned that they preferred traditional means as opposed to formal mental health services. This corresponds with the TPB's attitudes towards the behaviour construct, which states that an individual's intention to seek help is influenced by their perceptions of the advantages of treatment.

The interviewee's responses:

"I do not think people trust doctors enough yet. Traditional ways are more common "Traditional healers are more trusted by the locals than hospitals. They consider mental illness to be a spiritual problem" (P004)

"I would first go to a traditional healer, you know, just to check if I am not being attacked, then I would see a professional" (P004)

"I think I would rather speak to a traditional healer first." (P007)

This theme supports the PMB variable findings from the quantitative data. The variable highlighted that many respondents preferred to deal with mental health problems on their own rather than seeking professional assistance.

The theme of a Preference for Traditional Health Care, as revealed through qualitative interviews, reflects a deeply rooted inclination among participants to seek help from traditional

or spiritual healers rather than formal mental health services. The quantitative results under the Perceptions of Mental Health Barriers variable, which showed that many respondents had little use of formal services and emphasised the cultural significance of traditional methods, are in good agreement with this. This preference can be explained by the Theory of Planned Behaviour (TPB), specifically the construct of attitudes toward the behaviour, which holds that a person's beliefs about the appropriateness and efficacy of a particular action, like seeking mental health treatment, have a significant impact on their likelihood of engaging in that action (Ajzen, 2020). Even when formal treatment is available, people are less likely to seek it out in settings where traditional healing is seen as more accessible or culturally relevant.

Traditional health systems remain the primary point of contact for many individuals experiencing psychological distress, particularly in rural areas, according to studies conducted in South Africa and throughout Sub-Saharan Africa (Gqaleni & Mkhize, 2023; Mendenhall et al., 2021). These services are not only more geographically and financially accessible, but they are also embedded in local belief systems that frame mental illness in spiritual or ancestral terms. As such, formal services are often viewed with scepticism or perceived as less effective in addressing culturally defined problems. The integration of these findings highlights the importance of culturally informed mental health education and the potential for collaboration between traditional and biomedical systems. Rigid promotion of formal services alone may fail to shift community behaviour if perceived advantages do not align with cultural beliefs.

Theme 5: The Perceived Barriers- Cost and Accessibility of Services

Participants identified cost and accessibility as significant barriers to receiving professional mental health therapy. This is consistent with the HBM's perceived barriers construct, which claims that financial and logistical hurdles often impede access to services.

Participant (P007) said:

"Mental health services are costly and scarce. People may want to get help. However, I think in Mkhuhlu. The hospital they refer people to from Matikwana is Acorn Hoek and that is far, about 1 hour and 30 minutes, so maybe people cannot afford the costs to travel to Acorn Hoek or Mapulaneng" (P007)

Participant (P001) said that:

"Most people cannot afford them as it is expensive. At Matikwana, they will tell you that you need to go to Mapulaneng Hospital or Acornhoek, that is where there is a psychologist and that is very far from Mkhuhlu."

Participant P(005) added that:

"They say depression is a rich/white man's disease and I can agree with that. We as black people do not have the luxury of having such conditions, because where will the money for all the treatments and doctor visits come from?"

"*Treating mental health conditions is costly and time-consuming. You will need to travel far to see a psychologist; there are no psychologists at Matikwana. You will have to travel to Mapulaneng, or you need to have money to see a private one, maybe in Hazyview,"* says participant (P003)

This theme confirms results from the quantitative data's PMB and COMM variables. it shows

The theme 'Perceived Barriers: Cost and Accessibility of Services' emerged strongly in the qualitative findings, with participants emphasising financial constraints and logistical challenges as significant impediments to seeking professional mental health care. This resonates directly with the perceived barriers construct of the Health Belief Model (HBM), which posits that individuals are less likely to engage in health-seeking behaviours when they anticipate significant obstacles, such as high costs or difficult access to services (Rosenstock, 2020). The qualitative data corroborate the quantitative results from the Perceptions of Mental Health Barriers and Coping, Culture and Community Views variables, which together illustrate that the physical location of services and the associated financial burden substantially limit access in rural communities.

These results align with other studies conducted in rural South Africa and Sub-Saharan Africa, where individuals are often discouraged from seeking mental health care due to a lack of infrastructure, transportation issues and out-of-pocket expenses (Abraham & Lund, 2022; Petersen et al., 2022). Furthermore, these obstacles are exacerbated by the economic conditions in low-income rural areas, which widen the treatment gap and reinforce disparities in service utilisation (Sibeko et al., 2020). To increase equitable access, solutions that lessen the financial and geographic barriers to mental health services, such as mobile clinics, community-based care, or subsidised transportation, are desperately needed, as evidenced by the convergence of qualitative and quantitative data.

Theme 6: The Need for Increased Mental Health Awareness and Resources

Most participants spoke about the improvements they would like to see in their community, specifically in terms of mental health resources and education. The participants believe that raising awareness would help to increase access to care and reduce stigma. The theme aligns with the perceived behavioural control construct from the TPB, which states that the available resources greatly influence people's views of their capacity to seek help.

This is what Participants had to say:

"The community needs to host more mental health awareness events. For instance, people typically visit clinics for various reasons. If they could hold information sessions or display signs indicating that a professional is available, it would be beneficial. The same way they go around at the shopping complex, educating people about HIV and PREP, they should do the same for mental health, which is equally important. That way their services can be effective" (P003)

"They need to work on bringing more awareness about mental health. I think we are forgotten because we see these mental health days and awareness happening. But they only happen in the city and not here for us" (P005)

"Mkhuhlu needs its own mental health professionals; we are too far from Acornhoek or Mapulaneng. They want us to use their services, but we do not have access to them. We need to have at least a psychologist who serves the people of Mkhuhlu and we must be educated about these types of things" (P008)

Participant (P006) stated:

"Even if people want help, there is nowhere to go. We hear about mental health on the radio or TV, but when you look around here, there are no services that you can actually access."

Participant (P009) explained:

"If there were regular talks at clinics or community halls, people would learn that mental health is something real and treatable. Right now, many people don't seek help because they don't know where to start."

The present theme is consistent with the numerical results obtained from the COMM and KNW themes. The respondents emphasised the need for enhanced mental health education and resources to support the community's well-being.

The participants' need for more visible, easily accessible mental health education, services, and support networks in their rural communities is highlighted in the subject, "The Need for Increased Mental Health Awareness and Resources." According to several participants, increasing awareness will not only lessen the stigma but also give them the confidence to ask for help. This perspective is consistent with the Theory of Planned Behaviour's (TPB) perceived behavioural control construct, which holds that the availability of enabling resources affects a person's perceived capacity to carry out a behaviour, in this case, seeking mental health treatment (Ajzen, 2020). Community members' motivation and perceived ability to seek assistance are significantly reduced when they believe that resources are insufficient or unavailable.

The quantitative results from the Coping, Culture, and Community Views and Knowledge of Mental Health variables, which demonstrate a clear need for more community-level services and significant support for mental health education, are supplemented by this qualitative insight. These views are supported by research conducted in rural South Africa, which found that inadequate referral mechanisms, low public awareness and a lack of mental health infrastructure are significant obstacles to care (Petersen et al., 2021; Van der Watt et al., 2020). Additionally, research has demonstrated that stigma declines and service utilisation rise in rural communities equipped with reliable mental health information and readily available options (Abraham & Lund, 2022). The statistics reveal a clear community thirst for change, underscoring that increasing awareness and resource availability are about more than just access; they are also about instilling confidence, autonomy and agency in help-seeking behaviours.

In summary, the themes identified in this qualitative phase emphasised the complexities of the interconnections between cultural norms, stigma, social support, and barriers that influence community members' decisions to seek treatment. A better understanding of the elements that influence mental health-seeking behaviours was gained. The following section will focus on integrating quantitative and qualitative data.

5.8 The Integration of Quantitative and Qualitative Data

In this section of the study. The quantitative and qualitative data will be integrated to address the study's primary hypotheses. The study aimed to determine whether attitudes differed. Behavioural intentions. Moreover, perceived social norms related to mental health-seeking behaviours. The results from both phases are triangulated to provide a more comprehensive and nuanced interpretation.

i. Hypothesis One

- Null Hypothesis (H0): There is no significant difference in attitudes towards mental health care, social norms, perceived behavioural control and intentions to seek help amongst individuals living in rural communities in South Africa.
- Alternative Hypothesis (H1): There is a significant difference in attitudes towards mental health care, perceived social norms, perceived behavioural control and intentions to seek help amongst individuals living in rural communities in South Africa.

Quantitative Data: Based on age and gender, the Kruskal-Wallis test revealed significant differences (p-values < 0.001 in both cases). This suggests that opinions about mental health services varied among different demographic groups.

Qualitative Data: The interviews highlighted a range of viewpoints. Younger participants, especially those with higher education, expressed greater openness to the idea. Older participants, especially men, were more reluctant to seek mental health care because of societal stigmas. For example, one interview participant (P001) mentioned that mental health was not a common topic and that many people believed it could be overcome. At the same time, participant (P008) highlighted that the increased level of awareness was due to education. Therefore, the null hypothesis is rejected as individuals show differing attitudes and Conventions regarding mental health care and help-seeking.

ii. Hypothesis Two

- Null Hypothesis (H0): A significant difference in factors influencing individual behaviour when it comes to seeking mental health care between the different demographic groups can be identified.

- Alternative Hypothesis (H1): No significant difference can be identified in factors influencing the behaviours of individuals seeking mental health care between demographic groups.

Quantitative Data: The KNW and PMB variables indicate significant differences between education levels and age groups (p-values < 0.001 and 0.046, respectively). Respectively. The differences reveal that older and less educated people have greater difficulty. Younger and more educated people have more knowledge and perceive fewer barriers.

Qualitative Data: Interviewees revealed significant differences in participants' viewpoints. Participant 5 has greater access to and knowledge of the information. Participant 3 feels that not enough information is available. This supports the result that demographic characteristics significantly influence mental health-seeking behaviour. The null hypothesis is therefore rejected.

iii. Hypothesis Three

- Null Hypothesis (H0): The intentions to seek mental health care are not significantly influenced by factors such as perceived susceptibility. Severity. Benefits and barriers.
- Alternative Hypothesis (H1): Intentions to seek mental health care are significantly influenced by factors such as perceived susceptibility. Severity. Benefits and barriers.

Quantitative Data: The results reveal a significant difference ($p < 0.001$) between KNW and PMB. This means that intentions to seek mental health care are stronger when perceived barriers are lower and knowledge is higher.

Qualitative Data: participant (P003) demonstrated greater mental health knowledge and stated that greater awareness of services helps make informed decisions. Whereas participants with high perceived barriers (e.g., P002) hesitated to seek help because they did not want to seem “Weak”. Therefore, the null hypothesis is rejected, and the alternative hypothesis is retained.

iv. Hypothesis Four

- Null Hypothesis (H0): There is no significant difference in the facilitators encouraging mental health support across cultural norms, social networks and access to resources within the community.

- Alternative Hypothesis (H1): There is a significant difference in facilitators that encourage mental health support across cultural norms, social networks and access to resources within the community.

Quantitative Data: The findings from the comm variable reveal no significant differences ($p = 0.102$). This suggests that there may not be a significant difference in access to community resources across demographic groups. Contrastingly, the KNW variable ($p < 0.001$) indicates a significant difference in knowledge and awareness of these resources across educational levels.

Qualitative Data: The interviews revealed that while Sangomas and clinics were readily available to all participants. There were differences in their awareness of mental health resources and in their desire to use them. Participant 6 appeared to be more knowledgeable about mental health resources and how to access them. However, participant 8 reported that they were unaware of any mental health services. As a result, the null hypothesis is partially rejected, as the quantitative data revealed no significant variations in access to community resources ($p = 0.102$), suggesting that the availability of resources, such as Sangomas and clinics, is uniform across the sample. The qualitative data provides more profound insight. The differences in knowledge and awareness ($p < 0.001$) indicate that, even though resources may be accessible, they are not used. Individuals' awareness and understanding of how to utilise these resources vary significantly.

5.9 Summary

The discussion of findings from this study highlights the intricate interplay of sociocultural, educational and structural factors that influence mental health help-seeking behaviours in the rural context of Mkhuhlu, Bushbuckridge. While mental health issues are becoming more widely recognised, there are still many obstacles to overcome, such as stigma, ignorance, a preference for conventional therapeutic methods and restricted access to resources, according to both quantitative and qualitative evidence. The findings revealed demographic differences in mental health literacy, indicating that knowledge and attitudes were influenced by gender, age and educational attainment. These findings were enhanced by themes from the qualitative stage, which captured the real-life experiences of people overcoming these obstacles in situations with limited resources and cultural norms. The use of behavioural theories, such as the Health Belief Model (HBM), Theory of Planned Behaviour (TPB), and Social Cognitive Theory (SCT), provided a valuable lens through which to interpret the drivers behind observed

behaviours. Ultimately, the discussion underscores the need for holistic, community-informed mental health strategies that not only improve service access but also address entrenched beliefs and structural inequities that hinder help-seeking in rural South African settings.

CHAPTER 6
SUMMARY, CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

6.1 Introduction

This chapter summarises the study's findings on mental health-seeking behaviours in Bushbuckridge Mkhuhlu. Conclusions will be drawn from the study's findings. Limitations will be identified, and recommendations for enhancing mental health awareness and services in rural communities will be proposed, along with suggestions for future research. The study's implications will be clearly outlined.

6.2 Summary of Findings

The study aimed to determine the key factors and facilitators that influence mental health-seeking behaviours among individuals in Mkhuhlu. The study also aimed to understand attitudes towards mental health care, whether certain beliefs influenced help-seeking and how facilitators intersected with cultural norms, social networks and access to resources within the community.

The quantitative results indicated that stigma, a lack of understanding, and negative perceptions of mental health were the main factors influencing the help-seeking behaviours of most respondents. Differences related to age, gender, and educational level were all significant. The study, employing quantitative research methods and the Kruskal-Wallis H test for analysis, revealed notable disparities in help-seeking behaviours among various demographic groups. These findings illuminate the connection between social variables and attitudes towards mental health support in rural regions, where stigma, accessibility challenges, and cultural standards often play intricate roles in shaping the mental health context.

Regarding aspects such as awareness of mental health, perceptions of obstacles, and sociocultural and attitudinal effects, the quantitative findings indicated significant variations based on gender, age, and educational background. Studies indicate a connection between education, gender socialisation, and enhanced health literacy. Typically, women and individuals with higher educational attainment possess a better grasp of mental health topics and the resources available for support (Van der Watt et al., 2020; Petersen et al., 2021). Younger people tend to exhibit higher levels of awareness and more progressive views, as evidenced by notable age-related differences. This phenomenon is likely due to generational shifts in access to information and exposure to narratives that help diminish stigma.

Attitudes towards mental health services and views on stigma did not display significant variations among different demographic groups. This suggests that stigma is a pervasive problem rooted in cultural beliefs rather than individual traits. Various factors contributed to these results, including insufficient mental health knowledge, the significance of social and community support, a preference for traditional healthcare systems, perceived structural obstacles such as cost and accessibility, stigma, and cultural challenges. Moreover, five primary themes identified in the qualitative research illuminate the lived experiences and contextual realities that influence these patterns. These themes correspond with the quantitative results, especially regarding perceptions of mental health issues, coping mechanisms, cultural and community perspectives, and understanding of mental health.

The use of the Health Belief Model (HBM), Theory of Planned Behaviour (TPB), and Social Cognitive Theory (SCT) provided additional context to the findings. Perceived obstacles (HBM), such as the distance to health facilities and the cost of services, as well as low perceived behavioural control (TPB) due to limited resources, were often mentioned. Regarding the influence of stigma, family expectations, and community narratives on decision-making, social cognitive theory (SCT) has emerged as a significant factor influencing behaviour (Ajzen, 2020; Bandura, 2001). Notably, both qualitative and quantitative data revealed that traditional healing is a favoured and culturally appropriate method of care, highlighting the continued importance of indigenous health systems in rural South African communities (Gqaleni & Mkhize, 2023).

Lastly, the study's findings demonstrate the complex interactions among social norms, cultural perspectives, individual knowledge and structural access. Increased service accessibility, more community-based support networks and culturally sensitive mental health education are clearly and urgently needed. Efforts to improve mental health help-seeking in rural areas would probably remain limited if these overlapping issues were not addressed holistically. Future policy and programmatic interventions must consider both the shared community-level attitudes and the practical structural barriers that shape mental health behaviours in rural South Africa.

The research study revealed that systemic barriers, such as a lack of resources, make it even more difficult to access mental health care. Additionally, community and individual attitudes significantly influence behaviours related to seeking mental health services. The study emphasised the urgent need to combat stigma, promote mental health literacy, and ensure that culturally appropriate therapy is accessible.

6.3 Conclusions of the Study

Based on the findings presented, the study draws the following conclusions. The data indicated that a mix of structural, cultural, and individual factors shapes the behaviour of seeking mental health support in rural areas. Participants consistently pointed out that long distances to travel, a lack of mental health professionals, financial limitations, and inadequate service availability are significant barriers to accessing formal care. These structural obstacles lead to delays in seeking help and strengthen reliance on informal support systems.

Additionally, the findings highlight that stigma, cultural beliefs, and a lack of mental health awareness significantly affect how individuals perceive mental health issues and the sources they select for assistance. Informal and traditional methods of care, such as those provided by family, religious figures, and traditional healers, continue to exert considerable influence due to their accessibility, cultural relevance, and trusted positions within the community. Although these sources offer valuable social support, they may also lead to a delayed engagement with formal mental health services.

A key takeaway from the research is that age, gender, and educational background significantly affect help-seeking behaviour. The findings reveal apparent variations across these demographics, indicating that mental health-seeking behaviours are not consistent throughout the community. Women showed a greater willingness to recognise their distress and consider seeking support, while men felt more hindered by stigma, societal expectations of masculinity, and fears of being judged. Younger individuals demonstrated hesitance, linked to how peers perceive them, and uncertainty about available services. Those with lower levels of education exhibited less awareness of mental health issues and formal treatment options, impacting their ability to identify symptoms and pursue appropriate care. These results imply that sociodemographic factors influence both attitudes toward mental health and the choices individuals make when seeking help.

Overall, the research highlights that a combination of accessibility issues, cultural standards, societal expectations, and individual sociodemographic traits affects mental health-seeking behaviour in this rural area.

6.4 Limitations of the Study

This study has several limitations that need to be acknowledged to provide context for interpreting its results. The first limitation in this study is the sample size. The sample was suitable for the research; however, this limitation limited the generalizability of the results to

other rural communities in South Africa or the Sub-Saharan region. In the future. It would be advisable to expand the sample size to include participants from diverse rural backgrounds. This would benefit the research by allowing for broader conclusions to be drawn.

The cross-sectional approach is also another limitation of the study. A cross-sectional approach captures only a snapshot of participants' attitudes, beliefs, and behaviours at a given point in time. In the future, a longitudinal approach can be considered to examine how attitudes towards mental health change over time, especially when resources and mental health education in these areas improve. Although the quantitative phase provided quantifiable insights. It, however, might not have conveyed the complexity of the cultural ideas and variations in perspectives sufficiently. Future studies may find it more beneficial to conduct research using ethnographic or in-depth qualitative approaches, which have the potential to offer a deeper comprehension of how local views, societal norms and traditional healing interact with behaviours related to seeking mental health treatment.

Finally, self-report questionnaires were used, particularly regarding stigma and attitudes toward mental health care. Bias is a constraint that cannot be ignored. It is important to note that some participants may have over-reported their intention to seek treatment or under-reported their negative attitudes toward mental health care due to social desirability bias.

6.5 Short-Term Recommendations

These research outcomes could influence mental health policies and the design of interventions in rural areas. The study's conclusions may offer guidance for developing culturally sensitive mental health education programs that take into account local cultural and community norms. Furthermore, this research could lay the groundwork for partnerships between mental health practitioners and traditional healers to establish a more holistic approach to care by identifying distinct factors that affect behaviour related to seeking mental health services. It is feasible to develop community-based interventions that enhance mental well-being while respecting cultural practices.

Promoting mental health awareness in rural communities requires a coordinated approach grounded in the local context, addressing both informational gaps and cultural influences on mental health perceptions (Masemola et al., 2022). First, mental health education initiatives should be designed collaboratively with local leaders, traditional healers, religious organisations, and community health workers to ensure they are culturally relevant and gain trust within the community. These initiatives should aim to improve awareness of common

mental health issues, identify early symptoms, and explain the available avenues for care (Bila & Carbonatto, 2022).

Secondly, incorporating mental health education into established community structures, such as schools, clinics, agricultural cooperatives, and social events, can broaden outreach and help normalise discussions about mental wellness. Customised messaging should be developed for various demographic groups, especially men, youth, and individuals with lower educational backgrounds, as they are often found to have lesser awareness and higher stigma levels (Mokwena & Madiga, 2023).

Thirdly, equipping community-based workers and lay counsellors with the skills to provide psychoeducation and support can enhance early detection and encourage timely help-seeking behaviours. Lastly, utilising trusted communication methods like radio shows, community gatherings, and mobile outreach can help bridge literacy gaps and reach households with limited access to information (Craig et al., 2022). Together, these approaches can foster a more informed and supportive atmosphere that encourages early identification and appropriate help-seeking for mental health issues in rural regions.

In summary, this study underscores the necessity for an integrated strategy that addresses challenges at both individual and community levels, promoting a healthier environment for mental health across Mkhuhlu and Bushbuckridge.

6.6 Long-Term Recommendations

Building upon the results of this research, subsequent studies should explore how community-centred mental health education initiatives impact stigma reduction and the practice of seeking long-term treatment. Researchers might consider partnering with traditional healers to gain a deeper understanding of the interplay between formal and traditional mental health treatments. Such collaboration could yield strategies to effectively bridge the divide between these two approaches. Furthermore, examining how social networks, such as support from peers or family, affect the choice to pursue mental health care may uncover additional facilitators or barriers in rural settings.

To start, future investigations should analyse the relationships between traditional mental health care practices and cultural norms to facilitate the creation of more tailored interventions. Longitudinal research assessing the effects of mental health education on stigma reduction and help-seeking behaviours could prove beneficial going forward. Additionally, expanding the

study to include a wider array of rural populations could be advantageous, as it may help develop universally applicable strategies that foster healthy attitudes towards mental health care across sub-Saharan Africa. Moreover, future research should delve deeper into the specific barriers associated with gender, age, and education, as the current findings reveal notable differences across these demographics. Gaining a more detailed understanding of these distinctions can help design targeted interventions. Investigating men's mental health, the experiences of youth, and the perspectives of individuals with low literacy would be particularly valuable.

Furthermore, a closer examination of the roles of informal and traditional support systems is crucial. Research should look into how collaborative models involving formal providers, traditional healers, religious figures, and community organisations can enhance early detection and referral processes. Lastly, future studies should assess the effectiveness of community-led awareness initiatives and identify the most effective and impactful methods within rural environments. This could involve participatory action research that includes rural residents as co-researchers to ensure cultural relevance and sustainability.

Additionally, when considering future research directions, it may be helpful to investigate the emerging role of Artificial Intelligence (AI) in mental health contexts. As digital tools become more integrated into healthcare, it is vital to understand how AI affects help-seeking behaviours, service delivery, and patient outcomes (Watanabe, 2023). Future research could specifically focus on the ethical, practical, and cultural implications of incorporating AI-driven technologies in rural and resource-limited communities (Baumans et al., 2022). This line of inquiry would help determine whether AI can improve accessibility, assist in the early identification of mental health issues, and enhance decision-making among mental health professionals (Baumans et al., 2022). Crucially, examining the safeguards necessary to ensure responsible, culturally sensitive AI utilisation will aid the formulation of ethical guidelines and best practices (Steinman et al., 2020). By integrating AI into future research strategies, scholars can help shape a more informed, equitable, and practical framework for mental health that yields positive outcomes for diverse populations.

6.7 Implications of the Study

The study's primary conclusions highlight significant aspects of residents' help-seeking behaviours in Mkhuhlu Bushbuckridge, including stigma, knowledge levels, cultural norms, social networks, and resource availability. Demographic factors, including age, gender, and

educational attainment, were taken into consideration. The quantitative results revealed substantial differences, indicating that younger individuals and those with higher levels of education held more positive views than older individuals with lower levels of education. This implies that the first group is increasingly open to mental health care, while the latter group still associates it with shame or views it as a sign of personal weakness. In addition to a lack of knowledge regarding mental health care, stigma was identified as a significant barrier to accessing support. The study's outcomes align with previous research highlighting the stigma that groups with lower mental health awareness encounter, which adversely affects their willingness to seek formal care (Mofokeng & van den Heever, 2020).

Qualitative data reinforced these conclusions by illustrating how cultural beliefs and values shape individuals' perspectives on mental health, particularly in the Bushbuckridge community, which has a deep-rooted history of traditional healing practices. Many participants acknowledged traditional healers as vital members of their mental health support systems. This finding aligns with research demonstrating that cultural and religious practices strongly influence mental health-seeking behaviours across numerous Sub-Saharan African communities (Campbell, 2019). According to Kganya (2023), while traditional healers provide accessible and culturally relevant support to communities, they also contribute to mixed perceptions of formal mental health services. Participants in the qualitative phase reported feeling more comfortable seeking help from traditional healers due to shared cultural values and a sense of trust. It is noteworthy that several participants expressed a willingness to pursue formal mental health care if it were more accessible and culturally relevant.

Moreover, a significant number of participants expressed a preference for seeking informal mental health support due to fears of judgment and concerns about privacy. The quantitative analysis indicated that awareness campaigns played a vital role. Additionally, individuals with more positive attitudes had previously received mental health education. These findings are consistent with earlier studies suggesting that emphasising mental health education can lower stigma and improve attitudes toward seeking treatment (Kim & Lee, 2020). However, it is essential to emphasise the significant benefits of mental health education. Systemic challenges, such as limited access to mental health services in remote areas, continue to hinder the availability of care while increasing reliance on traditional or community-based approaches (Sorsdahl et al., 2023).

There are significant practical and policy implications for enhancing mental health literacy and addressing stigma in rural regions, such as Mkhuhlu. It is essential to implement community-based awareness and education initiatives that are attuned to cultural differences and provide accurate information. Ensuring that resources are allocated to rural communities should be a high priority to promote access to affordable, culturally suitable mental health care. Developing partnerships with traditional healers and strengthening ties between formal and informal mental health care systems are examples of policy measures that can benefit rural communities. Furthermore, to foster more favourable attitudes towards help-seeking behaviours, it is vital to introduce programs aimed at reducing stigma and increasing awareness of mental health as a legitimate medical condition.

6.8 Conclusions

This research emphasises the significance of cultural beliefs, societal factors, and resource availability in shaping how individuals in rural Bushbuckridge, Mkhuhlu, engage with and pursue mental health care. Employing a mixed-methods approach, the study highlighted the critical aspects, including stigma, the influence of traditional healers, and the importance of community resources, that affect individuals' willingness to seek assistance. The findings of the study further highlight the necessity for integrated and culturally sensitive mental health therapies, offering valuable insights into the complex interplay between formal and informal mental health practices.

To mitigate stigma and enhance mental health within remote communities, it is recommended that the study's suggestions be applied or adjusted as needed. Improving community-based mental health education involves bridging the gap between formal healthcare systems and community perspectives, engaging traditional healers, and offering affordable, accessible treatments. This could help nurture an atmosphere where individuals feel encouraged and empowered to seek support. Policymakers should prioritise mental health support in rural areas, ensuring that resources and initiatives meet the unique needs of these communities.

Additionally, lawmakers, healthcare professionals, and community leaders are encouraged to take the initiative in addressing mental health challenges in rural regions. Cooperation between formal and informal mental health services could facilitate the creation of a framework that preserves cultural values while promoting mental health awareness. The study highlighted the need for community-centred initiatives and the importance of addressing mental health inequalities in rural areas. The aim is to strive for a future in which mental health support is

comprehensive, inclusive, and accessible across all South African communities, through further research and the implementation of culturally relevant interventions.

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APPENDIX A: QUESTIONNAIRE

Mental Health Seeking Behaviours in Rural Areas

Section 1: Introduction and Awareness of Mental Health.

This section will include an introductory phase, where mental health will be explained, including what it is, how one can seek help, and debunking myths about mental health and mental health conditions. It will also provide education to help eliminate any potential stigma related to mental health conditions and help-seeking.

Instructions: Read the following questions and statements and indicate the correct answer with an X.

Section 2: Biographical Information

Please mark the correct answer with an X.

What is your Gender?

Female	Male	Non-binary	Transgender	I prefer not to say
1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

What is your age range?

18-23	24-29	30-35	36-41	42-47	48-53	54-59	60-65	66-71	72-77+
1	2	3	4	5	6	7	8	9	10

What is your current level of education?

No formal schooling	Primary school	High school	Diploma	University degree
1	2	3	4	5

☐	☐	☐	☐	☐

Section 3: Understanding Of Mental Health Care

The statements present your understanding of mental health care. Please indicate how much you agree or disagree with each of the statements by marking them with an X.

	1.Strongly disagree	2.Disagree	3.Neutral	4.Agree	5.Strongly agree
1.I Know about conditions such as Depression					
2.I know about anxiety					
3. I know about bipolar disorder					
4. Access to mental health services can help individuals cope with their mental health concerns					
5. Mental health stigma					

can hinder seeking mental health support					
6. Lack of access to mental health services can hinder seeking mental health support					
7. Cultural beliefs in my community discourage seeking professional mental health services.					
8. Pressure from family members may push one to seek mental health care.					
9.You often see people in the community seeking mental health support					
10. I would be able to access					

mental health services if I needed them.					
11. One can manage mental health effectively without professional help.					
12. I have positive attitudes towards seeking professional help for mental health conditions.					
13. Seeking mental health support is a sign of strength.					
14. One may feel pressure from the community to seek mental health support					

15. I would be comfortable discussing mental health concerns with family members.					
16. There is a stigma associated with seeking mental health services in my community.					
17. One may find it difficult to manage their mental health, given the resources available in the community					
18. One may easily manage their mental health with the resources available in the community					
19. I know where to go					

should I need mental health services.					
20. Mental health problems last forever					
21. I have received help for mental health concerns in the past.					
22. I am happy with the mental health services I have accessed in the past.					
23. I know about the mental health resources or support networks available in my community					
24. The available mental health care resources					

are effective in addressing mental health needs in the community.					
25. I cope well with stress.					
26. I have effective stress coping strategies					
27. Culture impacts attitudes towards mental health in my community.					
28. I would be comfortable with discussing mental health openly in my cultural context.					
29. Changes need to be made in mental health services					

in rural communities.					
30. The community needs to prioritise mental health awareness and support.					
31. A person showing signs of mental disturbance should seek mental health care from the hospital					
32. People with mental health conditions should not be treated like outcasts in society					
33. It is best to avoid anyone who has mental health problems					

34. People in my community look down on those who seek mental health services.					
35. Mental health services are expensive					
36. Mental health issues should be kept private and not discussed openly.					
38. I have felt overwhelmed in the past few months					
39. Overall, I would say I have good mental health					
40. Mental health services are an important resource for maintaining overall health					

and well-being.					
41. My community provides enough support for those seeking mental health services.					
42. Mental health services are effective in treating mental health issues.					
43. Mental health issues are common and not something to be ashamed of.					
44. Mental health education programs in my community would help reduce stigma and encourage					

people to seek help.					
45. I am knowledgeable about mental health issues.					
46. Discussing mental health issues with family and friends can be helpful.					
47. Mental health problems can have serious consequences if left untreated					
48. Mental health problems are serious and can affect anyone.					
49. Traditional healing methods are more effective than modern mental health services.					

50. If I had mental health issues, I would go to a traditional healer (Sangoma)					
51. I would be able to identify when I need to seek help for my mental health.					
52. Early intervention can prevent mental health issues from becoming more serious.					
53. The fear of being judged by others may prevent people from seeking mental health services.					
54. Peer support groups within the community					

can be effective in helping individuals with mental health issues.					

APPENDIX B: INTERVIEW QUESTIONS

1. What are the most common reasons why people do not seek help for mental health problems?
2. Do you believe mental health services in the community are effective?
3. Do people in your community believe that mental health issues are under your personal control?
4. What makes someone in your community take mental health seriously?
5. What roles do your peers or friends play in influencing your beliefs about mental health?
6. What roles do you think your community, social circles and the media play in shaping beliefs about mental health?
7. How would you personally feel about seeking professional help for mental health issues?
8. How do you think your family and cultural beliefs affect your own views on mental health?

APPENDIX C: INFORMED CONSENT

INFORMATION LEAFLET

Researcher: Ayanda Fiona, Magagule (240901088)

Supervisor: Prof Thoko Mayekiso

Co-supervisor: Dr Mercy Kutu

Name: Ayanda Fiona Magagule

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Dear Potential Research Participant,

I am Ayanda Fiona Magagule, a Master of Arts Psychology Student at the University of Mpumalanga, in the social science and economic development. You are invited to participate in a research project titled **Understanding Mental Health Seeking Behaviours in Rural Communities: Insights from the Bushbuckridge community, Mpumalanga Province**

Give specific research objectives.

1. To explore the factors influencing mental health-seeking behaviours among individuals in rural communities in South Africa, including demographic variations and community contexts, through in-depth interviews and thematic analysis.
2. To investigate the variations in attitudes towards mental health care, perceived social norms, perceived behavioural control and intentions to seek help among individuals residing in rural communities in South Africa.
3. To develop predictive models examining the relationships between perceived susceptibility, severity, benefits and barriers and intentions to seek mental health care among individuals in rural communities in South Africa, using regression analysis and structural equation modelling.

4. To integrate quantitative and qualitative findings to provide a comprehensive understanding of the factors influencing mental health-seeking behaviours in rural communities in South Africa, identifying common themes, discrepancies and opportunities for intervention and policy development.

If you decide to take part in the study, you will be required to do the following:

- Sign this informed consent form
- Indicate what participants are required to do for your specific research project:

1. Partake in a 30–40-minute interview session.
2. Fill out a questionnaire

The questions are strictly for this research study. Please note that your participation in answering this questionnaire/interview questions is entirely voluntary, and you are allowed to withdraw at any time should you wish to. Your name will not be recorded anywhere, and no one will be able to connect you to the answers you give. Your answers will be assigned a code number or a pseudonym, and you will be referred to in this manner during the data analysis and discussion of results in the research report. All responses will be aggregated with other respondents' responses, without reference to individual participants. This research is strictly for educational or academic purposes.

Your co-operation and participation in the study will be appreciated. Please sign the informed consent below if you agree to participate in the study.

Kindly answer each question honestly and accurately, as your participation in this process is essential to the success of this study.

Yours faithfully

_____

Signature

Ayanda Magagule (of researcher)

CONSENT FORM

1. I _____agree to and am voluntarily taking part in this research project.
2. I understand that I have the right to withdraw from the study at any time and may choose no longer to participate without having to explain myself.
3. I am aware that the information I provide on the questionnaire is for educational/academic purposes.
4. I understand that my name will not be recorded.
5. I have been provided with and have read the information leaflet regarding this research study.
6. I have had the opportunity to ask any questions related to this study and received satisfactory answers to my questions and any additional details I wanted.
7. I agree to answer the questions to the best of my ability.
8. I understand that I may refuse to answer any questions that I do not feel comfortable answering.
9. By signing this letter, I give free and informed consent to participate in this research study.

DATE			
PARTICIPANT SIGNATURE			
RESEARCHER NAME	Ayanda Magagule	RESEARCHER SIGNATURE	AF Magagule

Ayanda Magagule is conducting this research.

Telephone: 072 861 2364 E-mail: ayandamagagule@gmail.com

If you have any further questions about the research study or the questions themselves, please contact the Supervisor (Prof. Thoko Mayekiso or Co-Supervisor Dr M. Kutu at UMP. The Supervisor's contact details are as follows:

Supervisor

Tel: 013 002 0001 Email: thoko.mayekiso@ump.ac.za

Co – Supervisor

Tel: 081 778 4433 Email: mercy.kutu@ump.ac.za

This research project has received ethical approval from the School Ethics Committee / Faculty Research Ethics Committee / UMP Research Ethics Committee for Human and Social Sciences.

Ethical Clearance Number: UMP/Magagule/08/2024

APPENDIX D: GATEKEEPERS' LETTER

Dear Nkuna, Tribal Council (Hosi Nkuna)

My name is Ayanda Fiona Magagule, and I am currently beginning a research project for my Master of Arts in Psychology at the University of Mpumalanga. Subject to approval by the University of Mpumalanga Research Ethics Committee, this project will be a questionnaire and Interview schedule to assess the mental health-seeking behaviours of people residing in Mkhuhlu Bushbuckridge, which is within your jurisdiction. I am writing to ask your permission to be allowed access to your community to seek research participants, distribute a questionnaire and conduct interviews. This should take no more than 14 days to complete. All I will need to do is distribute questionnaires to residents of Mkhuhlu and conduct interviews with those interested in participating. All answers and results from the research are kept strictly confidential. The results will be reported in a research paper, which will be made available to all participants upon completion, should they be interested. If this is possible, please could you email me at 240901088@ump.ac.za to confirm that you are willing to allow access to your community, provided they agree and are happy to participate. Thank you for your time and I look forward to hearing from you soon.

Yours sincerely

Ayanda Magagule

APPENDIX E: FREC ETHICAL CLEARANCE

Ref: UMP/Magagule/08/2024
Date: 15 August 2024

Ayanda Fiona Magagule (240901088)

School of Social Sciences
Faculty of Economics, Development and Business Sciences, University of Mpumalanga

RE: APPROVAL FOR ETHICAL CLEARANCE FOR THE STUDY:

Mental Health Seeking Behaviours in Rural Communities: Insights from the Bushbuckridge Mkhuhlu Community

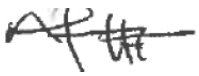
Reference is made to the above heading.

The Chairperson, on behalf of the Faculty Research Ethics Committee (Faculty of Economics, Development and Business Sciences), UMP, approved the ethical clearance of the above-mentioned study.

Any alteration/s to the approved research protocol, i.e., Title of the Project, Location of the Study, Research Approach, and Methods, must be reviewed and approved through the amendment/ modification prior to its implementation.

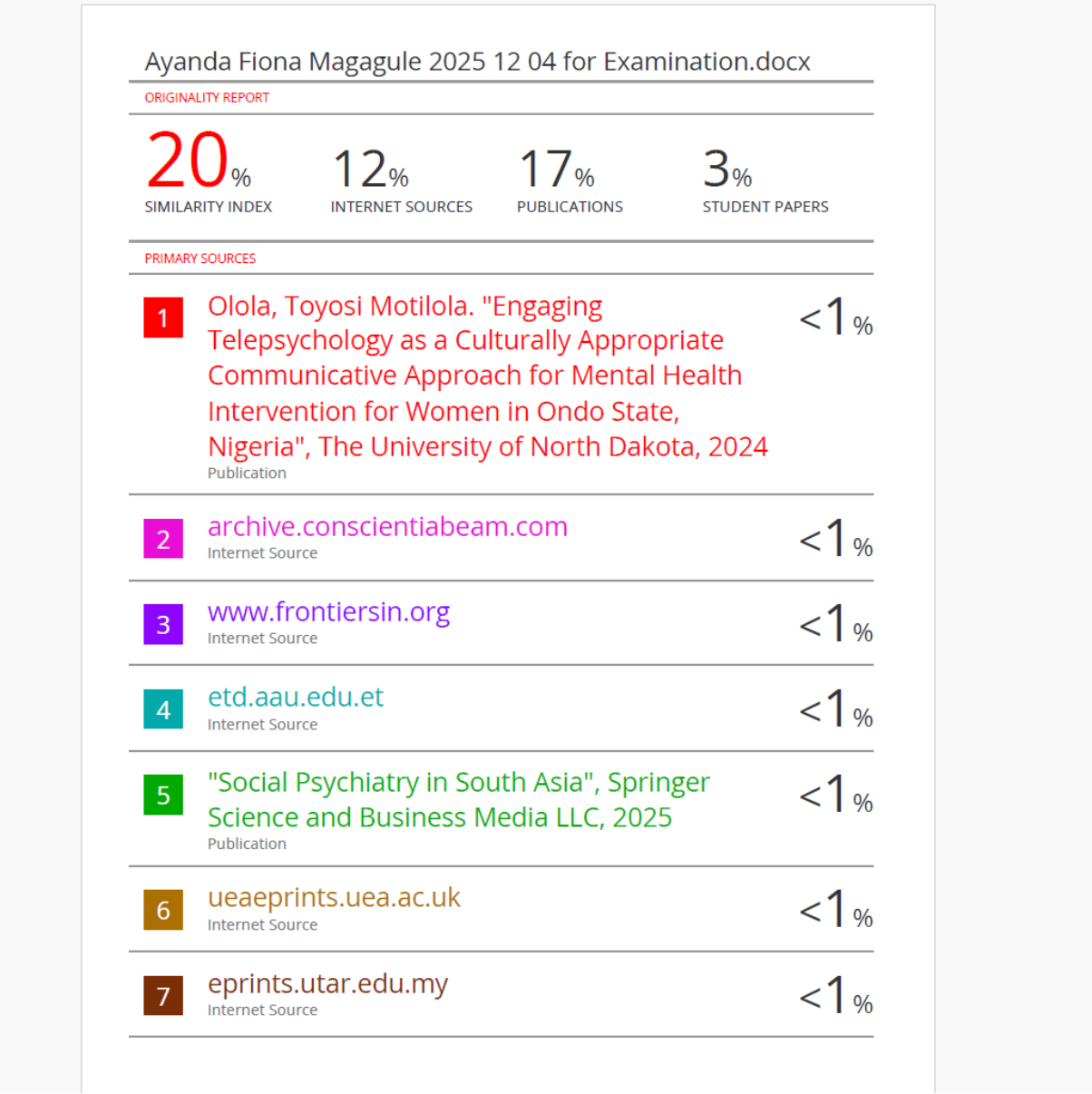
PLEASE NOTE: Research data should be securely stored at the school/division for 5 years.

The Ethical Clearance certificate is valid for 3 years from the date of issue. Thereafter, Recertification must be applied for annually.



Prof. Ogujiuba
Kanayo
Chairperson:
FREC,
Faculty of Economics, Development and Business Sciences, University of Mpumalanga

APPENDIX F: SIMILARITY INDEX



Ayanda Fiona Magagule 2025 12 04 for Examination.docx

ORIGINALITY REPORT

20%	12%	17%	3%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Olola, Toyosi Motilola. "Engaging Telepsychology as a Culturally Appropriate Communicative Approach for Mental Health Intervention for Women in Ondo State, Nigeria", The University of North Dakota, 2024 Publication	<1%
2	archive.conscientiabeam.com Internet Source	<1%
3	www.frontiersin.org Internet Source	<1%
4	etd.aau.edu.et Internet Source	<1%
5	"Social Psychiatry in South Asia", Springer Science and Business Media LLC, 2025 Publication	<1%
6	ueaeprints.uea.ac.uk Internet Source	<1%
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